2018-19
KPI AND IMPROVEMENT MEASURE
DATA SUPPLEMENT
(AUGUST 2018 REVISION)
Version 1.1
August 2018

Contact:
Further information regarding this document can be obtained from the System Information and Analytics Branch.

- For queries relating to the documentation, including clarification of definitions:
  acand@doh.health.nsw.gov.au

- For queries relating to how the Key Performance Indicators and Improvement Measures are calculated and reported:
  agold@doh.health.nsw.gov.au
<table>
<thead>
<tr>
<th>Date</th>
<th>ID</th>
<th>Measure</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>04/12/2017</td>
<td>PH-011B</td>
<td>Get Healthy Information and Coaching Service – Health Professional Referrals (% change)</td>
<td>Updated dates in numerator &amp; denominator</td>
</tr>
<tr>
<td>04/12/2017</td>
<td>PH-008B</td>
<td>Healthy Children Initiative – Children’s Healthy Eating and Physical Activity Program – Trained primary schools achieving agreed proportion of Live Life Well @ School program practices (%)</td>
<td>Revised targets, updated date in indicator definition</td>
</tr>
<tr>
<td>04/12/2017</td>
<td>PH-008A</td>
<td>Healthy Children Initiative - Children’s Healthy Eating and Physical Activity Program: Early Childhood Services – Sites achieving agreed proportion of Munch and Move Program practices (%)</td>
<td>Revised targets, updated date in indicator definition</td>
</tr>
<tr>
<td>04/12/2017</td>
<td>PH-013A,</td>
<td>Smoking During Pregnancy - At any time (%)</td>
<td>Minor revision to title</td>
</tr>
<tr>
<td></td>
<td>SPH007</td>
<td></td>
<td></td>
</tr>
<tr>
<td>04/12/2017</td>
<td>DPH_1201</td>
<td>Pregnant Women Quitting Smoking - By second half of pregnancy (%)</td>
<td>Minor revision to title</td>
</tr>
<tr>
<td>04/12/2017</td>
<td>PH-010A</td>
<td>Human Immunodeficiency Virus (HIV) Testing - Within publicly-funded HIV and sexual health services (% change)</td>
<td>KPI retired – replaced by KS1410</td>
</tr>
<tr>
<td>04/12/2017</td>
<td>KS1410</td>
<td>Human Immunodeficiency Virus (HIV) Testing - Within publicly-funded HIV and sexual health services (number)</td>
<td>New KPI for 2018-19, replacing PH-010A</td>
</tr>
<tr>
<td>04/12/2017</td>
<td>MS1401,</td>
<td>Hepatitis C treatment dispensed - LHD residents who have been dispensed hepatitis C treatment by prescriber type (%)</td>
<td>Re-categorised from a KPI to an Improvement Measure</td>
</tr>
<tr>
<td></td>
<td>MS1402</td>
<td></td>
<td></td>
</tr>
<tr>
<td>04/12/2017</td>
<td>PH-014C</td>
<td>Hepatitis C Antiviral Treatment Initiation – Direct acting - by LHD residents (number)</td>
<td>Re-categorised from an Improvement Measure to a KPI.</td>
</tr>
<tr>
<td>04/12/2017</td>
<td>KS2101</td>
<td>Fall-Related Injuries in Hospital (Rate)</td>
<td>Minor revision to title</td>
</tr>
<tr>
<td>04/12/2017</td>
<td>KQS205</td>
<td>Hospital Acquired Pressure Injuries (Rate)</td>
<td>Minor revision to title, updated ICD10AM edition in numerator</td>
</tr>
<tr>
<td>04/12/2017</td>
<td>MS2104</td>
<td>Surgical Site Infections - Rate (per 1,000 surgical procedural DRG separations)</td>
<td>Minor revision to title</td>
</tr>
<tr>
<td>04/12/2017</td>
<td>SSQ117</td>
<td>Patient Experience Following Treatment - Overall survey rating of care received - Adult Admitted - good or very good (%)</td>
<td>Updated denominator source, minor revision to title</td>
</tr>
<tr>
<td>04/12/2017</td>
<td>MS2305</td>
<td>Equitable Experience of Health Care: Overall Patient Experience Survey rating of care received for adult admitted patients: Disaggregated (%)</td>
<td>Updated denominator source, minor revision to title</td>
</tr>
<tr>
<td>04/12/2017</td>
<td>KSA205</td>
<td>Electronic Discharge Summaries Completed: (%)</td>
<td>Added inclusion to make the scope of indicator clearer.</td>
</tr>
<tr>
<td>Date</td>
<td>ID</td>
<td>Measure</td>
<td>Change</td>
</tr>
<tr>
<td>------------</td>
<td>-------------</td>
<td>-------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------</td>
</tr>
<tr>
<td>04/12/2017</td>
<td>SSQ106; SSQ107</td>
<td>Unplanned Hospital Readmissions: all unplanned admissions within 28 days of separation (%)</td>
<td>Added additional comments to give greater clarity around patients who die and the aboriginal persons disaggregation.</td>
</tr>
<tr>
<td>04/12/2017</td>
<td>KQS206</td>
<td>Mental Health: Acute Seclusion Occurrence - Episodes (per 1,000 bed days)</td>
<td>Revised numerator and denominator source, minor revision to title</td>
</tr>
<tr>
<td>04/12/2017</td>
<td>KSA202</td>
<td>Mental Health Access Block – Emergency department to inpatient unit (Number)</td>
<td>Revised title to reflect what the indicator is meant to identify.</td>
</tr>
<tr>
<td>04/12/2017</td>
<td>SSQ123</td>
<td>Mental Health: Acute Seclusion Duration – Average (Hours)</td>
<td>Revised numerator and denominator source, minor revision to title</td>
</tr>
<tr>
<td>04/12/2017</td>
<td>SSQ127</td>
<td>Mental Health: Involuntary Patients Absconded – From an inpatient mental health unit – Incident Types 1 and 2 (Number)</td>
<td>Minor revision to title</td>
</tr>
<tr>
<td>04/12/2017</td>
<td>SSQ122</td>
<td>Mental Health Consumer Experience Measure (YES) - Completion rate (%)</td>
<td>Minor revision to title</td>
</tr>
<tr>
<td>04/12/2017</td>
<td>KMH202</td>
<td>Mental Health Peer Workforce Employment – Full time equivalents (FTEs) (Number)</td>
<td>Minor revision to title</td>
</tr>
<tr>
<td>04/12/2017</td>
<td>KS3101</td>
<td>Aged Care Assessment Timeliness - Average time from ACAT referral to delegation - Admitted patients (Days)</td>
<td>Updated targets, minor revision to title</td>
</tr>
<tr>
<td>04/12/2017</td>
<td>KF-007</td>
<td>Out of Home Care Health Pathway Program - Children and young people completing a primary health assessment (%)</td>
<td>Updated data sources, minor revision to title</td>
</tr>
<tr>
<td>04/12/2017</td>
<td>KF-009</td>
<td>Sexual Assault Service Access – High priority referrals receiving an initial psychosocial assessment (%)</td>
<td>Minor revision to title</td>
</tr>
<tr>
<td>04/12/2017</td>
<td>SPC110</td>
<td>Staff Engagement: People Matter Survey Engagement Index - Variation from previous year (%)</td>
<td>Minor revision to title</td>
</tr>
<tr>
<td>04/12/2017</td>
<td>KPC201</td>
<td>Staff Performance Reviews - Within the last 12 months (%)</td>
<td>Minor revision to title</td>
</tr>
<tr>
<td>04/12/2017</td>
<td>SPC108</td>
<td>Aboriginal Workforce Participation: Aboriginal Workforce as a proportion of total workforce (%)</td>
<td>Indicator revised to include breakdown on occupations. Revised target. Provided details of salary bands</td>
</tr>
<tr>
<td>04/12/2017</td>
<td>KS4401</td>
<td>Compensable Workplace Injury - Claims (Number)</td>
<td>Updated numerator availability, minor revision to title</td>
</tr>
<tr>
<td>04/12/2017</td>
<td>DSR_7401</td>
<td>Asset Maintenance Expenditure – as a proportion of asset replacement value (%)</td>
<td>Re-categorised from an Improvement Measure to a KPI, title revised, established targets.</td>
</tr>
<tr>
<td>04/12/2017</td>
<td>AI-001</td>
<td>Purchased Activity Volumes – Variance: Acute Admitted – NWAU (%)</td>
<td>Updated reporting years and NWAU version, removed obsolete mental health exclusions, minor revision to title</td>
</tr>
<tr>
<td>04/12/2017</td>
<td>ED-001</td>
<td>Purchased Activity Volumes – Variance: Emergency Department - NWAU (%)</td>
<td>Updated reporting years and NWAU version, minor revision to title</td>
</tr>
<tr>
<td>Date</td>
<td>ID</td>
<td>Measure</td>
<td>Change</td>
</tr>
<tr>
<td>------------</td>
<td>--------------</td>
<td>-------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>04/12/2017</td>
<td>NA-001</td>
<td>Purchased Activity Volumes – Variance: Non-admitted Patient - NWAU (%)</td>
<td>Updated reporting years and NWAU version, minor revision to title</td>
</tr>
<tr>
<td>04/12/2017</td>
<td>SA-001</td>
<td>Purchased Activity Volumes – Variance: Sub and non-acute admitted - NWAU (%)</td>
<td>Updated reporting years and NWAU version, removed obsolete mental health exclusions, minor revision to title</td>
</tr>
<tr>
<td>04/12/2017</td>
<td>KS8101</td>
<td>Purchased Activity Volumes – Variance: Mental Health Admitted - NWAU (%)</td>
<td>Updated reporting years and NWAU version, removed obsolete ED only admission exclusion, minor revision to title</td>
</tr>
<tr>
<td>04/12/2017</td>
<td>MHDA-005</td>
<td>Purchased Activity Volumes – Variance: Mental Health Non-Admitted - NWAU (%)</td>
<td>Updated reporting years and NWAU version, minor revision to title</td>
</tr>
<tr>
<td>04/12/2017</td>
<td>PD-001</td>
<td>Purchased Activity Volumes – Variance: Public Dental Clinical Service - DWAU (%)</td>
<td>Minor revision to title</td>
</tr>
<tr>
<td>04/12/2017</td>
<td>KS8102</td>
<td>Cost Ratio Performance (%)</td>
<td>Minor revision to title; updated numerator and denominator availability, frequency and time lag to reporting, and comments.</td>
</tr>
<tr>
<td>21/12/2017</td>
<td>KS3201</td>
<td>Mental Health: Pathways to Community Living – People transitioned to the community (Number)</td>
<td>Revised targets</td>
</tr>
<tr>
<td>21/12/2017</td>
<td>KS5301</td>
<td>Ethics Application Approvals - By the Human Research Ethics Committee within 60 calendar days - Involving more than low risk to participants (%)</td>
<td>KPI retired – replaced by KS5303</td>
</tr>
<tr>
<td>21/12/2017</td>
<td>KS5303</td>
<td>Ethics Application Approvals - By the Human Research Ethics Committee within 45 calendar days - Involving more than low risk to participants (%)</td>
<td>New KPI for 2018-19, replacing KS5301</td>
</tr>
<tr>
<td>21/12/2017</td>
<td>KS5302</td>
<td>Research Governance Application Authorisations – Site specific Within 30 calendar days - Involving more than low risk to participants (%)</td>
<td>KPI retired – replaced by KS5304</td>
</tr>
<tr>
<td>21/12/2017</td>
<td>KS5304</td>
<td>Research Governance Application Authorisations – Site specific Within 25 calendar days - Involving more than low risk to participants (%)</td>
<td>New KPI for 2018-19, replacing KS5302</td>
</tr>
<tr>
<td>02/02/2018</td>
<td>KS5304</td>
<td>Research Governance Application Authorisations – Site specific Within 15 calendar days - Involving more than low risk to participants (%)</td>
<td>Corrected KPI from 25 days to 15 days, in line with the Service Agreement.</td>
</tr>
<tr>
<td>02/02/2018</td>
<td>KF-006A; KF-006B</td>
<td>Sustaining NSW Families Programs</td>
<td>Missed in original draft Data Supplement; Updated reporting years.</td>
</tr>
<tr>
<td>02/02/2018</td>
<td>PH-014C</td>
<td>Hepatitis C Antiviral Treatment Initiation – Direct acting - by LHD residents (number)</td>
<td>Corrected misspelled reference from HNWLDH to HNELHD. Updated definition to include financial year reference.</td>
</tr>
<tr>
<td>Date</td>
<td>Code</td>
<td>Description</td>
<td>Notes/Changes</td>
</tr>
<tr>
<td>------------</td>
<td>---------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>02/02/2018</td>
<td>KS1410</td>
<td>Human Immunodeficiency Virus (HIV) Testing - Within publicly-funded HIV and sexual health services (number)</td>
<td>Corrected Not performing and Under performing targets.</td>
</tr>
<tr>
<td>05/02/2018</td>
<td>PH-008A</td>
<td>Healthy Children Initiative - Children’s Healthy Eating and Physical Activity Program: Early Childhood Services – Sites achieving agreed proportion of Munch and Move Program practices (%)</td>
<td>Corrected targets to align with the Service Agreement.</td>
</tr>
<tr>
<td>05/02/2018</td>
<td>PH-008B</td>
<td>Healthy Children Initiative – Children’s Healthy Eating and Physical Activity Program – Trained primary schools achieving agreed proportion of Live Life Well @ School program practices (%)</td>
<td>Corrected targets to align with the Service Agreement.</td>
</tr>
<tr>
<td>05/02/2018</td>
<td>SSQ117</td>
<td>Patient Experience Following Treatment - Overall survey rating of care received - Adult Admitted - good or very good (%)</td>
<td>Aligned numerator and denominator sources</td>
</tr>
<tr>
<td>05/02/2018</td>
<td>MS2305</td>
<td>Equitable Experience of Health Care: Overall Patient Experience Survey rating of care received for adult admitted patients: Disaggregated (%)</td>
<td>Aligned numerator and denominator sources</td>
</tr>
<tr>
<td>05/02/2018</td>
<td>KS2101</td>
<td>Fall-Related Injuries in Hospital (Rate)</td>
<td>Removed incorrect reference to patients aged 70 years and older in denominator definition.</td>
</tr>
<tr>
<td>07/02/2018</td>
<td>SPC110</td>
<td>Staff Engagement: People Matter Survey Engagement Index - Variation from previous year (%)</td>
<td>Updated Desired Outcome</td>
</tr>
<tr>
<td>27/03/2018</td>
<td>PH-011B</td>
<td>Get Healthy Information and Coaching Service – Health Professional Referrals (Number)</td>
<td>Updated measure type (% to Number), removed denominator, revised targets</td>
</tr>
<tr>
<td>27/03/2018</td>
<td>PH-008B</td>
<td>Healthy Children Initiative – Children’s Healthy Eating and Physical Activity Program – Primary schools achieving agreed proportion of Live Life Well @ School program practices (%)</td>
<td>Revised title, target, and numerator definition (removed term “Trained”), revised data collection source, primary data source. Added notes in Comments and Usable data available from.</td>
</tr>
<tr>
<td>27/03/2018</td>
<td>PH-008A</td>
<td>Healthy Children Initiative - Children’s Healthy Eating and Physical Activity Program: Early Childhood Services – Sites achieving agreed proportion of Munch and Move Program practices (%)</td>
<td>Revised numerator definition (removed term “Trained”), revised data collection source, primary data source. Added comment.</td>
</tr>
<tr>
<td>27/03/2018</td>
<td>DPH_1201</td>
<td>Pregnant Women Quitting Smoking - By second half of pregnancy (%)</td>
<td>Updated Frequency of Reporting; updated targets.</td>
</tr>
<tr>
<td>27/03/2018</td>
<td>KS1410</td>
<td>Human Immunodeficiency Virus (HIV) Testing - Within publicly-funded HIV and sexual health services (number)</td>
<td>Updated indicator definition and numerator definition. Updated targets, updated inclusions, updated Frequency of Reporting.</td>
</tr>
<tr>
<td>27/03/2018</td>
<td>PH-014C</td>
<td>Hepatitis C Antiviral Treatment Initiation – Direct acting - by LHD residents (number)</td>
<td>Removed years from indicator definition and numerator definition, revised Contact – Data.</td>
</tr>
<tr>
<td>Date</td>
<td>Code</td>
<td>Description</td>
<td>Changes</td>
</tr>
<tr>
<td>------------</td>
<td>---------</td>
<td>-----------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>04/04/2018</td>
<td>SA-001</td>
<td>Purchased Activity Volumes – Variance: Sub and non-acute admitted - NWAU (%)</td>
<td>Updated indicator definition, revised numerator to exclude incomplete episodes, updated exclusions.</td>
</tr>
<tr>
<td>26/04/2018</td>
<td>MS4104</td>
<td>Additional Frontline Staff (from a 2015 Baseline) - Hospital Support (Number)</td>
<td>Revised definition and indicator with change from Hospital Support Staff to Clinical Support Officers. Updated Primary Point of Collection.</td>
</tr>
<tr>
<td>26/04/2018</td>
<td>SPC105</td>
<td>Leave Liability: Reduction in the total number of staff who have accrued leave balances of more than 30 days (Number)</td>
<td>Revised title to reflect the indicator definition; revised numerator source and availability; updated comments section.</td>
</tr>
<tr>
<td>26/04/2018</td>
<td>SPC109</td>
<td>Public Service Commission (PSC) People Matter Employee Survey Response Rate (%)</td>
<td>Revised title; major revision to indicator definition, numerator and denominator, denominator source and availability. Updated scope, outcome, target, context, useable data and frequency of reporting.</td>
</tr>
<tr>
<td>26/04/2018</td>
<td>DWPDS_4202</td>
<td>Workplace Diversity Improvement: Women in Senior Executive Roles (%)</td>
<td>Minor update to inclusions.</td>
</tr>
<tr>
<td>26/04/2018</td>
<td>SPC102, SPC103</td>
<td>Premium Staff Usage: average paid hours per FTE</td>
<td>Minor amendment to indicator definition, numerator and denominator, context.</td>
</tr>
<tr>
<td>26/04/2018</td>
<td>PI-03</td>
<td>Hospital in the home: Admitted Activity (%)</td>
<td>Updated indicator definition, revised goal and context</td>
</tr>
<tr>
<td>26/04/2018</td>
<td>MS3101</td>
<td>Integrated Care Program – Patients Enrolled (Number)</td>
<td>Updated data collection source, primary data source and numerator source</td>
</tr>
<tr>
<td>26/04/2018</td>
<td>KIC201</td>
<td>Chronic Disease Management Plan - Transition performance (%)</td>
<td>RETIRED for 2018-19</td>
</tr>
<tr>
<td>27/04/2018</td>
<td>SSA132</td>
<td>Home Based Dialysis – Proportion of renal dialysis service events that are home based (%)</td>
<td>Revised data sources, numerator and denominator data sources.</td>
</tr>
<tr>
<td>27/04/2018</td>
<td>MS2505</td>
<td>Acute separations – same day (Number)</td>
<td>Removed newborn care type from the inclusions.</td>
</tr>
<tr>
<td>27/04/2018</td>
<td>MS2504</td>
<td>Acute separations – overnight (Number)</td>
<td>Removed newborn care type from the inclusions.</td>
</tr>
<tr>
<td>27/04/2018</td>
<td>SPH001, SPH003</td>
<td>Children fully immunised at one year of age</td>
<td>Updated targets</td>
</tr>
<tr>
<td>27/04/2018</td>
<td>SPH002, SPH004</td>
<td>Children fully immunised at four years of age</td>
<td>Updated targets</td>
</tr>
<tr>
<td>27/04/2018</td>
<td>PH-006</td>
<td>Human Papillomavirus Vaccination</td>
<td>Minor update to title, revised target</td>
</tr>
<tr>
<td>27/04/2018</td>
<td>DPH_1402</td>
<td>Meningococcal Vaccination - Coverage in Years 10 and 11 for serogroups A, C, W, Y (%)</td>
<td>Major revision of scope and indicator definition</td>
</tr>
<tr>
<td>27/04/2018</td>
<td>KS2410</td>
<td>Aboriginal paediatric patients undergoing otitis media procedures (number)</td>
<td>NEW for 2018-19</td>
</tr>
<tr>
<td>27/04/2018</td>
<td>MS4105</td>
<td>Staff Turnover: FTE leaving in a year per 100 FTE employed (number)</td>
<td>RETIRED for 2018-19</td>
</tr>
<tr>
<td>27/04/2018</td>
<td>DWPDS_4103b</td>
<td>Emergency Medicine Specialists in Rural LHDs (% variance)</td>
<td>RETIRED for 2018-19</td>
</tr>
<tr>
<td>27/04/2018</td>
<td>DWPDS_4103a</td>
<td>Rural General Practitioners in Rural LHDs (% variance)</td>
<td>RETIRED for 2018-19</td>
</tr>
<tr>
<td>Date</td>
<td>Code</td>
<td>Description</td>
<td>Notes</td>
</tr>
<tr>
<td>------------</td>
<td>--------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>27/04/2018</td>
<td>MS4106, MS4107, MS4108</td>
<td>Rural and Regional Medical Workforce Increase (%)</td>
<td>NEW for 2018-19</td>
</tr>
<tr>
<td>27/04/2018</td>
<td>DSR_7302</td>
<td>Deliver Infrastructure: Construction Commenced (%)</td>
<td>Revised indicator definition, numerator and denominator, added exclusions, updated data sources</td>
</tr>
<tr>
<td>27/04/2018</td>
<td>DSR_7303</td>
<td>Deliver Infrastructure: Construction Completed (%)</td>
<td>Revised indicator definition, numerator and denominator, added exclusions, updated data sources</td>
</tr>
<tr>
<td>27/04/2018</td>
<td>PC-001</td>
<td>Access to Aged Care Services: Acute to Aged-Related Care Services - patients seen (number)</td>
<td>RETIRED for 2018-19</td>
</tr>
<tr>
<td>27/04/2018</td>
<td>PC-002</td>
<td>Access to Aged Care Services: Aged Care Services in Emergency Teams (ASET) - patients seen (number)</td>
<td>RETIRED for 2018-19</td>
</tr>
<tr>
<td>27/04/2018</td>
<td>KF-008</td>
<td>New Street Services – New primary clients accepted into the program (Number)</td>
<td>RETIRED for 2018-19</td>
</tr>
<tr>
<td>27/04/2018</td>
<td>KF-0081</td>
<td>New Street Services – Primary clients completing treatment (%)</td>
<td>NEW for 2018-19</td>
</tr>
<tr>
<td>27/04/2018</td>
<td>SSA106</td>
<td>Patients with Total time in ED &lt;= 4hrs: Mental Health (%)</td>
<td>Updated reference to SNOMED CT Reference Set map, updated national definition reference link</td>
</tr>
<tr>
<td>27/04/2018</td>
<td>MS3203</td>
<td>Mental Health Access Block: Mental Health Presentations staying in ED &gt; 12 hours (number)</td>
<td>Minor revision to title, updated reference to SNOMED CT Reference Set map</td>
</tr>
<tr>
<td>30/04/2018</td>
<td>MS7401, MS7402</td>
<td>Asbestos Documentation Upload to AFM Online</td>
<td>NEW for 2018-19</td>
</tr>
<tr>
<td>30/04/2018</td>
<td>MS7403</td>
<td>AFM Online – Data Description Completion (%)</td>
<td>NEW for 2018-19</td>
</tr>
<tr>
<td>30/04/2018</td>
<td>MS7404</td>
<td>AFM Online – GBA Survey Measure (%)</td>
<td>NEW for 2018-19</td>
</tr>
<tr>
<td>30/04/2018</td>
<td>MS7405</td>
<td>AFM Online – Building Age Recorded (%)</td>
<td>NEW for 2018-19</td>
</tr>
<tr>
<td>01/05/2018</td>
<td>SSA111</td>
<td>Elective Surgery: Activity Compared to Previous Year (Number)</td>
<td>Revised Representational Form and Layout</td>
</tr>
<tr>
<td>01/05/2018</td>
<td>PH-008C, PH-008D</td>
<td>Healthy Children Initiative - Targeted Family Healthy Eating and Physical Activity Program (Go4Fun)</td>
<td>Updated data sources, targets</td>
</tr>
<tr>
<td>01/05/2018</td>
<td>MS1102</td>
<td>Childhood Obesity: Children with height/length and weight recorded (%)</td>
<td>Clarified age references to aged 17 years throughout the measure; updated target.</td>
</tr>
<tr>
<td>03/05/2018</td>
<td>MS1401, MS1402</td>
<td>Hepatitis C treatment dispensed - LHD residents who have been dispensed hepatitis C treatment by prescriber type (%)</td>
<td>RETIRED for 2018-19; replaced by MS1403</td>
</tr>
<tr>
<td>03/05/2018</td>
<td>MS1403</td>
<td>Hepatitis C Treatment Initiated by a GP (%)</td>
<td>NEW for 2018-19. Replaces MS1401 and MS1402</td>
</tr>
<tr>
<td>03/05/2018</td>
<td>MS1303</td>
<td>Pregnant women engaged in sustained home visiting who use drugs (%)</td>
<td>RETIRED for 2018-19; replaced by MS1304</td>
</tr>
<tr>
<td>03/05/2018</td>
<td>MS1304</td>
<td>Pregnant women who use substances engaged in treatment and home visiting support (Number)</td>
<td>NEW for 2018-19. Replaces MS1303</td>
</tr>
<tr>
<td>Date</td>
<td>Code</td>
<td>Description</td>
<td>Notes</td>
</tr>
<tr>
<td>------------</td>
<td>----------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>------------------------------------</td>
</tr>
<tr>
<td>03/05/2018</td>
<td>MS1103</td>
<td>Healthy Children Initiative - Children’s Healthy Eating and Physical Activity Program (Munch &amp; Move) - Family Day Care Service Providers (sites) achieving agreed proportion of Family Day Care practices (%)</td>
<td>NEW for 2018-19</td>
</tr>
<tr>
<td>03/05/2018</td>
<td>PH-013B, PH-013C</td>
<td>Quit for New Life Program</td>
<td>RETIRED for 2018-19</td>
</tr>
<tr>
<td>03/05/2018</td>
<td>DPH_1301b</td>
<td>Drug and Alcohol Opioid Treatment Program – Unique public patients prescribed buprenorphine or buprenorphine-naloxone (%)</td>
<td>Minor revision to title</td>
</tr>
<tr>
<td>03/05/2018</td>
<td>SSQ120</td>
<td>Hospital Acquired Venous Thromboembolism (rate per 1000 separations)</td>
<td>Major revision to improvement measure (definition, numerator, denominator, inclusions and exclusions), more closely aligning with the national HAC indicator</td>
</tr>
<tr>
<td>03/05/2018</td>
<td>KQS202</td>
<td>Incorrect Procedures: Operating Theatre - Resulting in Death or Major Permanent Loss of Function (Number)</td>
<td>Revised Time lag to available data and usable data available from</td>
</tr>
<tr>
<td>03/05/2018</td>
<td>DSR_7401</td>
<td>Asset Maintenance Expenditure – as a proportion of asset replacement value (%)</td>
<td>Removed Justice Health &amp; Forensic Mental Health Network from Inclusions</td>
</tr>
<tr>
<td>03/05/2018</td>
<td>MS3204</td>
<td>Mental Health Line Call Abandonment (%)</td>
<td>NEW for 2018-19</td>
</tr>
<tr>
<td>03/05/2018</td>
<td>MS2105</td>
<td>National Sentinel Events</td>
<td>Revised National Sentinel Events list, updated data sources</td>
</tr>
<tr>
<td>03/05/2018</td>
<td>KF-004</td>
<td>Child Protection Counselling Services - new family referrals allocated to a counsellor (Number)</td>
<td>Updated data source and availability</td>
</tr>
<tr>
<td>03/05/2018</td>
<td>MS3601</td>
<td>JIRT Health Attendances – Clients referred to Violence, Abuse and Neglect health services who attend the service within 6 weeks of referral (%)</td>
<td>NEW for 2018-19</td>
</tr>
<tr>
<td>03/05/2018</td>
<td>DSR_7309</td>
<td>Deliver Infrastructure: Business Cases Completed (%)</td>
<td>NEW for 2018-19</td>
</tr>
<tr>
<td>04/05/2018</td>
<td>NA-001</td>
<td>Purchased Activity Volumes – Variance: Non-admitted Patient - NWAU (%)</td>
<td>Replaced references to Tier 2 clinics with Establishment Type.</td>
</tr>
<tr>
<td>07/05/2018</td>
<td>KS3202</td>
<td>Mental Health Consumer Experience: Mental Health consumers with a score of Very Good or Excellent (%)</td>
<td>NEW for 2018-19</td>
</tr>
<tr>
<td>09/05/2018</td>
<td>SSQ122</td>
<td>Mental Health Consumer Experience Measure (YES) - Completion rate (%)</td>
<td>Reclassified from a KPI to an Improvement Measure.</td>
</tr>
<tr>
<td>09/05/2018</td>
<td>KQS206</td>
<td>Mental Health: Acute Seclusion Occurrence - Episodes (per 1,000 bed days)</td>
<td>Revised targets</td>
</tr>
<tr>
<td>09/05/2018</td>
<td>KS3201</td>
<td>Mental Health: Pathways to Community Living – People transitioned to the community (Number)</td>
<td>Revised targets</td>
</tr>
<tr>
<td>Date</td>
<td>Code</td>
<td>Description</td>
<td>Notes</td>
</tr>
<tr>
<td>----------</td>
<td>------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>10/05/18</td>
<td>KSA204</td>
<td>Non-Urgent Patients waiting more than 365 days for an initial specialist</td>
<td>RETIRED for 2018-19; replaced by MS2406</td>
</tr>
<tr>
<td></td>
<td></td>
<td>outpatient service appointment (number)</td>
<td></td>
</tr>
<tr>
<td>10/05/18</td>
<td>MS2406</td>
<td>Outpatient On Time Performance: Patients waiting more than 365 days for an</td>
<td>NEW for 2018-19. Replaces KSA204</td>
</tr>
<tr>
<td></td>
<td></td>
<td>initial outpatient service appointment (Number)</td>
<td></td>
</tr>
<tr>
<td>10/05/18</td>
<td>MS8102</td>
<td>Variation Against Reported Expenditure: Small Rural Hospitals &amp; Specialist</td>
<td>Updated source, availability and frequency. Updated inclusions.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hospitals (%)</td>
<td></td>
</tr>
<tr>
<td>10/05/18</td>
<td>MS8101</td>
<td>Total Activity Delivered (NWAU)</td>
<td>Updated numerator definition, deleted calculation details in notes</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>section, updated data contact and representation size.</td>
</tr>
<tr>
<td>11/05/18</td>
<td>MS3102</td>
<td>Electronic Discharge Summary Performance: Created within 48 hours of patient</td>
<td>Minor revision to title</td>
</tr>
<tr>
<td></td>
<td></td>
<td>discharge from hospital (%)</td>
<td></td>
</tr>
<tr>
<td>11/05/18</td>
<td>SFA105</td>
<td>Coding Timeliness: Uncoded Acute Separations (%)</td>
<td>Revised inclusions and exclusions, minor revision to title</td>
</tr>
<tr>
<td>11/05/18</td>
<td>MS2213</td>
<td>Telehealth Service Access: Non-admitted services provided through telehealth</td>
<td>MAJOR REVISION - revised</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(%)</td>
<td>inclusions for numerator.</td>
</tr>
<tr>
<td>14/05/18</td>
<td>KS1410</td>
<td>Human Immunodeficiency Virus (HIV) Testing - Within publicly-funded HIV and</td>
<td>Revised KPI to be a % variance measure, with updated denominator</td>
</tr>
<tr>
<td></td>
<td></td>
<td>sexual health services: Variance (%)</td>
<td></td>
</tr>
<tr>
<td>14/05/18</td>
<td>PH-014C</td>
<td>LHD residents initiating Hepatitis C direct acting antiviral treatment:</td>
<td>Revised KPI to be a % variance measure, with updated denominator</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Variance (%)</td>
<td></td>
</tr>
<tr>
<td>14/05/18</td>
<td>PH-011B</td>
<td>Get Healthy Information and Coaching Service – Health Professional</td>
<td>Revised KPI to be a % variance measure, with updated denominator</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Referrals: Variation (%)</td>
<td></td>
</tr>
<tr>
<td>14/05/18</td>
<td>DSR_7401</td>
<td>Asset Maintenance Expenditure – as a proportion of asset replacement value</td>
<td>Provided consistent target</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(%)</td>
<td></td>
</tr>
<tr>
<td>14/05/18</td>
<td>KF-006A, KF-</td>
<td>Sustaining NSW Families Programs:</td>
<td>RETIRED for 2018-19; replaced by KF-0061 and KF-0062</td>
</tr>
<tr>
<td></td>
<td>006B</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14/05/18</td>
<td>KF-0061</td>
<td>Sustaining NSW Families Programs: Families completing the program when</td>
<td>NEW for 2018-19; replaces KF-006A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>child reached 2 years of age (%)</td>
<td></td>
</tr>
<tr>
<td>14/05/18</td>
<td>KF-0062</td>
<td>Sustaining NSW Families Programs: Families enrolled and continuing in the</td>
<td>NEW for 2018-19; replaces KF-006B</td>
</tr>
<tr>
<td></td>
<td></td>
<td>program (%)</td>
<td></td>
</tr>
<tr>
<td>15/05/18</td>
<td>MS2405</td>
<td>One-Year Survival after Surgery for Colon or Rectal Cancer (%)</td>
<td>Minor revision to title, updated inclusion ICD codes, updated</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>exclusions, minor updates to indicator definition, numerator and</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>denominator, context, goal and scope.</td>
</tr>
<tr>
<td>15/05/18</td>
<td>MS2404</td>
<td>One-Year Survival after Surgery for Lung Cancer (%)</td>
<td>Minor revision to title, updated exclusions, minor updates to indicator</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>definition, numerator and denominator, inclusions, context, goal</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>and scope.</td>
</tr>
<tr>
<td>15/05/18</td>
<td>MS2407</td>
<td>Oesophageal Cancer Resection Caseload Threshold (with Active MDT) (%)</td>
<td>NEW for 2018-19</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date</td>
<td>Code</td>
<td>Description</td>
<td>Notes</td>
</tr>
<tr>
<td>------------</td>
<td>----------</td>
<td>----------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>15/05/2018</td>
<td>MS2408</td>
<td>Pancreatic Cancer Resection Caseload Threshold (with Active MDT) (%)</td>
<td>NEW for 2018-19</td>
</tr>
<tr>
<td>17/05/2018</td>
<td>KF-009</td>
<td>Sexual Assault Service Initial Assessment – Referrals for victims of sexual assault receiving an initial psychosocial assessment (%)</td>
<td>Revision to title for greater clarification, update to indicator definition, numerator and denominator to align with title. Scope, Frequency of reporting, and Business Owners updated.</td>
</tr>
<tr>
<td>18/05/2018</td>
<td>KF-005</td>
<td>Domestic Violence Routine Screening – Routine Screens conducted (%)</td>
<td>Revision to title for greater clarification, revised data sources, exclusions.</td>
</tr>
<tr>
<td>21/05/2018</td>
<td>KS2101</td>
<td>Fall-Related Injuries in Hospital – resulting in fracture or intracranial injury (Rate per 1,000 bed days)</td>
<td>Major update of indicator, aligning computation to the national HAC indicator. Updated indicator definition and numerator.</td>
</tr>
<tr>
<td>21/05/2018</td>
<td>KQS205</td>
<td>Hospital Acquired Pressure Injuries (Rate)</td>
<td>Major update of indicator, aligning computation to the national HAC indicator. Changed from rate per 1,000 separations to rate per 1,000 bed days. Updated indicator definition and numerator, revised denominator, inclusions and exclusions.</td>
</tr>
<tr>
<td>21/05/2018</td>
<td>MS2104</td>
<td>Surgical Site Infections - Rate (per 1,000 surgical procedural DRG separations)</td>
<td>Recategorised as an Improvement Measure.</td>
</tr>
<tr>
<td>21/05/2018</td>
<td>KS2110</td>
<td>Healthcare Associated Infections (Rate per 1,000 bed days)</td>
<td>NEW KPI for 2018-19</td>
</tr>
<tr>
<td>21/05/2018</td>
<td>SSQ120</td>
<td>Hospital Acquired Venous Thromboembolism (Rate per 1,000 bed days)</td>
<td>Recategorised as a KPI. Major update of indicator, aligning computation to the national HAC indicator. Changed from rate per 1,000 separations to rate per 1,000 bed days. Updated indicator definition and numerator, revised denominator, inclusions and exclusions.</td>
</tr>
<tr>
<td>21/05/2018</td>
<td>KS2111</td>
<td>Hospital Acquired Medication Complications (Rate per 1,000 bed days)</td>
<td>NEW KPI for 2018-19</td>
</tr>
<tr>
<td>21/05/2018</td>
<td>KS2112</td>
<td>Surgical Complications Requiring Unplanned Return to Theatre (Rate per 1,000 bed days)</td>
<td>NEW KPI for 2018-19</td>
</tr>
<tr>
<td>21/05/2018</td>
<td>MS2103</td>
<td>3rd or 4th Degree Perineal Lacerations (Rate per 1,000 bed days)</td>
<td>Recategorised as a KPI. Major update of indicator, aligning computation to the national HAC indicator. Changed from rate per 1,000 vaginal delivery separations to rate per 1,000 vaginal delivery bed days. Updated indicator definition and numerator, revised denominator, inclusions and exclusions.</td>
</tr>
<tr>
<td>21/05/2018</td>
<td>KS2113</td>
<td>Hospital Acquired Neonatal Birth Trauma (Rate per 1,000 bed days)</td>
<td>NEW KPI for 2018-19</td>
</tr>
<tr>
<td>21/05/2018</td>
<td>DSQ_2101</td>
<td>Hospital Acquired Complications (rate per 1,000 bed days)</td>
<td>RETIRED for 2018-19</td>
</tr>
<tr>
<td>21/05/2018</td>
<td>MS3401</td>
<td>National Disability Insurance Scheme (NDIS) – Patients with an NDIS Status: (Number)</td>
<td>Revised measure to report Status instead of alerts, revised indicator definition, numerator and denominator</td>
</tr>
</tbody>
</table>

Page 11
<table>
<thead>
<tr>
<th>Date</th>
<th>Code</th>
<th>Description</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>21/05/2018</td>
<td>MS3402</td>
<td>National Disability Insurance Scheme (NDIS) – Inpatients with an NDIS Related Wait recorded (Number)</td>
<td>Revised measure to report related wait instead of discharge delay, revised indicator definition, numerator and denominator, scope and outcome.</td>
</tr>
<tr>
<td>22/05/2018</td>
<td>AMB-001</td>
<td>STEMI Pre Hospital Management (%)</td>
<td>NEW for 2018-19 (NSW Ambulance only)</td>
</tr>
<tr>
<td>22/05/2018</td>
<td>AMB-002</td>
<td>Major Trauma Management (%)</td>
<td>NEW for 2018-19 (NSW Ambulance only)</td>
</tr>
<tr>
<td>22/05/2018</td>
<td>AMB-003</td>
<td>Stroke Fast Positive Pre Hospital Management (%)</td>
<td>NEW for 2018-19 (NSW Ambulance only)</td>
</tr>
<tr>
<td>22/05/2018</td>
<td>AMB-004</td>
<td>Mental Health Assessments (%)</td>
<td>NEW for 2018-19 (NSW Ambulance only)</td>
</tr>
<tr>
<td>22/05/2018</td>
<td>AMB-005a</td>
<td>Complaints Management Acknowledgement (%)</td>
<td>NEW for 2018-19 (NSW Ambulance only)</td>
</tr>
<tr>
<td>22/05/2018</td>
<td>AMB-005b</td>
<td>Complaints Management Resolution (%)</td>
<td>NEW for 2018-19 (NSW Ambulance only)</td>
</tr>
<tr>
<td>22/05/2018</td>
<td>AMB-006</td>
<td>Deaths Review Performance (%)</td>
<td>NEW for 2018-19 (NSW Ambulance only)</td>
</tr>
<tr>
<td>22/05/2018</td>
<td>MS2120</td>
<td>Clinical Incidents Management Completion (%)</td>
<td>NEW for 2018-19 (NSW Ambulance only)</td>
</tr>
<tr>
<td>22/05/2018</td>
<td>AMB-007</td>
<td>Triple Zero Call Answer Time Performance (%)</td>
<td>NEW for 2018-19 (NSW Ambulance only)</td>
</tr>
<tr>
<td>22/05/2018</td>
<td>AMB-008</td>
<td>Make Ready Time Performance (%)</td>
<td>NEW for 2018-19 (NSW Ambulance only)</td>
</tr>
<tr>
<td>22/05/2018</td>
<td>AMB-009</td>
<td>Median Ambulance Response Time (Minutes)</td>
<td>NEW for 2018-19 (NSW Ambulance only)</td>
</tr>
<tr>
<td>22/05/2018</td>
<td>AMB-010</td>
<td>Frequent User Management Program Monitoring (%)</td>
<td>NEW for 2018-19 (NSW Ambulance only)</td>
</tr>
<tr>
<td>29/05/2018</td>
<td>SSQ117</td>
<td>Patient Experience Following Treatment - Overall survey rating of care received - Adult Admitted - good or very good (%)</td>
<td>RETIRED for 2018-19; replaced by KS2301 and KS2302</td>
</tr>
<tr>
<td>29/05/2018</td>
<td>MS2305</td>
<td>Equitable Experience of Health Care: Overall Patient Experience Survey rating of care received for adult admitted patients: Disaggregated (%)</td>
<td>RETIRED for 2018-19</td>
</tr>
<tr>
<td>29/05/2018</td>
<td>KS2301</td>
<td>Overall Patient Experience Index (Number)</td>
<td>NEW for 2018-19</td>
</tr>
<tr>
<td>29/05/2018</td>
<td>KS2302</td>
<td>Patient Engagement Index (Number)</td>
<td>NEW for 2018-19</td>
</tr>
<tr>
<td>29/05/2018</td>
<td>MS2311</td>
<td>Patient Experience Survey – Respect And Dignity Score (Number)</td>
<td>NEW for 2018-19</td>
</tr>
<tr>
<td>01/07/2018</td>
<td>DWPDS_4202</td>
<td>Workplace Diversity Improvement: Women in Senior Executive Roles (%)</td>
<td>Updated inclusion criteria to reflect 2018-19 figures.</td>
</tr>
<tr>
<td>01/07/2018</td>
<td>KS2101</td>
<td>Fall-Related Injuries in Hospital – resulting in fracture or intracranial injury (Rate per 1,000 bed days)</td>
<td>Updated (i) scope, (ii) numerator and denominator and (iii) inclusions and exclusions to align with targets.</td>
</tr>
<tr>
<td>01/07/2018</td>
<td>KQS205</td>
<td>Hospital Acquired Pressure Injuries (Rate)</td>
<td>Updated (i) scope, (ii) numerator and denominator and (iii) inclusions and exclusions to align with targets.</td>
</tr>
<tr>
<td>01/07/2018</td>
<td>KS2110</td>
<td>Healthcare Associated Infections (Rate per 1,000 bed days)</td>
<td>Updated (i) scope, (ii) numerator and denominator and (iii) inclusions and exclusions to align with targets.</td>
</tr>
<tr>
<td>Date</td>
<td>Code</td>
<td>Description</td>
<td>Update Details</td>
</tr>
<tr>
<td>-----------</td>
<td>---------</td>
<td>-----------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>01/07/2018</td>
<td>SSQ120</td>
<td>Hospital Acquired Venous Thromboembolism (Rate per 1,000 bed days)</td>
<td>Updated (i) scope, (ii) numerator and denominator and (iii) inclusions and exclusions to align with targets. Added additional ICD10AM code in numerator.</td>
</tr>
<tr>
<td>01/07/2018</td>
<td>KS2111</td>
<td>Hospital Acquired Medication Complications (Rate per 1,000 bed days)</td>
<td>Updated (i) scope, (ii) numerator and denominator and (iii) inclusions and exclusions to align with targets. Added additional condition in the first computation algorithm dot point.</td>
</tr>
<tr>
<td>01/07/2018</td>
<td>KS2112</td>
<td>Surgical Complications Requiring Unplanned Return to Theatre (Rate per 1,000 bed days)</td>
<td>Updated (i) scope, (ii) numerator and denominator and (iii) inclusions and exclusions to align with targets. Added additional condition in the first computation algorithm dot point.</td>
</tr>
<tr>
<td>01/07/2018</td>
<td>MS2103</td>
<td>3rd or 4th Degree Perineal Lacerations (Rate per 1,000 bed days)</td>
<td>Corrected error in the indicator definition (replaced reference to “100 Vaginal Deliveries” with “1,000 occupied bed days”). Updated (i) scope, (ii) numerator and denominator and (iii) inclusions and exclusions to align with targets.</td>
</tr>
<tr>
<td>01/07/2018</td>
<td>KS2113</td>
<td>Hospital Acquired Neonatal Birth Trauma (Rate per 1,000 bed days)</td>
<td>Updated (i) scope, (ii) numerator and denominator and (iii) inclusions and exclusions to align with targets. Added ICD10AM codes in computation description and numerator exclusions (1st dot point).</td>
</tr>
<tr>
<td>25/07/2018</td>
<td>KS3202</td>
<td>Mental Health Consumer Experience: Mental Health consumers with a score of Very Good or Excellent (%)</td>
<td>Revised Exclusions</td>
</tr>
<tr>
<td>25/07/2018</td>
<td>DSR_7401</td>
<td>Asset Maintenance Expenditure – as a proportion of asset replacement value (%)</td>
<td>Updated numerator and denominator source</td>
</tr>
<tr>
<td>25/07/2018</td>
<td>SSA106</td>
<td>Patients with Total time in ED &lt;= 4hrs: Mental Health (%)</td>
<td>Provided link to SNOMED CT Reference Set map</td>
</tr>
<tr>
<td>25/07/2018</td>
<td>MS3203</td>
<td>Mental Health Access Block: Mental Health Presentations staying in ED &gt; 12 hours (number)</td>
<td>Provided link to SNOMED CT Reference Set map</td>
</tr>
<tr>
<td>25/07/2018</td>
<td>KSA202</td>
<td>Mental Health Access Block – Emergency department to inpatient unit (Number)</td>
<td>Provided link to SNOMED CT Reference Set map</td>
</tr>
<tr>
<td>27/07/2018</td>
<td>KS1410</td>
<td>Human Immunodeficiency Virus (HIV) Testing - Within publicly-funded HIV and sexual health services: Variance (%)</td>
<td>Corrected indicator definition to reflect the variance percentage based on the numerator and denominator.</td>
</tr>
<tr>
<td>27/07/2018</td>
<td>PH-014C</td>
<td>LHD residents initiating Hepatitis C direct acting antiviral treatment: Variance (%)</td>
<td>Corrected indicator definition to reflect the variance percentage based on the numerator and denominator.</td>
</tr>
<tr>
<td>31/07/2018</td>
<td>KSA201</td>
<td>Emergency Department Extended Stays: Presentations staying in ED &gt; 24 hours (number)</td>
<td>Corrected title to reflect the measure - previously “Access Block – Emergency department to inpatient unit: Presentations staying in ED &gt; 24 hours (number)”</td>
</tr>
<tr>
<td>31/07/2018</td>
<td>MS2401</td>
<td>Emergency Department Extended Stays: Presentations staying in ED &gt; 12 hours (number)</td>
<td>Corrected title to reflect the measure - previously “Access Block – Emergency department to inpatient unit: Presentations staying in ED &gt; 12 hours (number)”</td>
</tr>
<tr>
<td>Date</td>
<td>Code</td>
<td>Description</td>
<td>Notes</td>
</tr>
<tr>
<td>------------</td>
<td>--------</td>
<td>-----------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>31/07/2018</td>
<td>MS3203</td>
<td>Emergency Department Extended Stays: Mental Health Presentations staying in ED &gt; 12 hours (number)</td>
<td>Corrected title to reflect the measure - previously “Mental Health Access Block: Mental Health Presentations staying in ED &gt; 12 hours (number)”</td>
</tr>
<tr>
<td>31/07/2018</td>
<td>KSA202</td>
<td>Emergency Department Extended Stays: Mental Health Presentations staying in ED &gt; 24 hours (number)</td>
<td>Corrected title to reflect the measure - previously “Mental Health Access Block: Mental Health Presentations staying in ED &gt; 24 hours (number)”</td>
</tr>
<tr>
<td>06/08/2018</td>
<td>KFA102</td>
<td>Expenditure Matched to Budget: June projection Variance – General Fund (%)</td>
<td>Reclassified as an Improvement Measure to align with the released Service Agreements.</td>
</tr>
<tr>
<td>06/08/2018</td>
<td>KFA104</td>
<td>Own Source Revenue Matched to Budget: June projection variance – General Fund (%)</td>
<td>Reclassified as an Improvement Measure to align with the released Service Agreements.</td>
</tr>
</tbody>
</table>
## Table of Contents

INTRODUCTION TO KEY PERFORMANCE INDICATOR TARGETS AND IMPROVEMENT MEASURES ................................................................. 23

Summary of Indicators and Targets for 2018-19 Service Agreements ............ 25

Improvement Measures ........................................................................... 29

Premier’s Priorities .................................................................................. 35

State Priorities ......................................................................................... 35

KEY PERFORMANCE INDICATORS FOR 2018-19 .................................... 36

### STRATEGY 1 KPIs: Keep People Healthy ............................................. 37

Get Healthy Information and Coaching Service – Health Professional Referrals:
Variance (%) ............................................................................................. 37

Healthy Children Initiative – Children’s Healthy Eating and Physical Activity Program –
Primary schools achieving agreed proportion of Live Life Well @ School program practices (%). ................................................................. 40

Healthy Children Initiative - Children’s Healthy Eating and Physical Activity Program: Early Childhood Services – Sites achieving agreed proportion of Munch and Move Program practices (%). .................................................................................. 43

Smoking During Pregnancy - At any time: (%) ......................................... 46

Pregnant Women Quitting Smoking - By second half of pregnancy (%) .......... 49

Human Immunodeficiency Virus (HIV) Testing - Within publicly-funded HIV and sexual health services: Variance (%) ............................................................... 52

Hepatitis C Antiviral Treatment Initiation – Direct acting - by LHD residents: Variance (%) ........................................................................ 55

### STRATEGY 2 KPIs: Provide World-Class Clinical Care Where Patient Safety is First ................................................................. 58

Fall-Related Injuries in Hospital – resulting in fracture or intracranial injury (Rate per 1,000 bed days) ............................................................... 58

Hospital Acquired Pressure Injuries (Rate) ............................................... 62

Healthcare Associated Infections (Rate per 1,000 bed days) ...................... 65

Hospital Acquired Venous Thromboembolism (Rate per 1000 bed days) ........ 68

Hospital Acquired Medication Complications (Rate per 1,000 bed days) ....... 72

Surgical Complications Requiring Unplanned Return to Theatre (Rate per 1,000 bed days) ........................................................................... 76

3rd or 4th Degree Perineal Lacerations (Rate per 1,000 bed days) ................. 80

Hospital Acquired Neonatal Birth Trauma (Rate per 1,000 bed days) ......... 84

Unplanned Hospital Readmissions: all unplanned admissions within 28 days of separation (%): ........................................................................... 87

Overall Patient Experience Index (Number) .............................................. 91

Patient Engagement Index (Number) ................................................................ 94

Elective Surgery Access Performance: Elective Surgery Patients Treated on Time (%) .................................................................................. 97
Overdue Elective Surgery Patients (Number) ............................................................ 100
Emergency Treatment Performance: Patients with Total time in ED <= 4hrs (%) 103
Transfer of Care – patients transferred from Ambulance to ED<= 30 minutes (%) 107

STRATEGY 3 KPIs: Integrate Systems to Deliver Truly Connected Care ...... 111

Aged Care Assessment Timeliness - Average time from ACAT referral to delegation - Admitted patients (Days) ................................................................................................... 111
Mental Health: Acute Post Discharge Community Care (%): ......................... 113
Mental Health: Acute Readmission - within 28 days (%) .................................. 117
Mental Health: Acute Seclusion Occurrence - Episodes (per 1,000 bed days) .... 121

Emergency Department Extended Stays: Mental Health Presentations staying in ED > 24 hours (number) ............................................................................................................ 124
Mental Health: Acute Seclusion Duration – Average (Hours) ......................... 127
Mental Health: Involuntary Patients Absconded – From an inpatient mental health unit – Incident Types 1 and 2 (Number) ................................................................................................... 129
Mental Health Consumer Experience: Mental Health consumers with a score of Very Good or Excellent (%) ....................................................................................................... 131
Mental Health: Pathways to Community Living – People transitioned to the community (Number)........................................................................................................................... 133
Mental Health Peer Workforce Employment – Full time equivalents (FTEs) (Number) ......................................................................................................................................... 135
Electronic Discharge Summaries Completed: (%) ............................................. 138
Domestic Violence Routine Screening – Routine Screens conducted (%) ........ 141
Out of Home Care Health Pathway Program - Children and young people completing a primary health assessment (%) ......................................................................................... 143
Sexual Assault Services Initial Assessments – Referrals for victims of sexual assault receiving an initial psychosocial assessment (%) ...................................................................... 145
Sustaining NSW Families Programs: ..................................................................... 147

STRATEGY 4 KPIs: Develop and Support our People & Culture ....................... 150

Staff Engagement: People Matter Survey Engagement Index - Variation from previous year (%) ....................................................................................................................... 150
Staff Performance Reviews - Within the last 12 months (%) ................................ 152
Aboriginal Workforce Participation: Aboriginal Workforce as a proportion of total workforce: (%) .................................................................................................................. 155
Compensable Workplace Injury - Claims (Number) ........................................ 159

STRATEGY 5 KPIs: Support and Harness Health & Medical Research and Innovation ................................................................................................................................. 161

Ethics Application Approvals - By the Human Research Ethics Committee within 45 calendar days - Involving more than low risk to participants (%) ........................................... 161
Research Governance Application Authorisations – Site specific Within 15 calendar days - Involving more than low risk to participants (%) .......................................................................... 164

STRATEGY 7 KPIs: Deliver Infrastructure & System Capability ....................... 167
Capital Variation: Against Approved Budget: (%) ........................................... 167
Asset Maintenance Expenditure – as a proportion of asset replacement value (%).... 169
STRATEGY 8 KPIs: Build Financial Sustainability and Robust Governance.. 173

Purchased Activity Volumes – Variance: Acute Admitted – NWAU (%) .......................... 173
Purchased Activity Volumes – Variance: Emergency Department - NWAU (%) ............... 176
Purchased Activity Volumes – Variance: Non-admitted Patient - NWAU (%) ............... 178
Purchased Activity Volumes – Variance: Sub and non-acute admitted - NWAU (%) ..... 185
Purchased Activity Volumes – Variance: Mental Health Admitted - NWAU (%) ........... 187
Purchased Activity Volumes – Variance: Mental Health Non-Admitted - NWAU (%) .... 189
Purchased Activity Volumes – Variance: Public Dental Clinical Service - DWAU (%) .... 191
Expenditure Matched to Budget: Year to date variance – General Fund (%) ................. 194

Own Source Revenue Matched to Budget: Year to date variance – General Fund (%) ...

Cost Ratio Performance (%): ................................................................. 196

IMPROVEMENT MEASURES FOR 2018-19 ............................................................. 200

STRATEGY 1 IMs: Keep People Healthy ............................................................. 201

Healthy Children Initiative - Targeted Family Healthy Eating and Physical Activity Program (Go4Fun): ................................................................. 201
Childhood Obesity: Children with height/length and weight recorded (%) ................. 204
Healthy Children Initiative - Children’s Healthy Eating and Physical Activity Program (Munch & Move) - Family Day Care Service Providers (sites) achieving agreed proportion of Family Day Care practices (%) ................................................................. 207
Tobacco Compliance Monitoring: compliance with the NSW Health Smoke-free Health Care Policy (%) ................................................................. 210
Pregnant women who use substances engaged in treatment and home visiting support (Number) ...................................................................................... 212
Drug and Alcohol Opioid Treatment Program – Unique public patients prescribed buprenorphine or buprenorphine-naloxone (%) .................................................. 215
Drug and Alcohol Opioid Treatment Program – Public patients who were prescribed opioid pharmacotherapies (Number) .......................................................... 218
Hepatitis C Treatment Initiated by a GP (%) ......................................................... 220
Children fully immunised at one year of age: ..................................................... 223
Children fully immunised at four years of age: ................................................... 225
Human Papillomavirus Vaccination: ........................................................................ 228
Meningococcal Vaccination - Coverage in Years 10 and 11 for serogroups A, C, W, Y (%) ............................................................................................................. 230
Aboriginal Maternal Infant Health Services - Women with Aboriginal babies accessing the service (Number) ............................................................................. 232
Building Strong Foundations for Aboriginal Children, Families and Communities – Children enrolled (Number) ............................................................................. 234
Comprehensive Antenatal Visits - for all pregnant women before 14 weeks gestation: ............................................................................................................. 236
Quality of Aboriginal Identification in Reported Data (%): .................................... 239

STRATEGY 2 IMs: Provide World-Class Clinical Care Where Patient Safety is First ............................................................. 241
Inpatients Discharged Against Medical Advice (%) .................................................. 241
Staphylococcus Aureus Bloodstream Infections (SA-BSI): ........................................ 244
ICU Central Line Associated Bloodstream (CLAB) Infections (Number)............... 247
Surgical Site Infections - Rate (per 1,000 surgical procedural DRG separations) .... 249
Harm-free Admitted Care: Inpatient Stays without Harm (%)................................ 252
Incorrect Procedures: Operating Theatre - Resulting in Death or Major Permanent Loss of Function (Number) ................................................................. 255
Root Cause Analysis (%) .......................................................................................... 257
Clinical Incident Monitoring: Severity Assessment Code (SAC) 1 and 2 incidents (Number)........................................................................................................ 259
National Sentinel Events (number)........................................................................... 261
Deteriorating Patients – Rapid Response Calls (Rate)............................................. 263
Deteriorating Patients – Unexpected cardiopulmonary arrest (Rate)..................... 266
Risk Standardised Mortality Ratio (RSMR): 30-day mortality following hospitalization: (%) ......................................................................................................................................... 269
Unplanned hospital readmission rates for patients discharged following management of targeted conditions (%) ................................................................. 271
Oesophageal Cancer Resection Caseload Threshold (with Active MDT) (%) ........ 278
Pancreatic Cancer Resection Caseload Threshold (with Active MDT) (%) ............... 281
Telehealth Service Access: Non-admitted services provided through telehealth (%).. 283
Pain Management (NWAU) ....................................................................................... 285
Leading Better Value Care: Non-admitted Service Units established to support services provided to targeted patient cohorts (Number) ...................................................... 287
Leading Better Value Care: Non-admitted Patient Service Events provided to Targeted Patient Cohorts (NWAU) ..................................................................................... 290
Leading Better Value Care: Completion of education modules for inpatient diabetic care (Number)........................................................................................................ 293
Leading Better Value Care: Services investigating inpatient clinical variation (Number)......................................................................................................................... 295
Breast Screen Participation Rates: ............................................................................ 298
Patient Reported Experience Measures: Medications - adults who received information about safe use of medicines (%) ........................................................................... 301
Patient Experience Survey – Emergency Department Patients: overall rating of care (%) .................................................................................................................... 303
Patient Experience Survey – Respect and Dignity Score (Number) ......................... 305
Organ and Tissue Donation: .................................................................................... 308
Elective Surgery Access Performance Impact (%): ................................................ 311
Patients with Total time in ED <= 4hrs: ................................................................... 314
ED Presentations Treated within Benchmark Times (%) ........................................ 318
Emergency Department Extended Stays: Presentations staying in ED > 24 hours (number) ................................................................................................................ 321
Emergency Department Extended Stays: Presentations staying in ED > 12 hours (number) ................................................................................................................ 324
| **Outpatient On Time Performance:** | Patients waiting more than 365 days for an initial outpatient service appointment (Number) ................................................................. | 327 |
| | **Median waiting time for elective surgery** (Days)... | 330 |
| | **Elective Surgery: Activity Compared to Previous Year** (Number) ................................................................. | 333 |
| | **Surgical Services - Elective Surgery:** | 335 |
| | **Aboriginal Paediatric Patients Undergoing Otitis Media Procedures** (number) | 340 |
| | **Surgery for Children - Proportion of children (0 to 16 years) treated within their LHD of residence:** | 342 |
| | **One-Year Survival after Surgery for Colon or Rectal Cancer** (%) | 344 |
| | **One-Year Survival after Surgery for Lung Cancer** (%) | 347 |
| | **Stroke Care Quality Improvement:** | 349 |
| | **Radiotherapy – Courses, New and Old** (Number) | 352 |
| | **Statewide Infant Screening – Hearing** – Newborn hearing screens provided (Number) ................................................................. | 355 |
| | **Statewide Eyesight for Preschoolers Screening (StEPS)** - Eyesight screens provided to 4 year olds (Number) ................................................................. | 357 |
| | **Universal Health Home Visits provided within 2 weeks of baby’s birth** (Number) ... | 359 |
| | **Efficiency by Specialty:** | 361 |
| | **Unplanned Hospital Readmission Distributions:** all unplanned admissions within 28 days of separation – Cohort comparisons (%) | 364 |
| | **Unplanned and Emergency Re-presentations - to same ED within 48 hours** (%) | 368 |
| | **Potentially Preventable Hospitalisations** (Rate per 100,000) | 371 |
| | **Home Based Dialysis** – Proportion of renal dialysis service events that are home based (%) | 376 |
| | **Average Length of Episode Stay - Overnight Acute Patients** (Days) | 378 |
| | **Acute separations - overnight** (Number) | 381 |
| | **Acute separations – same day** (Number) | 383 |
| | **Admitted Patient Separations** (Number) | 385 |
| | **Attendances Admitted from ED** (number) | 387 |
| | **Hospital in the Home:** | 389 |
| | **Mental Health Consumer Experience Measure** (YES) - Completion rate (%) | 406 |
| | **Community Mental Health Enhancements:** | 409 |
| | **Mental Health: Acute mental health service overnight separations** (Number) | 411 |

**STRATEGY 3 IMs: Integrate Systems to Deliver Truly Connected Care ........ 391**

| **Com Packs - Packages** (Number) | 391 |
| **Patients with Total time in ED <= 4hrs:** | Mental Health (%) | 393 |
| **Emergency Department Extended Stays:** | Mental Health Presentations staying in ED > 12 hours (number) | 397 |
| **Mental Health: Frequency of Seclusion** (%) | 400 |
| **Mental Health: Outcome Readiness – HoNOS Completion Rates** (%) | 402 |
| **Mental Health Consumer Experience Measure** (YES) - Completion rate (%) | 406 |
| **Community Mental Health Enhancements:** | Target contact hours (%) | 409 |
| **Mental Health: Acute mental health service overnight separations** (Number) | 411 |
Mental Health: non-acute mental health inpatient days (Number) ......................... 413
Mental Health Line Call Abandonment (%) .............................................................. 415
Last-Days-of-Life Home Support - Patients referred to support service who died at home (%) .............................................................................................................. 417
Last-Days-of-Life Home Support - Completed packages in the quarter (Number). 419
End of Life Care - Advance Care Directives (ACDs) - Patients in acute facilities who die with a valid ACD (Number) ..................................................................................... 421
National Disability Insurance Scheme (NDIS) – Patients with an NDIS Status (Number) ......................................................................................................................... 423
National Disability Insurance Scheme (NDIS) – Inpatients with an NDIS Related Wait Recorded (Number) ........................................................................................................... 425
Electronic Discharge Summary Performance: Created within 48 hours of patient discharge from hospital (%) .......................................................................................... 427
Integrated Care Program – Patients Enrolled (Number) ........................................ 429
Patient Reported Measures: Surveys Completed (Number) ..................................... 431
New Street Services – Primary clients completing treatment (%) ......................... 433
Child Protection Counselling Services - new family referrals allocated to a counsellor (Number) ..................................................................................................................... 435
JIRT Health Attendances – Clients referred to Violence, Abuse and Neglect health services who attend the service within 6 weeks of referral (%) .............................. 437

STRATEGY 4 IMs: Develop and Support our People & Culture .......................... 439
Recruitment: Improvement on baseline average time taken from request to recruit to decision to approve/decline/defer recruitment (days) ................................................................. 439
Additional Frontline Staff (Number): ........................................................................ 441
Skilled Workforce Growth: Increase in Enrolled Nurses (%) ................................ 443
Rural and Regional Medical Workforce Increase (%) .......................................... 445
Premium Staff Usage: average paid hours per FTE ................................................. 448
Public Service Commission (PSC) People Matter Employee Survey Response Rate (%) .......................................................................................................................... 451
Workplace Diversity Improvement: Women in Senior Executive Roles (%) ....... 453
Workplace Injuries: Return to work experience (days): ......................................... 456
Work Health & Safety: Targeted staff required to attend Personal Safety Training that have attended (%) .......................................................... 458
Compensable Workplace Injuries: Compensable Injuries by Occupational category and by Type (Number) ................................................................................................. 460
Leave Liability: Reduction in the total number of staff who have accrued leave balances of more than 30 days (Number) ................................................................. 463
Hand Hygiene Compliance (%) ............................................................................... 465

STRATEGY 5 IMs: Support and Harness Health & Medical Research and Innovation ............................................................................................................................... 467
Clinical Trials: Persons recruited to cancer clinical trials (Number) .................... 467
Participants enrolled to commercial clinical trial projects: .................................... 471
Client Data Linkage - Records linked in the Centre for Health Record Linkage Master Linkage Key (Number) ......................................................................................................... 474
STRATEGY 6 IMs: Enable eHealth, Health Information and Data Analytics ...

eMR2 Implementation Progress: Hospitals where the eMR2 has been implemented (%)
......................................................................................................................................... 476

EMeds Implementation Progress: Hospitals where eMeds has been implemented (%)
......................................................................................................................................... 478

eRIC Implementation Progress: Hospitals where eRIC has been implemented (%)
Electronic Discharge Summaries: sent electronically and accepted by a GP Broker system (%)
......................................................................................................................................... 482

HealthRoster Implementation Progress: Health Employees Rostered Within HealthRoster (%)
......................................................................................................................................... 484

HWAN Implementation Progress: Facilities connected to the Health Wide Area Network (%)
......................................................................................................................................... 486

SWIS Implementation (Identity Management) Progress: Facilities Standardised under the Statewide Infrastructure as a Service Program (%)
......................................................................................................................................... 488

Data Centre Reform Server Migration Progress: Servers Migrated to Government Data Centres (GovDC) (%)
......................................................................................................................................... 490

Data Centre Reform Application Migration Progress: Health Applications Migrated to Government Data Centres (GovDC) (%)
......................................................................................................................................... 492

STRATEGY 7 IMs: Deliver Infrastructure & System Capability

Deliver Infrastructure: Business Cases Completed (%)
......................................................................................................................................... 494

Deliver Infrastructure: Construction Commenced (%)
......................................................................................................................................... 496

Deliver Infrastructure: Construction Completed (%)
......................................................................................................................................... 498

Whole of Lifecycle Asset Management: Asset and Facilities Management (AFM) Online Take-up (%)
......................................................................................................................................... 500

Asbestos Documentation Upload to AFM Online
......................................................................................................................................... 503

AFM Online – Data Description Completion (%)
......................................................................................................................................... 506

AFM Online – GBA Survey Measure (%)
......................................................................................................................................... 509

AFM Online – Building Age Recorded (%)
......................................................................................................................................... 512

STRATEGY 8 IMs: Build Financial Sustainability and Robust Governance

Sub and Non Acute Admitted Patient Episodes - grouped to an AN-SNAP Class (%)
......................................................................................................................................... 515

ED Records unable to be grouped:
......................................................................................................................................... 517

Coding Timeliness: Uncoded Acute Separations (%)
......................................................................................................................................... 520

Total Activity Delivered (NWAU) (Number)
......................................................................................................................................... 523

Expenditure Matched to Budget: June projection Variance – General Fund (%)
......................................................................................................................................... 526

Own Source Revenue Matched to Budget: June projection variance – General Fund (%)
......................................................................................................................................... 528

Variation Against Reported Expenditure: Small Rural Hospitals & Specialist Hospitals (%)
......................................................................................................................................... 530

Patient Fee Debtors > 45 days as a percentage of rolling prior 12 months patient fee revenues (%)
......................................................................................................................................... 532

Small Business Creditors - Paid within 30 days from receipt of a correctly rendered invoice (%)
......................................................................................................................................... 534

Recurrent Trade Creditors > 45 days correct and ready for payment (Number)
......................................................................................................................................... 536
SUPPLEMENT- AMBULANCE KEY PERFORMANCE INDICATORS FOR 2018-19

NSW Ambulance Services Supplement

STEMI Pre Hospital Management (%) .......................................................... 541
Major Trauma Management (%) ............................................................. 543
Stroke Fast Positive Pre Hospital Management (%) ............................... 546
Mental Health Assessments (%) ............................................................... 549
Complaints Management Acknowledgement (%) .................................... 551
Complaints Management Resolution (%) ................................................ 553
Deaths Review Performance (%) ............................................................ 555
Clinical Incidents Management Completion (%) ...................................... 557
Triple Zero Call Answer Time Performance (%) ....................................... 559
Make Ready Time Performance (%) ........................................................ 561
Median Ambulance Response Time (Minutes) ........................................... 564
Frequent User Management Program Monitoring (%) ............................. 566
INTRODUCTION TO KEY PERFORMANCE INDICATOR TARGETS AND IMPROVEMENT MEASURES

The NSW Performance Framework (PF) applies to the 15 geographical NSW Local Health Districts, the Ambulance Service NSW, Sydney Children's Hospitals Network, the St Vincent's Health Network, the Justice Health and Forensic Mental Health Network. In this document, these organisations are referred to collectively as Health Services, except where particular reference to Local Health Districts is required.

The definitions provided in this document will assist Health Services and other data users with the calculation and interpretation of the Key Performance Indicators referenced in the Service Agreements for 2018-19. It should be noted that some KPIs may be calculated differently when applied to different purposes outside the management of the Service Agreements. The KPIs contained in this document have been defined specifically with the intent to meet the reporting requirements under 2018-19 agreements and to align to the Ministry of Health's monthly performance monitoring reports. Should you require further assistance with the definitions or have comments regarding them please contact either the System Information & Analytics Branch or the Data/Policy contacts listed in the KPI documentation.

The Service Agreement is a key component of the Performance Framework for Health Services – providing a clear and transparent mechanism for assessment and improvement of performance. The Service Agreement document only covers KPIs.

**Key Performance Indicators (KPIs),** if not met, may contribute to escalation under the Performance Framework processes. Performance against these KPIs will be reported regularly to Health Services in the Health System Performance Report prepared by System Information & Analytics Branch at the Ministry of Health.

**Improvement Measures (IMs):** A range of Improvement Measures are included in this data supplement to assist the organisation to improve provision of safe and efficient patient care and to provide the contextual information against which to assess performance. These are NOT part of the agreed Service Agreements, and therefore are NOT for the purposes of performance management. They are included as an addendum in this document. Improvement Measures are reported regularly to Health Services by a range of stakeholders including Ministry Branches, Pillars and Shared Service providers. System Information & Analytics Branch will provide information to Health Services around where information on Improvements Measures can be accessed.

Note that the KPIs and Improvement Measures listed above are not the only measures collected and monitored by the NSW Health System. A range of other measures are used for a variety of reasons, including monitoring the implementation of new service models, reporting requirements to NSW Government central agencies and the Commonwealth, and participation in nationally agreed data collections. Relevant measures specified by the National Health Performance Authority, and in the Premier's Priorities and State Priorities, have been assigned as NSW Health KPIs or Improvement Measures, as appropriate.

The KPIs and Improvement Measures are aligned with the eight Strategies identified in the NSW Health 2018-19 Corporate Planning Framework:

1. Keep People Healthy
2. Provide World-Class Clinical Care Where Patient Safety is First
3. Integrate Systems to Deliver Truly Connected Care
4. Develop and Support our People and Culture
5. Support and Harness Health & Medical Research and Innovation
6. Enable eHealth, Health Information and Data Analytics
7. Deliver Infrastructure & System Capability
8. Build Financial Sustainability and Robust Governance

The performance of Districts, Networks, other Health Services and Support Organisations is assessed in terms of whether it is meeting performance targets for individual key performance indicators for each NSW Health Strategic Priority.

- Performing: Performance at, or better than, target
- Underperforming: Performance within a tolerance range
- Not performing: Performance outside the tolerance threshold

Detailed specifications for the key performance indicators are provided in this Service Agreement Data Supplement along with Improvement Measures that will continue to be tracked by the Ministry’s Business Owners. Performance concerns will be raised with the Organisation for focused discussion at performance review meetings in line with the NSW Health Performance Framework.

This Data Supplement includes indicators and measures that align to key strategic programs, including:

- Premier’s and State Priorities
- Election Commitments
- Safety and Quality Framework
- Better Value Care
- Mental Health Reform
- Financial Management Transformations

Key deliverables under the Ministry’s Business Plan will also be monitored, noting that process key performance indicators and milestones are held in the detailed Operational Plans developed by each Health Service and Support Service.

As in previous years, the 2018-19 KPI and Improvement Measures data elements are also located on the NSW Health Information Resource Directory and are accessible via the following link:

Each individual indicator and Improvement Measure may be viewed and downloaded via this portal. Further, additional documentation (where available) for each of the indicators and service measures (such as specific identification of which fields from the data warehouse are used for the calculation, sample .sas code, detailed calculation formulae, etc) may be found under the “Ext Info” tab for each individual indicator and service measure, which may be downloaded as well.

For 2018-19, the Data Supplement also includes a supplementary section listing and defining the specific KPIs and Improvement Measures that have been agreed for the NSW Ambulance Services.

The table below provides a summary of the performance measures and targets against the KPIs as well as listing the Improvement Measures for each of the domains.
## Summary of Indicators and Targets for 2018-19 Service Agreements

<table>
<thead>
<tr>
<th>Strategic Priority</th>
<th>Safety &amp; Quality Framework Domain</th>
<th>Measure</th>
<th>Target</th>
<th>Not Performing</th>
<th>Under Performing</th>
<th>Performing</th>
<th>ID</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategy 1:</strong></td>
<td>Keep People Healthy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Population Health</strong></td>
<td><strong>Safety</strong></td>
<td>Get Healthy Information and Coaching Service - Health professional referrals: Variance (%)</td>
<td>Individual - See Data Supplement</td>
<td>&gt;10.0 variation below Target</td>
<td>&lt;=10.0 variation below Target</td>
<td>Met or exceeded Target</td>
<td>PH-011B</td>
</tr>
<tr>
<td></td>
<td><strong>Equity</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Aboriginal women</td>
<td>Decrease from previous year</td>
<td>Increase on previous year</td>
<td>No change</td>
<td>Decrease from previous year</td>
<td>PH-012A</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-aboriginal women</td>
<td>Decrease from previous year</td>
<td>Increase on previous year</td>
<td>No change</td>
<td>Decrease from previous year</td>
<td>SPH007</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Effectiveness</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pregnant Women Quitting Smoking - By second half of pregnancy (%)</td>
<td>4% increase on previous year</td>
<td>≤1% increase on previous year</td>
<td>≥1% and ≤4% increase on previous year</td>
<td>4% increase on previous year</td>
<td>DPH 12 01</td>
<td></td>
</tr>
<tr>
<td><strong>Population Health</strong></td>
<td><strong>Effectiveness</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Human Immunodeficiency Virus (HIV) Testing - Within publicly-funded HIV and sexual health services: Variance (%)</td>
<td>Individual - See Data Supplement</td>
<td>&lt;98 Target</td>
<td>≥98 and &lt;100</td>
<td>≥100</td>
<td>KS1410</td>
<td></td>
</tr>
<tr>
<td><strong>Population Health</strong></td>
<td><strong>Effectiveness</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hepatitis C Antiviral Treatment Initiation – Direct acting - by LHD residents: Variance (%)</td>
<td>Individual - See Data Supplement</td>
<td>&lt;98 Target</td>
<td>≥98 and &lt;100</td>
<td>≥100</td>
<td>PH-014C</td>
<td></td>
</tr>
<tr>
<td><strong>Strategy 2:</strong></td>
<td>Provide World-Class Clinical Care Where Patient Safety is First</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Safety</strong></td>
<td>Fall-related Injuries in Hospital – Resulting in fracture or intracranial injury – Rate (per 1,000 bed days)</td>
<td>Individual - See Data Supplement</td>
<td>≥23% of Target</td>
<td>≤0% and &lt;23% of Target</td>
<td>&lt; Target</td>
<td>KS2101</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3rd or 4th Degree Perineal Lacerations During Delivery – Rate (per 1,000 bed days)</td>
<td>Individual - See Data Supplement</td>
<td>≥37% of Target</td>
<td>≤0% and &lt;37% of Target</td>
<td>&lt; Target</td>
<td>MS2103</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hospital Acquired Venous Thromboembolism – Rate (per 1,000 bed days)</td>
<td>Individual - See Data Supplement</td>
<td>≥46% of Target</td>
<td>≤0% and &lt;46% of Target</td>
<td>&lt; Target</td>
<td>SSQ120</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hospital Acquired Pressure Injuries – Rate (per 1,000 bed days)</td>
<td>Individual - See Data Supplement</td>
<td>≥65% of Target</td>
<td>≤0% and &lt;65% of Target</td>
<td>&lt; Target</td>
<td>KQS205</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Healthcare Associated Infections – Rate (per 1,000 bed days)</td>
<td>Individual - See Data Supplement</td>
<td>≥13% of Target</td>
<td>≤0% and &lt;13% of Target</td>
<td>&lt; Target</td>
<td>KS2110</td>
<td></td>
</tr>
</tbody>
</table>
### Strategy 2: Provide World-Class Clinical Care Where Patient Safety is First

<table>
<thead>
<tr>
<th>Strategic Priority</th>
<th>Safety &amp; Quality Framework Domain</th>
<th>Measure</th>
<th>Target</th>
<th>Not Performing</th>
<th>Under Performing</th>
<th>Performing</th>
<th>ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1 Safety</td>
<td>Safety</td>
<td>Surgical Complications Requiring Unplanned Return to Theatre – Rate (per 1,000 bed days)</td>
<td>Individual - See Data Supplement</td>
<td>&gt;=26% of Target</td>
<td>&gt;=0% and &lt;26% of Target</td>
<td>&lt; Target</td>
<td>KS2112</td>
</tr>
<tr>
<td></td>
<td>Safety</td>
<td>Hospital Acquired Medication Complications – Rate (per 1,000 bed days)</td>
<td>Individual - See Data Supplement</td>
<td>&gt;=32% of Target</td>
<td>&gt;=0% and &lt;32% of Target</td>
<td>&lt; Target</td>
<td>KS2111</td>
</tr>
<tr>
<td></td>
<td>Safety</td>
<td>Hospital Acquired Neonatal Birth Trauma – Rate (per 1,000 bed days)</td>
<td>Individual - See Data Supplement</td>
<td>&gt;=43% of Target</td>
<td>&gt;=0% and &lt;43% of Target</td>
<td>&lt; Target</td>
<td>KS2113</td>
</tr>
</tbody>
</table>

#### 2.1 Unplanned Hospital Readmissions – All admissions within 28 days of separation (%):

<table>
<thead>
<tr>
<th>Effectiveness</th>
<th>• All persons</th>
<th>Decrease from previous Year</th>
<th>Increase from previous Year</th>
<th>No change</th>
<th>Decrease from previous Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effectiveness</td>
<td>• Aboriginal persons</td>
<td>Decrease from previous Year</td>
<td>Increase from previous Year</td>
<td>No change</td>
<td>Decrease from previous Year</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSO106</td>
</tr>
<tr>
<td>SSO107</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2.3 Patient Centred Culture</th>
<th>Overall Patient Experience Index (Number)</th>
<th>&gt;=8.5</th>
<th>&lt;=8.2</th>
<th>&gt;8.2 and &lt;8.5</th>
<th>&gt;=8.5</th>
<th>KS2301</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Centred Culture</td>
<td>Patient Engagement Index (Number)</td>
<td>&gt;=8.5</td>
<td>&lt;=8.2</td>
<td>&gt;8.2 and &lt;8.5</td>
<td>&gt;=8.5</td>
<td>KS2302</td>
</tr>
</tbody>
</table>

#### 2.4 Elective Surgery:

**Access Performance - Patients treated on time (%):**

<table>
<thead>
<tr>
<th>Timeliness and Accessibility</th>
<th>• Category 1</th>
<th>100</th>
<th>&lt;100</th>
<th>N/A</th>
<th>100</th>
<th>KSA103a</th>
</tr>
</thead>
<tbody>
<tr>
<td>Timeliness and Accessibility</td>
<td>• Category 2</td>
<td>&gt;=97</td>
<td>&lt;93</td>
<td>&gt;=93 and &lt;97</td>
<td>&gt;=97</td>
<td>KSA103b</td>
</tr>
<tr>
<td>Timeliness and Accessibility</td>
<td>• Category 3</td>
<td>&gt;=97</td>
<td>&lt;95</td>
<td>&gt;=95 and &lt;97</td>
<td>&gt;=97</td>
<td>KSA103c</td>
</tr>
</tbody>
</table>

**Overdue - Patients (Number):**

<table>
<thead>
<tr>
<th>Timeliness and Accessibility</th>
<th>• Category 1</th>
<th>0</th>
<th>&gt;=1</th>
<th>N/A</th>
<th>0</th>
<th>SSA108</th>
</tr>
</thead>
<tbody>
<tr>
<td>Timeliness and Accessibility</td>
<td>• Category 2</td>
<td>0</td>
<td>&gt;=1</td>
<td>N/A</td>
<td>0</td>
<td>SSA109</td>
</tr>
<tr>
<td>Timeliness and Accessibility</td>
<td>• Category 3</td>
<td>0</td>
<td>&gt;=1</td>
<td>N/A</td>
<td>0</td>
<td>SSA110</td>
</tr>
</tbody>
</table>

#### 2.4 Emergency Department:

<table>
<thead>
<tr>
<th>Timeliness and Accessibility</th>
<th>• Emergency treatment performance - Patients with total time in ED &lt;= 4 hrs (%)</th>
<th>&gt;=81</th>
<th>&lt;71</th>
<th>&gt;=71 and &lt;81</th>
<th>&gt;=81</th>
<th>KSA102</th>
</tr>
</thead>
<tbody>
<tr>
<td>Timeliness and Accessibility</td>
<td>• Transfer of care – Patients transferred from ambulance to ED &lt;= 30 minutes (%)</td>
<td>&gt;=90</td>
<td>&lt;80</td>
<td>&gt;=80 and &lt;90</td>
<td>&gt;=90</td>
<td>KSA101</td>
</tr>
</tbody>
</table>
### 2018-19 Service Performance Agreements

<table>
<thead>
<tr>
<th>Strategic Priority</th>
<th>Safety &amp; Quality Framework Domain</th>
<th>Measure</th>
<th>Target</th>
<th>Not Performing</th>
<th>Under Performing</th>
<th>Performing</th>
<th>ID</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategy 3: Integrate Systems to Deliver Truly Connected Care</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>3.1 Timeliness and Access</strong></td>
<td></td>
<td>Aged Care Assessment Timeliness - Average time from ACAT referral to delegation - Admitted patients (Days).</td>
<td>&lt;=5</td>
<td>&gt;6</td>
<td>&gt;5 and &lt;=6</td>
<td>&lt;=5</td>
<td>KS3101</td>
</tr>
<tr>
<td><strong>Mental Health:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Effectiveness</strong></td>
<td></td>
<td>Acute Post-Discharge Community Care - Follow up within seven days (%)</td>
<td>&gt;=70</td>
<td>&lt;50</td>
<td>&gt;=50 and &lt;70</td>
<td>&gt;=70</td>
<td>KQS204</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Acute readmission - Within 28 days (%)</td>
<td>&lt;=13</td>
<td>&gt;=20</td>
<td>&gt;13 and &lt;20</td>
<td>&lt;=13</td>
<td>KQS203</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Acute Seclusion Occurrence - Episodes (per 1,000 bed days)</td>
<td>&lt;5.1</td>
<td>&gt;=5.1</td>
<td>N/A</td>
<td>&lt;5.1</td>
<td>KQS206</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Acute Seclusion Duration - Average (Hours)</td>
<td>&lt; 4</td>
<td>&gt;5.5</td>
<td>&lt;= 4 and &lt;= 5.5</td>
<td>&lt; 4</td>
<td>SSQ123</td>
</tr>
<tr>
<td><strong>Patient Centred Culture</strong></td>
<td></td>
<td>Involuntary Patients Absconded – From an inpatient mental health unit – Incident Types 1 and 2 (Number)</td>
<td>0</td>
<td>&gt;0</td>
<td>N/A</td>
<td>0</td>
<td>SSQ127</td>
</tr>
<tr>
<td><strong>3.2 Timeliness and Accessibility</strong></td>
<td></td>
<td>Mental Health Consumer Experience: Mental Health consumers with a score of Very Good or Excellent (%)</td>
<td>&gt;= 80</td>
<td>&lt;70</td>
<td>&gt;=70 and &lt;80</td>
<td>&gt;= 80</td>
<td>KS3202</td>
</tr>
<tr>
<td><strong>Mental Health Reform:</strong></td>
<td></td>
<td>Access Block - Emergency department to inpatient unit - Presentations staying in ED &gt; 24 hours (Number)</td>
<td>0</td>
<td>&gt;5</td>
<td>Between 1 and 5</td>
<td>0</td>
<td>KSA202</td>
</tr>
<tr>
<td><strong>Patient Centred Culture</strong></td>
<td></td>
<td>Pathways to Community Living - People transitioned to the community (Number) (Applicable LHDs only - see Data Supplement)</td>
<td>Increase on previous quarter</td>
<td>Decrease from previous quarter</td>
<td>No change</td>
<td>Increase on previous quarter</td>
<td>KS3201</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Peer Workforce Employment – Full time equivalents (FTEs) (Number)</td>
<td>Increase on previous quarter</td>
<td>Decrease from previous quarter</td>
<td>No change</td>
<td>Increase on previous quarter</td>
<td>KMH202</td>
</tr>
<tr>
<td><strong>3.5 Patient Centred Culture</strong></td>
<td></td>
<td>Electronic Discharge Summaries Completed - Sent electronically to State Clinical Repository (%)</td>
<td>Increase on previous month</td>
<td>Decrease from previous month</td>
<td>No change</td>
<td>Increase on previous month</td>
<td>KSA205</td>
</tr>
<tr>
<td><strong>Effectiveness</strong></td>
<td></td>
<td>Domestic Violence Routine Screening – Routine Screens conducted (%)</td>
<td>70</td>
<td>&lt;60</td>
<td>&gt;=60 and &lt;70</td>
<td>&gt;=70</td>
<td>KF-005</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Out of Home Care Health Pathway Program - Children and young people completing a primary health assessment (%)</td>
<td>100</td>
<td>&lt;90</td>
<td>&gt;=90 and &lt;100</td>
<td>100</td>
<td>KF-007</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sexual Assault Services Initial Assessments – Referrals for victims of sexual assault receiving an initial psychosocial assessment (%)</td>
<td>80</td>
<td>&lt;70</td>
<td>&gt;=70 and &lt;80</td>
<td>&gt;=80</td>
<td>KF-009</td>
</tr>
<tr>
<td><strong>Sustaining NSW Families Programs</strong></td>
<td></td>
<td>Families completing the program when child reached 2 years of age (%)</td>
<td>50</td>
<td>&lt;45</td>
<td>&gt;=45 and &lt;50</td>
<td>&gt;=50</td>
<td>KF-0061</td>
</tr>
<tr>
<td><strong>Effectiveness</strong></td>
<td></td>
<td>Families enrolled and continuing in the program (%)</td>
<td>65</td>
<td>&lt;55</td>
<td>&gt;=55 and &lt;65</td>
<td>&gt;=65</td>
<td>KF-0062</td>
</tr>
</tbody>
</table>
## 2018-19 Service Performance Agreements

<table>
<thead>
<tr>
<th>Strategic Priority</th>
<th>Safety &amp; Quality Framework Domain</th>
<th>Measure</th>
<th>Target</th>
<th>Not Performing</th>
<th>Under Performing</th>
<th>Performing</th>
<th>ID</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategy 4:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Develop and Support our People and Culture</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.1 Safety</td>
<td></td>
<td>Staff Engagement - People Matter Survey Engagement Index - Variation from previous year (%)</td>
<td>&gt;=0 (Increase)</td>
<td>&lt;= -5</td>
<td>&lt;0 &amp; &lt;5</td>
<td>&gt;=0</td>
<td>SPC110</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Staff Performance Reviews - Within the last 12 months (%)</td>
<td>100</td>
<td>&lt;85</td>
<td>&gt;=85 and &lt;90</td>
<td>&gt;=90</td>
<td>KPC201</td>
</tr>
<tr>
<td>4.3 Equity</td>
<td></td>
<td>Aboriginal Workforce Participation: Aboriginal Workforce as a proportion of total workforce (%)</td>
<td>1.8</td>
<td>Decrease from previous Year</td>
<td>Nil increase from previous year</td>
<td>Increase from previous Year</td>
<td>SPC108</td>
</tr>
<tr>
<td>4.5 Safety</td>
<td></td>
<td>Compensable Workplace Injury - Claims (Number)</td>
<td>10</td>
<td>Decrease</td>
<td>Increase</td>
<td>&gt;=0 and &lt;10</td>
<td>KS4401</td>
</tr>
<tr>
<td><strong>Strategy 5:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Support and Harness Health and Medical Research and Innovation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.4 Research</td>
<td></td>
<td>Ethics Application Approvals - By the Human Research Ethics Committee within 45 calendar days - Involving more than low risk to participants (%)</td>
<td>95</td>
<td>&lt;75</td>
<td>&gt;=75 and &lt;95</td>
<td>&gt;=95</td>
<td>KSS303</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Research Governance Application Authorisations – Site specific Within 15 calendar days - Involving more than low risk to participants - (%)</td>
<td>95</td>
<td>&lt;75</td>
<td>&gt;=75 and &lt;95</td>
<td>&gt;=95</td>
<td>KSS304</td>
</tr>
<tr>
<td><strong>Strategy 6:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Enable eHealth, Health Informatics and Data Analytics</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.2 Efficiency</td>
<td></td>
<td>See under 3.5 - Electronic Discharge Summaries</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td><strong>Strategy 7:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Deliver Future Focused Infrastructure and Strategic Commissioning</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.1 Efficiency</td>
<td></td>
<td>Capital Variation - Against Approved Budget (%)</td>
<td>On budget</td>
<td>&gt; +/- 10 of budget</td>
<td>NA</td>
<td>&lt; +/- 10 of budget</td>
<td>KS7301</td>
</tr>
<tr>
<td>7.3 Safety</td>
<td></td>
<td>Asset Maintenance Expenditure – as a proportion of asset replacement value (%)</td>
<td>&gt;=10</td>
<td>&lt; 5</td>
<td>&gt;= 5 and &lt; 10</td>
<td>&gt;=10</td>
<td>DSR 7401</td>
</tr>
<tr>
<td><strong>Strategy 8:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Build Financial Sustainability and Robust Governance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.1 Efficiency</td>
<td></td>
<td>Public dental clinical service - DWAU</td>
<td>See Purchased Volumes</td>
<td>&gt; +/- 2.0</td>
<td>&gt; +/-1.0 and &lt;= +/-2.0</td>
<td>&lt;= +/-1.0</td>
<td>PD-001</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Non-admitted patients – NWAU</td>
<td>Individual - See Budget</td>
<td>&gt; +/-2.0</td>
<td>&gt; +/-1.0 and &lt;= +/-2.0</td>
<td>&lt;= +/-1.0</td>
<td>AI-001</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Emergency department – NWAU</td>
<td>Individual - See Budget</td>
<td>&gt; +/-2.0</td>
<td>&gt; +/-1.0 and &lt;= +/-2.0</td>
<td>&lt;= +/-1.0</td>
<td>ED-001</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sub acute services - Admitted – NWAU</td>
<td>Individual - See Budget</td>
<td>&gt; +/-2.0</td>
<td>&gt; +/-1.0 and &lt;= +/-2.0</td>
<td>&lt;= +/-1.0</td>
<td>NA-001</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mental health – Admitted – NWAU</td>
<td>Individual - See Budget</td>
<td>&gt; +/-2.0</td>
<td>&gt; +/-1.0 and &lt;= +/-2.0</td>
<td>&lt;= +/-1.0</td>
<td>SA-001</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mental health - Non admitted – NWAU</td>
<td>Individual - See Budget</td>
<td>&gt; +/-2.0</td>
<td>&gt; +/-1.0 and &lt;= +/-2.0</td>
<td>&lt;= +/-1.0</td>
<td>MHDA-005</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Expenditure Matched to Budget - General Fund - Variance (%)</td>
<td>On budget or Favourable</td>
<td>&gt;0.5 Unfavourable</td>
<td>&gt;0 but &lt;=0.5 Unfavourable</td>
<td>On budget or Favourable</td>
<td>KFA101</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Own Sourced Revenue Matched to Budget - General Fund - Variance (%)</td>
<td>On budget or Favourable</td>
<td>&gt;0.5 Unfavourable</td>
<td>&gt;0 but &lt;=0.5 Unfavourable</td>
<td>On budget or Favourable</td>
<td>KFA103</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cost Ratio Performance - Cost per NWAU compared to state average - Current year against previous year (%)</td>
<td>Decrease from previous year</td>
<td>Increase on previous year</td>
<td>No Change</td>
<td>Decrease from previous year</td>
<td>KS8102</td>
</tr>
</tbody>
</table>

---

**Strategy 4: Develop and Support our People and Culture**

- **4.1 Safety**
  - Staff Engagement - People Matter Survey Engagement Index - Variation from previous year (%)
  - Target: >=0 (Increase)
  - Not Performing: <= -5
  - Under Performing: <0 & <5
  - Performing: >=0

- **4.3 Equity**
  - Aboriginal Workforce Participation: Aboriginal Workforce as a proportion of total workforce (%)
  - Target: 1.8
  - Not Performing: Decrease from previous Year
  - Under Performing: Nil increase from previous year
  - Performing: Increase from previous Year

- **4.5 Safety**
  - Compensable Workplace Injury - Claims (Number)
  - Target: 10
  - Not Performing: Decrease
  - Under Performing: Increase
  - Performing: >=0 and <10

**Strategy 5: Support and Harness Health and Medical Research and Innovation**

- **5.4 Research**
  - Ethics Application Approvals - By the Human Research Ethics Committee within 45 calendar days - Involving more than low risk to participants (%)
  - Target: 95
  - Not Performing: <75
  - Under Performing: >=75 and <95
  - Performing: >=95

- **5.4 Research (cont.)**
  - Research Governance Application Authorisations – Site specific Within 15 calendar days - Involving more than low risk to participants - (%)
  - Target: 95
  - Not Performing: <75
  - Under Performing: >=75 and <95
  - Performing: >=95

**Strategy 6: Enable eHealth, Health Informatics and Data Analytics**

- **6.2 Efficiency**
  - See under 3.5 - Electronic Discharge Summaries
  - Target: NA

**Strategy 7: Deliver Future Focused Infrastructure and Strategic Commissioning**

- **7.1 Efficiency**
  - Capital Variation - Against Approved Budget (%)
  - Target: On budget
  - Not Performing: > +/- 10 of budget
  - Under Performing: NA
  - Performing: < +/- 10 of budget

- **7.3 Safety**
  - Asset Maintenance Expenditure – as a proportion of asset replacement value (%)
  - Target: >=10
  - Not Performing: < 5
  - Under Performing: >= 5 and < 10
  - Performing: >=10

**Strategy 8: Build Financial Sustainability and Robust Governance**

- **8.1 Efficiency**
  - Public dental clinical service - DWAU
  - Target: See Purchased Volumes
  - Not Performing: > +/- 2.0
  - Under Performing: > +/-1.0 and <= +/-2.0
  - Performing: <= +/-1.0

- **8.1 Efficiency (cont.)**
  - Expenditure Matched to Budget - General Fund - Variance (%)
  - Target: On budget or Favourable
  - Not Performing: >0.5 Unfavourable
  - Under Performing: >0 but <=0.5 Unfavourable
  - Performing: On budget or Favourable

- **8.1 Efficiency (cont.)**
  - Own Sourced Revenue Matched to Budget - General Fund - Variance (%)
  - Target: On budget or Favourable
  - Not Performing: >0.5 Unfavourable
  - Under Performing: >0 but <=0.5 Unfavourable
  - Performing: On budget or Favourable

- **8.1 Efficiency (cont.)**
  - Cost Ratio Performance - Cost per NWAU compared to state average - Current year against previous year (%)
  - Target: Decrease from previous year
  - Not Performing: Increase on previous year
  - Under Performing: No Change
  - Performing: Decrease from previous year
## Improvement Measures

<table>
<thead>
<tr>
<th>2018-19 Strategic Priority</th>
<th>ID</th>
<th>Measure</th>
<th>Page No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>PH-008C</td>
<td>Healthy Children Initiative - Targeted Family Healthy Eating and Physical Activity Program (Go4Fun)</td>
<td>201</td>
</tr>
<tr>
<td>1.1</td>
<td>PH-008D</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1</td>
<td>MS1102</td>
<td>Childhood Obesity: Children with height/length and weight recorded (%)</td>
<td>204</td>
</tr>
<tr>
<td>1.1</td>
<td>MS1103</td>
<td>Healthy Children Initiative - Children’s Healthy Eating and Physical Activity Program (Munch &amp; Move) - Family Day Care Service Providers (sites) achieving agreed proportion of Family Day Care practices</td>
<td>207</td>
</tr>
<tr>
<td>1.2</td>
<td>PH-017A</td>
<td>Tobacco Compliance Monitoring: compliance with the NSW Health Smoke-free Health Care Policy (%)</td>
<td>210</td>
</tr>
<tr>
<td>1.3</td>
<td>MS1304</td>
<td>Pregnant women who use substances engaged in treatment and home visiting support (Number)</td>
<td>212</td>
</tr>
<tr>
<td>1.3</td>
<td>DPH_1301b</td>
<td>Drug and Alcohol Opioid Treatment Program – Unique public patients prescribed buprenorphine or buprenorphine-naloxone (%)</td>
<td>215</td>
</tr>
<tr>
<td>1.3</td>
<td>MS1302</td>
<td>Drug and Alcohol Opioid Treatment Program – Public patients who were prescribed opioid pharmacotherapies (Number)</td>
<td>218</td>
</tr>
<tr>
<td>1.4</td>
<td>MS1403</td>
<td>Hepatitis C Treatment Initiated by a GP (%)</td>
<td>220</td>
</tr>
<tr>
<td>1.4</td>
<td>SPH001</td>
<td>Children fully immunised at one year of age</td>
<td>223</td>
</tr>
<tr>
<td>1.4</td>
<td>SPH002</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.4</td>
<td>PH-006</td>
<td>Human Papillomavirus Vaccination</td>
<td>228</td>
</tr>
<tr>
<td>1.4</td>
<td>DPH_1402</td>
<td>Meningococcal Vaccination - Coverage in Years 10 and 11 for serogroups A, C, W, Y (%)</td>
<td>230</td>
</tr>
<tr>
<td>1.5</td>
<td>KF-001</td>
<td>Aboriginal Maternal Infant Health Services - Women with Aboriginal babies accessing the service (Number)</td>
<td>232</td>
</tr>
<tr>
<td>1.5</td>
<td>KF-002</td>
<td>Building Strong Foundations for Aboriginal Children, Families and Communities – Children enrolled (Number)</td>
<td>234</td>
</tr>
<tr>
<td>1.5</td>
<td>SPH008</td>
<td>Comprehensive Antenatal Visits - for all pregnant women before 14 weeks gestation</td>
<td>236</td>
</tr>
<tr>
<td>1.5</td>
<td>SPH009</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.5</td>
<td>SPH010</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.5</td>
<td>SPH011</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.5</td>
<td>MS2506</td>
<td>Quality of Aboriginal Identification in Reported Data (%)</td>
<td>239</td>
</tr>
<tr>
<td>2.1</td>
<td>SSQ114</td>
<td>Inpatients Discharged Against Medical Advice (%)</td>
<td>241</td>
</tr>
<tr>
<td>2.1</td>
<td>SSQ118</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.1</td>
<td>KQS101</td>
<td>Staphylococcus Aureus Bloodstream Infections (SA-BSI)</td>
<td>244</td>
</tr>
<tr>
<td>2.1</td>
<td>KQS201</td>
<td>ICU Central Line Associated Bloodstream (CLAB) Infections (Number)</td>
<td>247</td>
</tr>
<tr>
<td>2.1</td>
<td>MS2104</td>
<td>Surgical Site Infections - Rate (per 1,000 surgical procedural DRG separations)</td>
<td>249</td>
</tr>
<tr>
<td>2.1</td>
<td>MS2106</td>
<td>Harm-free Admitted Care: Inpatient Stays without Harm (%)</td>
<td>252</td>
</tr>
<tr>
<td>2.1</td>
<td>KQS202</td>
<td>Incorrect Procedures: Operating Theatre - Resulting in Death or Major Permanent Loss of Function (Number)</td>
<td>255</td>
</tr>
<tr>
<td>2.1</td>
<td>SSQ104</td>
<td>Root Cause Analysis (%)</td>
<td>257</td>
</tr>
<tr>
<td>2018-19 Strategic Priority</td>
<td>ID</td>
<td>Measure</td>
<td></td>
</tr>
<tr>
<td>---------------------------</td>
<td>-------</td>
<td>-------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>2.1</td>
<td>MS2107</td>
<td>Clinical Incident Monitoring: Severity Assessment Code (SAC) 1 and 2 incidents (Number)</td>
<td></td>
</tr>
<tr>
<td>2.1</td>
<td>MS2105</td>
<td>National Sentinel Events (number)</td>
<td></td>
</tr>
<tr>
<td>2.1</td>
<td>SSQ101</td>
<td>Deteriorating Patients – Rapid Response Calls (Rate)</td>
<td></td>
</tr>
<tr>
<td>2.1</td>
<td>SSQ102</td>
<td>Deteriorating Patients – Unexpected cardiopulmonary arrest (Rate)</td>
<td></td>
</tr>
<tr>
<td>2.1</td>
<td>MS2108</td>
<td>Risk Standardised Mortality Ratio (RSMR): 30-day mortality following hospitalization: (%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>SSQ108</td>
<td>Unplanned hospital readmission rates for patients discharged following management of targeted conditions (%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>SSQ109</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>SSQ110</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>SSQ111</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>MS2109</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>MS2110</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>MS2111</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>MS2112</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.1</td>
<td>MS2407</td>
<td>Oesophageal Cancer Resection Caseload Threshold (with Active MDT) (%)</td>
<td></td>
</tr>
<tr>
<td>2.1</td>
<td>MS2408</td>
<td>Pancreatic Cancer Resection Caseload Threshold (with Active MDT) (%)</td>
<td></td>
</tr>
<tr>
<td>2.2</td>
<td>MS2213</td>
<td>Telehealth Service Access: Non-admitted services provided through telehealth (%)</td>
<td></td>
</tr>
<tr>
<td>2.2</td>
<td>RXT001</td>
<td>Pain Management (NWAU)</td>
<td></td>
</tr>
<tr>
<td>2.2</td>
<td>MS2201</td>
<td>Leading Better Value Care: Non-admitted Service Units established to support services provided to targeted patient cohorts (Number)</td>
<td></td>
</tr>
<tr>
<td>2.2</td>
<td>MS2202</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.2</td>
<td>MS2203</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.2</td>
<td>MS2204</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.2</td>
<td>MS2208</td>
<td>Leading Better Value Care: Non-admitted Patient Service Events provided to Targeted Patient Cohorts (NWAU)</td>
<td></td>
</tr>
<tr>
<td>2.2</td>
<td>MS2209</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.2</td>
<td>MS2210</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.2</td>
<td>MS2211</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.2</td>
<td>MS2205</td>
<td>Leading Better Value Care: Completion of education modules for inpatient diabetic care (Number)</td>
<td></td>
</tr>
<tr>
<td>2.2</td>
<td>MS2206</td>
<td>Leading Better Value Care: Services investigating inpatient clinical variation (Number)</td>
<td></td>
</tr>
<tr>
<td>2.2</td>
<td>MS2207</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.3</td>
<td>SSA126</td>
<td>Breast Screen Participation Rates</td>
<td></td>
</tr>
<tr>
<td>2.3</td>
<td>SSA127</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.3</td>
<td>SSA128</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.3</td>
<td>SSA129</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.3</td>
<td>SSA130</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.3</td>
<td>SSA131</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.3</td>
<td>MS2307</td>
<td>Patient Reported Experience Measures: Medications - adults who received information about safe use of medicines (%)</td>
<td></td>
</tr>
<tr>
<td>2.3</td>
<td>SSQ119</td>
<td>Patient Experience Survey – Emergency Department Patients: overall rating of care (%)</td>
<td></td>
</tr>
<tr>
<td>2.3</td>
<td>MS2311</td>
<td>Patient Experience Survey – Respect and Dignity Score (Number)</td>
<td></td>
</tr>
<tr>
<td>2.3</td>
<td>PH-007A</td>
<td>Organ and Tissue Donation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>PH-007B</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2018-19 Strategic Priority</td>
<td>ID</td>
<td>Measure</td>
<td>Page No.</td>
</tr>
<tr>
<td>---------------------------</td>
<td>-------------</td>
<td>-------------------------------------------------------------------------</td>
<td>----------</td>
</tr>
<tr>
<td>2.3</td>
<td>MS2302</td>
<td>Elective Surgery Access Performance Impact (%)</td>
<td>311</td>
</tr>
<tr>
<td></td>
<td>MS2303</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>MS2304</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>MS2308</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>MS2309</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>MS2310</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.4</td>
<td>SSA101</td>
<td>Patients with Total time in ED &lt;= 4hrs</td>
<td>314</td>
</tr>
<tr>
<td></td>
<td>SSA102</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.4</td>
<td>SSA104</td>
<td>ED Presentations Treated within Benchmark Times (%)</td>
<td>318</td>
</tr>
<tr>
<td>2.4</td>
<td>KSA201</td>
<td>Emergency Department Extended Stays: Presentations staying in ED &gt; 24 hours (number)</td>
<td>321</td>
</tr>
<tr>
<td>2.4</td>
<td>MS2401</td>
<td>Emergency Department Extended Stays: Presentations staying in ED &gt; 12 hours (number)</td>
<td>324</td>
</tr>
<tr>
<td>2.4</td>
<td>MS2406</td>
<td>Outpatient On Time Performance: Patients waiting more than 365 days for an initial outpatient service appointment (Number)</td>
<td>327</td>
</tr>
<tr>
<td>2.4</td>
<td>MS2402</td>
<td>Median waiting time for elective surgery (Days)</td>
<td>330</td>
</tr>
<tr>
<td>2.4</td>
<td>SSA111</td>
<td>Elective Surgery: Activity Compared to Previous Year (Number)</td>
<td>333</td>
</tr>
<tr>
<td>2.4</td>
<td>SSA112</td>
<td>Elective Surgery Theatre Utilisation: Operating Room Occupancy (%)</td>
<td>335</td>
</tr>
<tr>
<td>2.4</td>
<td>SURG-001</td>
<td>Surgical Services - Elective Surgery</td>
<td>338</td>
</tr>
<tr>
<td></td>
<td>SURG-002</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.4</td>
<td>KS2410</td>
<td>Aboriginal Paediatric Patients Undergoing Otitis Media Procedures (number)</td>
<td>340</td>
</tr>
<tr>
<td>2.4</td>
<td>SSA113</td>
<td>Surgery for Children - Proportion of children (0 to 16 years) treated within their LHD of residence</td>
<td>342</td>
</tr>
<tr>
<td></td>
<td>SSA114</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.4</td>
<td>MS2405</td>
<td>One-Year Survival after Surgery for Colon or Rectal Cancer (%)</td>
<td>344</td>
</tr>
<tr>
<td>2.4</td>
<td>MS2404</td>
<td>One-Year Survival after Surgery for Lung Cancer (%)</td>
<td>347</td>
</tr>
<tr>
<td>2.4</td>
<td>MS2403</td>
<td>Stroke Care Quality Improvement: Patients with a final diagnosis of acute stroke who have documented treatment in a stroke unit (%)</td>
<td>349</td>
</tr>
<tr>
<td>2.4</td>
<td>RTX001</td>
<td>Radiotherapy – Courses, New and Old (Number)</td>
<td>352</td>
</tr>
<tr>
<td>2.4</td>
<td>KF-012</td>
<td>Statewide Infant Screening – Hearing – Newborn hearing screens provided (Number)</td>
<td>355</td>
</tr>
<tr>
<td>2.4</td>
<td>KF-010</td>
<td>Statewide Eyesight for Preschoolers Screening (StEPS) - Eyesight screens provided to 4 year olds (Number)</td>
<td>357</td>
</tr>
<tr>
<td>2.4</td>
<td>KF-003</td>
<td>Universal Health Home Visits provided within 2 weeks of baby’s birth (Number)</td>
<td>359</td>
</tr>
<tr>
<td>2.5</td>
<td>MS2101</td>
<td>Efficiency by Specialty:</td>
<td>361</td>
</tr>
<tr>
<td></td>
<td>MS2102</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.5</td>
<td>MS2306</td>
<td>Unplanned Hospital Readmission Distributions: all unplanned admissions within 28 days of separation – Cohort comparisons (%)</td>
<td>364</td>
</tr>
<tr>
<td>2.5</td>
<td>SSQ112</td>
<td>Unplanned and Emergency Re-presentations - to same ED within 48 hours (%)</td>
<td>368</td>
</tr>
<tr>
<td></td>
<td>SSQ113</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>SSQ125</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.5</td>
<td>SIC101</td>
<td>Potentially Preventable Hospitalisations (Rate per 100,000)</td>
<td>371</td>
</tr>
<tr>
<td></td>
<td>SIC102</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>SIC103</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>SIC104</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2018-19 Strategic Priority</td>
<td>ID</td>
<td>Measure</td>
<td>Page No.</td>
</tr>
<tr>
<td>---------------------------</td>
<td>-------</td>
<td>-----------------------------------------------------------------------------------------------</td>
<td>----------</td>
</tr>
<tr>
<td>2.5</td>
<td>SSA132</td>
<td>Home Based Dialysis – Proportion of renal dialysis service events that are home based (%)</td>
<td>376</td>
</tr>
<tr>
<td>2.2</td>
<td>SSA116</td>
<td>Average Length of Episode Stay - Overnight Acute Patients (Days)</td>
<td>378</td>
</tr>
<tr>
<td>2.5</td>
<td>MS2504</td>
<td>Acute separations - overnight (Number)</td>
<td>381</td>
</tr>
<tr>
<td>2.5</td>
<td>MS2505</td>
<td>Acute separations – same day (Number)</td>
<td>383</td>
</tr>
<tr>
<td>2.5</td>
<td>MS2503</td>
<td>Admitted Patient Separations (Number)</td>
<td>385</td>
</tr>
<tr>
<td>2.5</td>
<td>MS2502</td>
<td>Attendances Admitted from ED (number)</td>
<td>387</td>
</tr>
<tr>
<td>2.5</td>
<td>PI-03</td>
<td>Hospital in the Home: Admitted Activity (%)</td>
<td>389</td>
</tr>
<tr>
<td>3.1</td>
<td>PI-02</td>
<td>Com Packs - Packages (Number)</td>
<td>391</td>
</tr>
<tr>
<td>3.2</td>
<td>SSA106</td>
<td>Patients with Total time in ED &lt;= 4hrs: Mental Health (%)</td>
<td>393</td>
</tr>
<tr>
<td>3.2</td>
<td>MS3203</td>
<td>Emergency Department Extended Stays: Mental Health Presentations staying in ED &gt; 12 hours (number)</td>
<td>397</td>
</tr>
<tr>
<td>3.2</td>
<td>SSQ124</td>
<td>Mental Health: Frequency of Seclusion (%)</td>
<td>400</td>
</tr>
<tr>
<td>3.2</td>
<td>SSQ121</td>
<td>Mental Health: Outcome Readiness – HoNOS Completion Rates (%)</td>
<td>402</td>
</tr>
<tr>
<td>3.2</td>
<td>SSQ122</td>
<td>Mental Health Consumer Experience Measure (YES) - Completion rate (%)</td>
<td>406</td>
</tr>
<tr>
<td>3.2</td>
<td>DMH_3203</td>
<td>Community Mental Health Enhancements: Target contact hours (%)</td>
<td>409</td>
</tr>
<tr>
<td>3.2</td>
<td>MS3201</td>
<td>Mental Health: Acute mental health service overnight separations (Number)</td>
<td>411</td>
</tr>
<tr>
<td>3.2</td>
<td>MS3202</td>
<td>Mental Health: non-acute mental health inpatient days (Number)</td>
<td>413</td>
</tr>
<tr>
<td>3.2</td>
<td>MS3204</td>
<td>Mental Health Line Call Abandonment (%)</td>
<td>415</td>
</tr>
<tr>
<td>3.3</td>
<td>DPALC_3303</td>
<td>Last-Days-of-Life Home Support - Patients referred to support service who died at home (%)</td>
<td>417</td>
</tr>
<tr>
<td>3.3</td>
<td>DPALC_3302</td>
<td>Last-Days-of-Life Home Support - Completed packages in the quarter (Number)</td>
<td>419</td>
</tr>
<tr>
<td>3.3</td>
<td>MS3301</td>
<td>End of Life Care - Advance Care Directives (ACDs) - Patients in acute facilities who die with a valid ACD (Number)</td>
<td>421</td>
</tr>
<tr>
<td>3.4</td>
<td>MS3401</td>
<td>National Disability Insurance Scheme (NDIS) – Patients with an NDIS Status (Number)</td>
<td>423</td>
</tr>
<tr>
<td>3.4</td>
<td>MS3402</td>
<td>National Disability Insurance Scheme (NDIS) – Inpatients with an NDIS Related Wait Recorded (Number)</td>
<td>425</td>
</tr>
<tr>
<td>3.5</td>
<td>MS3102</td>
<td>Electronic Discharge Summary Performance: Created within 48 hours of patient discharge from hospital (%)</td>
<td>427</td>
</tr>
<tr>
<td>3.5</td>
<td>MS3101</td>
<td>Integrated Care Program – Patients Enrolled (Number)</td>
<td>429</td>
</tr>
<tr>
<td>3.5</td>
<td>MS3103</td>
<td>Patient Reported Measures: Surveys Completed (Number)</td>
<td>431</td>
</tr>
<tr>
<td>3.6</td>
<td>KF-0081</td>
<td>New Street Services – Primary clients completing treatment (%)</td>
<td>433</td>
</tr>
<tr>
<td>3.6</td>
<td>KF-004</td>
<td>Child Protection Counselling Services - new family referrals allocated to a counsellor (Number)</td>
<td>435</td>
</tr>
<tr>
<td>2018-19 Strategic Priority</td>
<td>ID</td>
<td>Measure</td>
<td>Page No.</td>
</tr>
<tr>
<td>---------------------------</td>
<td>------------</td>
<td>-------------------------------------------------------------------------</td>
<td>----------</td>
</tr>
<tr>
<td>3.6</td>
<td>MS3601</td>
<td>JIRT Health Attendances – Clients referred to Violence, Abuse and Neglect health services who attend the service within 6 weeks of referral (%)</td>
<td>437</td>
</tr>
<tr>
<td>4.1</td>
<td>SPC107</td>
<td>Recruitment: Improvement on baseline average time taken from request to recruit to decision to approve/decline/defer recruitment (days)</td>
<td>439</td>
</tr>
<tr>
<td>4.1</td>
<td>MS4101</td>
<td>Additional Frontline Staff (Number)</td>
<td>441</td>
</tr>
<tr>
<td></td>
<td>MS4102</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>MS4103</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>MS4104</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.1</td>
<td>DWPDS_4101</td>
<td>Skilled Workforce Growth: Increase in Enrolled Nurses (%)</td>
<td>443</td>
</tr>
<tr>
<td>4.1</td>
<td>MS4106</td>
<td>Rural and Regional Medical Workforce Increase (%)</td>
<td>445</td>
</tr>
<tr>
<td></td>
<td>MS4107</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>MS4108</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.1</td>
<td>SPC102</td>
<td>Premium Staff Usage: average paid hours per FTE</td>
<td>448</td>
</tr>
<tr>
<td></td>
<td>SPC103</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.3</td>
<td>SPC109</td>
<td>Public Service Commission (PSC) People Matter Employee Survey Response Rate (%)</td>
<td>451</td>
</tr>
<tr>
<td>4.3</td>
<td>DWPDS_4202</td>
<td>Workplace Diversity Improvement: Women in Senior Executive Roles (%)</td>
<td>453</td>
</tr>
<tr>
<td>4.5</td>
<td>SPC112</td>
<td>Workplace Injuries: Return to work experience (days)</td>
<td>456</td>
</tr>
<tr>
<td></td>
<td>SPC113</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>SPC114</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.5</td>
<td>DWPDS_4402</td>
<td>Work Health &amp; Safety: Targeted staff required to attend Personal Safety Training that have attended (%)</td>
<td>458</td>
</tr>
<tr>
<td>4.5</td>
<td>DWPDS_4403</td>
<td>Compensable Workplace Injuries: Compensable Injuries by Occupational category and by Type (Number)</td>
<td>460</td>
</tr>
<tr>
<td>4.5</td>
<td>SPC105</td>
<td>Leave Liability: Reduction in the total number of staff who have accrued leave balances of more than 30 days (Number)</td>
<td>463</td>
</tr>
<tr>
<td>4.5</td>
<td>MS4401</td>
<td>Hand Hygiene Compliance (%)</td>
<td>465</td>
</tr>
<tr>
<td>5.3</td>
<td>DHMR_5301</td>
<td>Clinical Trials: Persons recruited to cancer clinical trials (Number)</td>
<td>467</td>
</tr>
<tr>
<td>5.4</td>
<td>MS5301</td>
<td>Participants enrolled to commercial clinical trial projects:</td>
<td>471</td>
</tr>
<tr>
<td></td>
<td>MS5302</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.4</td>
<td>DHMR_5403</td>
<td>Client Data Linkage - Records linked in the Centre for Health Record Linkage Master Linkage Key (Number)</td>
<td>474</td>
</tr>
<tr>
<td>6.1</td>
<td>DeH_6101</td>
<td>eMR2 Implementation Progress: Hospitals where the eMR2 has been implemented (%)</td>
<td>476</td>
</tr>
<tr>
<td>6.1</td>
<td>Deh_6102</td>
<td>eMeds Implementation Progress: Hospitals where eMeds has been implemented (%)</td>
<td>478</td>
</tr>
<tr>
<td>6.1</td>
<td>DeH_6103</td>
<td>eRIC Implementation Progress: Hospitals where eRIC has been implemented (%)</td>
<td>480</td>
</tr>
<tr>
<td>6.2</td>
<td>SIC108</td>
<td>Electronic Discharge Summaries: sent electronically and accepted by a GP Broker system (%)</td>
<td>482</td>
</tr>
<tr>
<td>6.3</td>
<td>DWPDS_4104</td>
<td>HealthRoster Implementation Progress: Health Employees Rostered Within HealthRoster (%)</td>
<td>484</td>
</tr>
<tr>
<td>6.3</td>
<td>DSR_7305</td>
<td>HWAN Implementation Progress: Facilities connected to the Health Wide Area Network (%)</td>
<td>486</td>
</tr>
<tr>
<td>6.3</td>
<td>DSR_7306</td>
<td>SWIS Implementation (Identity Management) Progress: Facilities Standardised under the Statewide Infrastructure as a Service Program (%)</td>
<td>488</td>
</tr>
<tr>
<td>2018-19 Strategic Priority</td>
<td>ID</td>
<td>Measure</td>
<td>Page No.</td>
</tr>
<tr>
<td>---------------------------</td>
<td>----------</td>
<td>-------------------------------------------------------------------------</td>
<td>----------</td>
</tr>
<tr>
<td>6.3</td>
<td>DSR_7307</td>
<td>Data Centre Reform Server Migration Progress: Servers Migrated to Government Data Centres (GovDC) (%)</td>
<td>490</td>
</tr>
<tr>
<td>6.3</td>
<td>DSR_7308</td>
<td>Data Centre Reform Application Migration Progress: Health Applications Migrated to Government Data Centres (GovDC) (%)</td>
<td>492</td>
</tr>
<tr>
<td>7.1</td>
<td>DSR_7309</td>
<td>Deliver Infrastructure: Business Cases Completed (%)</td>
<td>494</td>
</tr>
<tr>
<td>7.1</td>
<td>DSR_7302</td>
<td>Deliver Infrastructure: Construction Commenced (%)</td>
<td>496</td>
</tr>
<tr>
<td>7.1</td>
<td>DSR_7303</td>
<td>Deliver Infrastructure: Construction Completed (%)</td>
<td>498</td>
</tr>
<tr>
<td>7.3</td>
<td>DSR_7402</td>
<td>Whole of Lifecycle Asset Management: Asset and Facilities Management (AFM) Online Take-up (%)</td>
<td>500</td>
</tr>
<tr>
<td>7.3</td>
<td>MS7401</td>
<td>Asbestos Documentation Upload to AFM Online</td>
<td>503</td>
</tr>
<tr>
<td>7.3</td>
<td>MS7402</td>
<td>AFM Online – Data Description Completion (%)</td>
<td>506</td>
</tr>
<tr>
<td>7.3</td>
<td>MS7403</td>
<td>AFM Online – GBA Survey Measure (%)</td>
<td>509</td>
</tr>
<tr>
<td>7.3</td>
<td>MS7404</td>
<td>AFM Online – Building Age Recorded (%)</td>
<td>512</td>
</tr>
<tr>
<td>8.1</td>
<td>SFA113</td>
<td>Sub and Non Acute Admitted Patient Episodes - grouped to an AN-SNAP Class (%)</td>
<td>515</td>
</tr>
<tr>
<td>8.1</td>
<td>SFA106</td>
<td>ED Records unable to be grouped</td>
<td>517</td>
</tr>
<tr>
<td>8.1</td>
<td>SFA107</td>
<td>Coding Timeliness: Uncoded Acute Separations (%)</td>
<td>520</td>
</tr>
<tr>
<td>8.1</td>
<td>SFA108</td>
<td>Total Activity Delivered (NWAU) (Number)</td>
<td>523</td>
</tr>
<tr>
<td>8.1</td>
<td>MS8101</td>
<td>Expenditure Matched to Budget: June projection Variance – General Fund (%)</td>
<td>526</td>
</tr>
<tr>
<td>8.1</td>
<td>KFA102</td>
<td>Own Source Revenue Matched to Budget: June projection variance – General Fund (%)</td>
<td>528</td>
</tr>
<tr>
<td>8.1</td>
<td>KFA104</td>
<td>Variation Against Reported Expenditure: Small Rural Hospitals &amp; Specialist Hospitals (%)</td>
<td>530</td>
</tr>
<tr>
<td>8.1</td>
<td>SFA103</td>
<td>Patient Fee Debtors &gt; 45 days as a percentage of rolling prior 12 months patient fee revenues (%)</td>
<td>532</td>
</tr>
<tr>
<td>8.4</td>
<td>KFA106</td>
<td>Small Business Creditors - Paid within 30 days from receipt of a correctly rendered invoice (%)</td>
<td>534</td>
</tr>
<tr>
<td>8.4</td>
<td>KFA105</td>
<td>Recurrent Trade Creditors &gt; 45 days correct and ready for payment (Number)</td>
<td>536</td>
</tr>
</tbody>
</table>
## Premier’s Priorities

**Purpose**
These performance measures are reported to DPC bimonthly in response to progress against the Making it Happen Priorities

<table>
<thead>
<tr>
<th>2017/18 Strategic Priority</th>
<th>ID</th>
<th>Measure</th>
<th>Page No.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tackling childhood obesity</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IM 1.1</td>
<td>PH-008D</td>
<td>Healthy Children Initiative - Targeted Family Healthy Eating and Physical Activity Program (Go4Fun) – Completed Program (%)</td>
<td>201</td>
</tr>
<tr>
<td>IM 1.1</td>
<td>PH-008C</td>
<td>Healthy Children Initiative - Targeted Family Healthy Eating and Physical Activity Program (Go4Fun) – Enrolments Achieved (Number)</td>
<td>201</td>
</tr>
<tr>
<td>IM 1.1</td>
<td>MS1102</td>
<td>Childhood Obesity: Children with height and weight recorded (%)</td>
<td>204</td>
</tr>
</tbody>
</table>

| **Improving service levels in hospitals** |         |                                                                         |          |
| KPI 2.4                     | KSA102  | Emergency Treatment Performance - Patients with total time in ED ≤ 4 hrs (%) | 98       |

## State Priorities

**Purpose**
These performance measures are reported to DPC bimonthly in response to progress against the Making it Happen Priorities

<table>
<thead>
<tr>
<th>2017/18 Strategic Priority</th>
<th>ID</th>
<th>Measure</th>
<th>Page No.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cutting wait times for planned surgery</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>KPI 2.4</td>
<td>KSA103a</td>
<td>Elective Surgery Access Performance: Category 1 Patients Treated on Time (%)</td>
<td>92</td>
</tr>
<tr>
<td>KPI 2.4</td>
<td>KSA103b</td>
<td>Elective Surgery Access Performance: Category 2 Patients Treated on Time (%)</td>
<td>92</td>
</tr>
<tr>
<td>KPI 2.4</td>
<td>KSA103c</td>
<td>Elective Surgery Access Performance: Category 3 Patients Treated on Time (%)</td>
<td>92</td>
</tr>
<tr>
<td>KPI 2.4</td>
<td>SSA108</td>
<td>Overdue Elective Surgery - Category 1 Patients (number):</td>
<td>95</td>
</tr>
<tr>
<td>KPI 2.4</td>
<td>SSA109</td>
<td>Overdue Elective Surgery - Category 2 Patients (number):</td>
<td>95</td>
</tr>
<tr>
<td>KPI 2.4</td>
<td>SSA110</td>
<td>Overdue Elective Surgery - Category 3 Patients (number):</td>
<td>95</td>
</tr>
</tbody>
</table>
KEY PERFORMANCE INDICATORS FOR 2018-19
# STRATEGY 1 KPIs: Keep People Healthy

<table>
<thead>
<tr>
<th>INDICATOR:</th>
<th>PH-011B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous ID:</td>
<td>Get Healthy Information and Coaching Service – Health Professional Referrals: Variance (%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Shortened Title</th>
<th>Get Healthy Information and Coaching Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Agreement Type</td>
<td>Key Performance Indicator</td>
</tr>
<tr>
<td>Framework Strategy</td>
<td>Strategy 1: Keep People Healthy</td>
</tr>
<tr>
<td>Framework Objective</td>
<td>1.1 (Reduce Childhood Obesity)</td>
</tr>
<tr>
<td>Status</td>
<td>Final</td>
</tr>
<tr>
<td>Version number</td>
<td>1.41</td>
</tr>
<tr>
<td>Scope</td>
<td>Adults aged 16 years and over across NSW</td>
</tr>
<tr>
<td>Goal</td>
<td>Reduced prevalence of overweight/obesity in adults 16 years and over across NSW.</td>
</tr>
<tr>
<td>Desired outcome</td>
<td>Reduce the risk of lifestyle related chronic disease by promoting healthy weight, increase consumption of fruits and vegetables and increase participation in recommended levels of physical activity.</td>
</tr>
<tr>
<td>Primary point of collection</td>
<td>Service provider – Healthways Australia</td>
</tr>
<tr>
<td>Data Collection Source/System</td>
<td>Embrace (Healthways Australia)</td>
</tr>
<tr>
<td>Primary data source for analysis</td>
<td>Monthly enrolment data entered into the Embrace system and transferred by Secure File Transfer to IPSOS- for independent analysis.</td>
</tr>
<tr>
<td>Indicator definition</td>
<td>Percentage increase in number of adults aged 16 years and over who are referred to the Get Healthy Information and Coaching Service by a Health Professional.</td>
</tr>
</tbody>
</table>

### Numerator
- **Numerator definition**: Total number of adults aged 16 years and over who were referred to the Get Healthy Information and Coaching Service by a Health Professional in the 2018-2019 reporting period.
- **Numerator source**: Embrace (Healthways Australia)
- **Numerator availability**: Quarterly

### Denominator
- **Denominator definition**: Target number of adults aged 16 years and over who are expected to be referred to the Get Healthy Information and Coaching Service by a Health Professional in the 2018-2019 reporting period.
- **Denominator source**:  
- **Denominator availability**:  

### Inclusions
- Adults aged 16 years and over.

### Exclusions
- Children and young people aged less than 16 years of age
- CCLHD – 0% increase (384 referrals by 30/06/2019)
- FWLHD – 0% increase (34 referrals)
- HNELHD – 75% increase (963 referrals)
- ISLHD – 18% increase (432 referrals)
- MNCLHD – 0% increase (246 referrals)
- MLHD – 18% increase (257 referrals)
- NBMLHD – 0% increase (440 referrals)
- NSLHD – 128% increase (666 referrals)
- NNSWLHD – 0% increase (317 referrals)
- SESLHD – 38% increase (966 referrals)
- SWSLHD – 0% increase (1,136 referrals)
- SNSWLHD – 0% increase (234 referrals)
- SLHD – 60% increase (672 referrals)
- WNSWLHD – 60% increase (296 referrals)
- WSLHD – 55% increase (1,017 referrals)

The targets are based on the LHD population size (approximately 100 per 100,000 population) as well as the previous 2017-18 targets. This results in some LHDs experiencing an increase in the targets, whilst others remain the same as 2017-18.

Performing: Met or exceeded target

Under Performing: <= 10% variation below target

Not Performing: > 10% variation below target

Context

The NSW Healthy Eating and Active Living Strategy (HE&AL) commits NSW to achieving targets related to the delivery of the Get Healthy Information and Coaching Service. Achieving the target for the Get Healthy Service (9,600 adults participating in the Program in 2016/17) requires an increase in program reach across NSW. LHDs are supported to promote this initiative.

Related Policies/ Programs

- NSW Healthy Eating and Active Living Strategy: Preventing overweight and obesity in New South Wales 2013-2018

Useable data available from

February 2009

Frequency of Reporting

Quarterly

Time lag to available data

60 days

Business owners

Office of the Chief Health Officer

Contact - Policy

Executive Director, Centre for Population Health (Dr Jo Mitchell)

Contact - Data

Manager, Strategy and Partnerships Branch

Representation

Data type

Numeric

Form

Percentage

Representational layout

NNN.NN

Minimum size

3

Maximum size

6
<table>
<thead>
<tr>
<th>Related National Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Data domain</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date effective</td>
<td></td>
</tr>
</tbody>
</table>

Source
INDICATOR: PH-008B

**Healthy Children Initiative** – Children’s Healthy Eating and Physical Activity Program – Primary schools achieving agreed proportion of Live Life Well @ School program practices (%)

**Indicators**

- **Previous ID:**
  - Healthy Children Initiative – Primary schools achieving agreed proportion of Live Life Well @ School program practices (%)

**Shortened Title**

Healthy Children Initiative – Live Life Well

**Service Agreement Type**

- Key Performance Indicator

**Framework Strategy**

- Strategy 1: Keep People Healthy

**Framework Objective**

- 1.1 (Reduce Childhood Obesity)

**Status**

- Final

**Version number**

- 3.11

**Scope**

- All primary school sites in NSW

**Goal**

To increase the proportion of primary schools in NSW that implement and adopt the Live life Well @ School program.

**Desired outcome**

Reduce the risk of lifestyle related chronic diseases by promoting healthy eating and physical activity to support healthy weight.

**Primary point of collection**

- LHD Program Manager and Health Promotion Officers

**Data Collection Source/System**

- Population Health Information Management System (PHIMS)

**Primary data source for analysis**

- Data entered into the Population Health Information Management System (PHIMS)

**Indicator definition**

The proportion of primary schools and nominated non main stream primary schools that have adopted the Live Life Well @ School program to attain Service Agreement targets by June 2019.

**Numerator**

- **Numerator definition**
  
  Total number of primary schools and nominated non main stream primary schools that:
  
  - are active or were active within the defined reporting period and
  - are enabled for schedule follow up, and
  - have attended training or are “deemed trained” and
  - are on the reference list of Primary schools in PHIMS, and
  - have achieved 65%, of the Live Life Well @ School program practices within the defined reporting period.

- **Numerator source**
  - PHIMS

- **Numerator availability**
  - Quarterly

**Denominator**

- **Denominator definition**
  
  Total number of primary schools and nominated non main stream primary schools that:
  
  - are active or were active within the defined reporting period and
  - are enabled for schedule follow up, and
  - have attended training or are “deemed trained” and
  - are on the reference list of Primary schools in PHIMS.

- **Denominator source**
  - NSW Department of Education and PHIMS
### 2018-19 Service Performance Agreements
#### Strategy 1 KPIs: Keep People Healthy

**Denominator availability**
Quarterly

**Inclusions**

**Exclusions**

**Targets**
60% of primary schools to achieve 65% of Live Life Well@ School program practices.

- Performing: >60% of sites adopting KPI target, with ≥ 65% of Practices achieved
- Under Performing: 55-59% of sites adopting KPI target, with ≥ 65% of Practices achieved
- Not Performing: <55% of sites adopting KPI target, with ≥ 65% of Practices achieved

**Comments:**
- Some practice(s) may not be relevant to a primary school. For example, a primary school may not have a canteen e.g. Practice 5.
- Geographical area of interest: whole state / LHD.

**Context**
The NSW Healthy Children Initiative commits NSW to attain targets related to training and adoption of the Children’s Healthy Eating and Physical Activity Program by primary schools LHDs are fully funded for this initiative

**Related Policies/ Programs**
- Premier’s Priority to reduce childhood overweight and obesity by 5% by 2025
- NSW Healthy Eating and Active Living Strategy: Preventing overweight and obesity in New South Wales 2013-2018
- Healthy Children Initiative

**Useable data available from**
July 2012

Note: Practice data comparable from July 2012- June 2017. Enhanced practices data available from July 2017 and not directly comparable period to July 2012 – June 2017.

**Frequency of Reporting**
Quarterly

**Time lag to available data**
30 days

**Business owners**
Centre for Population Health

- Contact - Policy: Executive Director, Centre for Population Health (Dr Jo Mitchell)
- Contact - Data: Manager, Strategy and Partnerships Branch

**Representation**

<table>
<thead>
<tr>
<th>Data type</th>
<th>Numeric</th>
</tr>
</thead>
<tbody>
<tr>
<td>Form</td>
<td>Number</td>
</tr>
<tr>
<td>Representational layout</td>
<td>NNN</td>
</tr>
<tr>
<td>Minimum size</td>
<td>2</td>
</tr>
<tr>
<td>Maximum size</td>
<td>3</td>
</tr>
<tr>
<td>Data domain</td>
<td>N/A</td>
</tr>
<tr>
<td>-------------</td>
<td>--------------</td>
</tr>
<tr>
<td>Date effective</td>
<td></td>
</tr>
</tbody>
</table>

**Related National Indicators**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Source</th>
</tr>
</thead>
</table>
### INDICATOR: PH-008A

**Previous ID:**

---

**INDICATOR:** PH-008A  
**Previous ID:**

---

**Healthy Children Initiative** - Children's Healthy Eating and Physical Activity Program: Early Childhood Services – Sites achieving agreed proportion of Munch and Move Program practices (%)

---

**Shortened Title**  
Healthy Children Initiative – Munch and Move

**Service Agreement Type**  
Key Performance Indicator

**Framework Strategy**  
Strategy 1: Keep People Healthy

**Framework Objective**  
1.1 (Reduce Childhood Obesity)

**Status**  
Final

**Version number**  
3.11

**Scope**  
All centre-based and nominated non centre-based Early Childhood Services (ECS) (i.e. mobile, early intervention and distance education) in NSW

**Goal**  
To increase the proportion of Early Childhood Services in NSW that implement and adopt the Munch & Move program.

**Desired outcome**  
Reduce the risk of lifestyle related chronic diseases by promoting healthy eating and physical activity to support healthy weight.

**Primary point of collection**  
LHD Program Manager and Health Promotion Officers

**Data Collection Source/System**  
Population Health Information Management System (PHIMS)

**Primary data source for analysis**  
Data entered into the Population Health Information Management System (PHIMS)

**Indicator definition**  
The proportion of centre-based and nominated non centre-based ECS's that have adopted the Munch & Move program to attain Service Agreement targets by June 2019.

**Numerator**

**Numerator definition**  
Total number of centre-based and nominated non centre-based ECS’s that:

- are active or were active within the defined reporting period and
- are enabled for scheduled follow up and
- have attended training or are “deemed trained” and
- are on the reference list of ECS’s in PHIMS and
- have achieved 65% of the relevant Munch and Move program practices within the defined reporting period.

**Numerator source**  
PHIMS

**Numerator availability**  
Quarterly

**Denominator**

**Denominator definition**  
Total number of centre-based and nominated non centre-based ECS’s that:

- are active or were active within the defined reporting period and
- are enabled for scheduled follow up and
- have attended training or are “deemed trained” and
- are on the reference list of ECS’s in PHIMS.
### 2018-19 Service Performance Agreements
#### Strategy 1 KPIs: Keep People Healthy

<table>
<thead>
<tr>
<th>Denominator source</th>
<th>PHIMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator availability</td>
<td>Quarterly</td>
</tr>
</tbody>
</table>

#### Inclusions

#### Exclusions

### Targets

- **Target**: 
  
  \[ \text{>= 60\% of Early Childhood Services to achieve 65\% of Munch & Move program practices} \]

- **Performing**: 
  
  \[ \text{>=60\% of sites adopting KPI target, with \geq 65\% of Practices achieved} \]

- **Under Performing**: 
  
  \[ \text{55-59\% of sites adopting KPI target, with \geq 65\% of Practices achieved} \]

- **Not Performing**: 
  
  \[ \text{<55\% of sites adopting KPI target, with \geq 65\% of Practices achieved} \]

#### Comments:

- Some practices may not be relevant to an ECS site. For example, an ECS that only caters for children 3-5 years of age would not be monitored on the practice of implementing a breastfeeding policy, procedure or guideline as this only applies to services providing care for children 0-12 months of age.

- Geographical area of interest: whole state / LHD.

#### Context

The NSW Healthy Children Initiative commits NSW to attain targets related to attendance at training and adoption of the Children’s Healthy Eating and Physical Activity Program by centre-based early childhood services. LHDs are fully funded for this initiative.

#### Related Policies/Programs

- Premier’s Priority to reduce childhood overweight and obesity by 5\% by 2025
- NSW Healthy Eating and Active Living Strategy: Preventing overweight and obesity in New South Wales 2013-2018
- Healthy Children Initiative

#### Useable data available from

July 2012

#### Frequency of Reporting

Quarterly

#### Time lag to available data

Real-time (though dependent on timely data entry)

#### Business owners

**Centre for Population Health**

- **Contact - Policy**: Executive Director, Centre for Population Health (Dr Jo Mitchell)
- **Contact - Data**: Manager, Information and Reporting Unit

#### Representation

<table>
<thead>
<tr>
<th>Data type</th>
<th>Numeric</th>
</tr>
</thead>
<tbody>
<tr>
<td>Form</td>
<td>Number</td>
</tr>
<tr>
<td>Representational layout</td>
<td>NNN.NN</td>
</tr>
<tr>
<td>Minimum size</td>
<td>3</td>
</tr>
<tr>
<td>Maximum size</td>
<td>5</td>
</tr>
</tbody>
</table>
2018-19 Service Performance Agreements
Strategy 1 KPIs: Keep People Healthy

Data domain: N/A
Date effective:

Related National Indicators

Indicator

Source
**INDICATOR:** PH-013A, SPH007

## Smoking During Pregnancy - At any time: (%) 

### Previous IDs:

- Smoking During Pregnancy
  - At any time (%)
  - Aboriginal women (%) (PH-013A)
  - Non-Aboriginal women (%) (SPH007)

### Shortened Title

Smoking During Pregnancy

### Service Agreement Type

Key Performance Indicator

### Framework Strategy

Strategy 1: Keep People Healthy

### Framework Objective

1.2 (Reduce Tobacco Use)

### Status

Final

### Version number

2.2

### Scope

All women giving birth in NSW (Aboriginal and non-Aboriginal)

### Goal

Reduce smoking rates of women during pregnancy (Aboriginal and non-Aboriginal)

### Desired outcome

Reduce the rate of smoking in pregnant Aboriginal women by 2% per year and in pregnant non-Aboriginal women by 0.5% per year (NSW State Health Plan)

### Primary point of collection

Local Health District maternity services

### Data Collection Source/System

ObstetriX and CERNER Facility based electronic obstetric systems and electronic transfer from private hospitals; Manual collection.

NSW Ministry of Health: MDCOS (Midwives Data Collection Online System)

### Primary data source for analysis

NSW Perinatal Data Collection (SAPHaRI)

### Indicator definition

Percentage of confinements for women who smoked at any time during pregnancy. This includes all women who responded yes to one or both of the following two data elements from the Perinatal Data Collection:

- Smoking in the first half of pregnancy
- Smoking in the second half of pregnancy

Indicator is reported separately for:

1. % of all Aboriginal women who smoked during pregnancy
2. % of all non-Aboriginal women who smoked during pregnancy

### Numerator

- **Numerator definition**
  - Number of Aboriginal women who smoked at any time during pregnancy
  - Number of non-Aboriginal women who smoked at any time during pregnancy

- **Numerator source**
  - NSW Perinatal Data Collection

- **Numerator availability**
  - Annual

### Denominator

- **Denominator definition**
  - Number of Aboriginal women giving birth in NSW (Number of
2018-19 Service Performance Agreements
Strategy 1 KPIs: Keep People Healthy

(ii) Number of non-Aboriginal women giving birth in NSW (Number of confinements)

Denominator source: NSW Perinatal Data Collection
Denominator availability: Annual

Inclusions: Aboriginal or non-Aboriginal women giving birth in NSW, NSW residents only

Exclusions: Aboriginal or non-Aboriginal women giving birth outside NSW, who normally reside in NSW

Targets: Decrease on previous year

- Performing: Decrease from previous year
- Under performing: No change
- Not performing: Increase on previous year

Long term objective: Reduce the rate of smoking by non-Aboriginal pregnant women by 0.5% per year and by 2% per year for pregnant Aboriginal women from a 2010 baseline.

Context: Smoking during pregnancy is often associated with poor health outcomes for the foetus such as increased risk of perinatal mortality, low birthweight, and other health related issues. The indicator is a key indicator to measure progress towards the national commitment to halve the gap in child mortality between Aboriginal and non-Aboriginal people by 2018.

Related Policies/ Programs
- COAG National Partnership Agreement on Closing the Gap
- COAG National Indigenous Reform Agreement (Closing the Gap)
- Aboriginal Maternal and Infant Health Strategy
- NSW Tobacco Strategy 2012-2017
- Quit for New Life Program

Useable data available from: 1990

Frequency of Reporting: Annual (calendar year)

Time lag to available data: 8 months, available August following the end of the calendar year

Business owners: Centre for Aboriginal Health and Centre for Population Health

Contact - Policy: Executive Director, Centre for Aboriginal Health and Executive Director, Centre for Population Health (Dr Jo Mitchell)

Contact - Data: Associate Director, Epidemiology and Biostatistics, Centre for Epidemiology & Evidence

Representation
- Data type: Numeric
- Form: Number, presented as a percentage (%)

Page 47
<table>
<thead>
<tr>
<th>Representational layout</th>
<th>NNN.NN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum size</td>
<td>3</td>
</tr>
<tr>
<td>Maximum size</td>
<td>6</td>
</tr>
<tr>
<td>Data domain</td>
<td></td>
</tr>
<tr>
<td>Date effective</td>
<td>1 January 2011</td>
</tr>
</tbody>
</table>

**Related National Indicator**

National Core Maternity Indicators: PI 01—Tobacco smoking in pregnancy for all women giving birth (2016)

[http://meteor.aihw.gov.au/content/index.phtml/itemId/613173](http://meteor.aihw.gov.au/content/index.phtml/itemId/613173)
| INDICATOR: DPH_1201 | **Pregnant Women Quitting Smoking** - By second half of pregnancy (%) |
|---------------------------------------------------------------|

**Previous IDs:**
- Pregnant Women Quitting Smoking

---

**Shortened Title**
Pregnant Women Quitting Smoking

**Service Agreement Type**
Key Performance Indicator

**Framework Strategy**
Strategy 1: Keep People Healthy

**Framework Objective**
1.2 (Reduce Tobacco Use)

**Status**
Final

**Version number**
1.11

**Scope**
All women giving birth in NSW

**Goal**
To reduce smoking during pregnancy

**Desired outcome**
Increase the number of women quitting smoking during pregnancy

**Primary point of collection**
Staff in Maternity Units at hospitals and Independent Midwives

**Data Collection Source/System**
Perinatal Data Collection (PDC)

**Primary data source for analysis**
NSW Perinatal Data Collection (SAPHaRI, MDCOS)

**Indicator definition**
Proportion of pregnant women who quit smoking during the second half of their pregnancy.

\[
\text{Women who quit smoking by the second half of pregnancy (\%) = } \frac{\text{Total number of women who reported smoking in the first half of pregnancy and who gave birth to a liveborn baby (or babies) regardless of gestation age or birth weight, or stillborn baby (or babies) of at least twenty (20) weeks gestation or four hundred (400) grams birth weight.}}{\text{Total number of women who reported smoking in the first half of pregnancy and who gave birth to a liveborn baby (or babies) regardless of gestation age or birth weight, or stillborn baby (or babies) of at least twenty (20) weeks gestation or four hundred (400) grams birth weight.}}
\]

**Numerator**
- **Definition**
  Total number of women who quit smoking by the second half of pregnancy and who gave birth to a liveborn baby (or babies) regardless of gestation age or birth weight, or stillborn baby (or babies) of at least twenty (20) weeks gestation or four hundred (400) grams birth weight.
  - **Source**
    NSW Perinatal Data Collection
  - **Availability**
    Six-monthly, data lag six months after the close of six month period based on date of birth of the baby

**Denominator**
- **Definition**
  Total number of women who reported smoking in the first half of pregnancy and who gave birth to liveborn babies regardless of gestation age or birth weight, and stillborn babies of at least twenty (20) weeks gestation or four hundred (400) grams birth weight.
gestation or four hundred (400) grams birth weight.

Denominator source: NSW Perinatal Data Collection
Denominator availability: Six-monthly, data lag six months after the close of six month period based on date of birth of the baby

**Inclusions**
Women giving birth in NSW, including live born babies regardless of gestational age or birth weight and stillborn babies of at least twenty (20) weeks gestation or four hundred (400) grams birth weight.

**Exclusions**
- Women who did not report smoking at any time during pregnancy, or where smoking status is not stated.
- Women giving birth outside NSW, who normally reside in NSW.

**Targets**
- Target: 4% Increase on previous year
  - Performing: 4% Increase on previous year
  - Under performing: ≥1% and <4% increase on previous year
  - Not performing: <1% increase on previous year

**Context**
Smoking during pregnancy is often associated with poor health outcomes for the fetus such as increased risk of perinatal mortality, low birth weight, and prematurity.

**Related Policies/ Programs**
- COAG National Partnership Agreement on Closing the Gap
- COAG National Indigenous Reform Agreement (Closing the Gap)
- Aboriginal Maternal and Infant Health Strategy
- NSW Tobacco Strategy 2012-2017
- Quit for New Life Program

**Useable data available from**
1 July 2016

**Frequency of Reporting**
Quarterly

**Time lag to available data**
Six-monthly, data lag six months after the close of six month period based on date of birth of the baby.

**Business owners**
- **Contact - Policy**: Executive Director, Centre for Population Health
- **Contact - Data**: Director, Epidemiology and Biostatistics, Centre for Epidemiology & Evidence

**Representation**
- **Data type**: Numeric
- **Form**: Number, presented as a percentage (%)
- **Representational layout**: NNN.NN
- Minimum size: 3
- Maximum size: 6
Data domain
Date effective 1 July 2016

Related National Indicator
COAG National Indigenous Reform Agreement:
National Core Maternity Indicators: PI 01-Tobacco smoking in pregnancy for all women giving birth

http://meteor.aihw.gov.au/content/index.phtml/itemId/557104
Human Immunodeficiency Virus (HIV) Testing - Within publicly-funded HIV and sexual health services: Variance (%)

Shortened Title: HIV Testing

Service Agreement Type: Key Performance Indicator
Framework Strategy: Strategy 1: Keep People Healthy
Framework Objective: 1.4 (Reduce impact of infectious diseases)

Status: Final
Version number: 1.02
Scope: All publicly-funded HIV and sexual health services in NSW

Goal: To maintain HIV testing levels and increase the proportion of specific priority populations accessing HIV testing in publicly-funded HIV and sexual health services.

Desired outcome: To improve case detection and early diagnosis of HIV and reduce late diagnosis.

Primary point of collection: Clinical staff at publicly funded HIV and Sexual Health services
Data Collection Source/System: Multiple data collections/source systems in NSW sexual health and HIV clinical services.

Primary data source for analysis: HIV-STI Clinical Services Database
Indicator definition: The percentage variance in HIV tests provided in publicly-funded HIV, sexual health services and other targeted services in the 2018-19 financial year against the target number of tests expected to be provided.

Numerator
  Numerator definition: Number of HIV tests provided in publicly-funded HIV, sexual health services and other targeted services in the 2018-19 financial year.
  Numerator source: HIV-STI Clinical Services Database
  Numerator availability: Quarterly

Denominator
  Denominator definition: Target number of HIV tests expected to be provided in publicly-funded HIV, sexual health services and other targeted services in the 2018-19 financial year.
  Denominator source: N/A
  Denominator availability: N/A

Inclusions
  • All laboratory HIV tests and HIV dried blood spots

Exclusions
  N/A

Targets
  • SLHD – 11,411
  • SWSLHD – 4,037
2018-19 Service Performance Agreements
Strategy 1 KPIs: Keep People Healthy

- SESLHD – 27,914
- ISLHD – 776
- WSLHD – 4,912
- NBMLHD – 1,225
- NSLHD – 3,569
- CCLHD – 1,051
- HNELHD – 4,042
- NNSWLHD – 1,561
- MNCLHD – 439
- SNSWLHD – 182
- MLHD – 596
- WNSWLHD – 922
- FWLHD – 168
- SVHN – 1,540

Performing: Met or exceeded target

Not performing: <98% Target

Under performing: >=98% and < Target

Context
NSW Government has committed to increase HIV testing as per NSW HIV Strategy 2016-2020

Related Policies/ Programs
NSW HIV Strategy 2016-2020

Useable data available from
July 2013

Frequency of Reporting
Quarterly and reported via the following sub-population groups:
number of HIV tests
- proportion in men who have sex with men
- proportion in Aboriginal people
- proportion in sex workers
- proportion in people who inject drugs

Time lag to available data
Reporting data available one month post last reporting period

Business owners
Office of the Chief Health Officer
Contact - Policy
Executive Director, Centre for Population Health (Dr Jo Mitchell)
Contact - Data
Director, Population Health Programs (Jo Holden)

Representation
Data type
Numeric
Form
Number
Representational layout
NNN{NN}
Minimum size
3
Maximum size
5
Data domain
N/A
Date effective

Related National Indicators

Indicator

- Proportion of gay men who have been tested for HIV in the previous 12 months

- Seventh National HIV Strategy 2014 - 2017

Source
INDICATOR: PH-014C

Previous IDs:

**Hepatitis C Antiviral Treatment Initiation** – Direct acting - by LHD residents: Variance (%)

**Shortened Title**
Hepatitis C Antiviral Treatment Initiation

**Service Agreement Type**
Key Performance Indicator

**Framework Strategy**
Strategy 1: Keep People Healthy

**Framework Objective**
1.4 (Reduce impact of infectious diseases)

**Status**
Final

**Version number**
1.02

**Scope**
All NSW residents with chronic hepatitis C prescribed direct acting antiviral treatments listed under the Pharmaceutical Benefits Scheme (PBS) from 1 March 2016.

**Goal**
To improve the health outcomes of people living with hepatitis C in NSW by providing treatment in a range of settings which can prevent the development of the major life-threatening complications of chronic liver disease including cirrhosis and liver cancer.

**Desired outcome**
Increase the number of people with chronic hepatitis C accessing hepatitis C treatment in NSW.

**Primary point of collection**
Pharmaceutical Benefits Scheme (PBS).

**Data Collection Source/System**
PBS Highly Specialised Drugs Programme data and Repatriation PBS data prepared by the Commonwealth Department of Health.

**Primary data source for analysis**
PBS data extract provided quarterly by the Commonwealth Department of Health (with a three to six month time lag as the PBS closes off the data three months post the relevant quarter).

**Indicator definition**
The percentage variance in LHD residents initiating hepatitis C direct acting antiviral treatment in the 2018-19 financial year against the target number of LHDs residents expected to be initiate hepatitis C direct acting antiviral treatment.

**Numerator**
- **Numerator definition**
  Total number of LHD residents with chronic hepatitis C initiating hepatitis C direct acting antiviral treatment listed under the PBS.

- **Numerator source**
  PBS Highly Specialised Drugs Program data and Repatriation PBS data prepared by the Commonwealth Department of Health

- **Numerator availability**
  Quarterly

**Denominator**
- **Denominator definition**
  Target number of expected LHD residents with chronic hepatitis C initiating hepatitis C direct acting antiviral treatment listed under the PBS.
2018-19 Service Performance Agreements
Strategy 1 KPIs: Keep People Healthy

Denominator availability

**Inclusions**
- NSW residents
- PBS dispensing from public hospital, private hospital and community pharmacies
- Hepatitis C direct acting antiviral treatments available through the PBS from 1 March 2016.

**Exclusions**
- Non-PBS dispensing
- People accessing treatment through other sources, including overseas purchase and clinical trials
- Patients who were treated with ‘old’ interferon treatments prior to 1 March 2016.

**Targets**

|--------|----------------|------------|-------------|-------------|---------------|-------------|-------------|--------------|-------------|-------------|----------------|----------------|--------------|--------|----------|

Performing: Met or exceeded target

Under performing: >=98% and < Target

Not performing: < 98% Target

**Context**
The NSW Government is committed to increasing the number of people accessing hepatitis C treatment by 100% over the lifetime of the NSW Hepatitis C Strategy 2014-2020 (The target was set with a note of it being subject to change once new treatments became available). The strategy includes a priority to increase the proportion of people treated through primary care models.

**Related Policies/ Programs**
- NSW Hepatitis C Strategy 2014 – 2020
- Fourth National Hepatitis C Strategy 2014-2017

**Useable data available from**
01/03/2016

**Frequency of Reporting**
Quarterly

**Time lag to available data**
Three to six months, The time lag is because the PBS closes off the data
three months post the relevant quarter.

**Business owners**
Office of the Chief Health Officer

Contact - Policy
Executive Director, Centre for Population Health (Dr Jo Mitchell)

Contact - Data
Manager, BBVs and STI Unit (Tim Duck)

**Representation**

<table>
<thead>
<tr>
<th>Data type</th>
<th>Numeric</th>
</tr>
</thead>
<tbody>
<tr>
<td>Form</td>
<td>Number</td>
</tr>
<tr>
<td>Representation layout</td>
<td>N(4)</td>
</tr>
<tr>
<td>Minimum size</td>
<td>1</td>
</tr>
<tr>
<td>Maximum size</td>
<td>4</td>
</tr>
<tr>
<td>Data domain</td>
<td>Number</td>
</tr>
</tbody>
</table>

**Related National Indicator**
N/A
**STRATEGY 2 KPIs: Provide World-Class Clinical Care Where Patient Safety is First**

**INDICATOR:** KS2101  
**Previous IDs:**  
**Shortened Title:** Fall-Related Injuries in Hospital  
**Service Agreement Type:** Key Performance Indicator  
**Framework Strategy:** Strategy 2: Provide World-Class Clinical Care Where Patient Safety is First  
**Framework Objective:** 2.1 (Embed quality improvement to ensure safer patient care)  
**Status:** Final  
**Version number:** 2.1  
**Scope:** All acute and neonatal admitted patients in NSW public hospitals  
**Goal:** To provide safe and quality care to reduce harm from falls in hospital in patients  
**Desired outcome:** Fewer instances of falls occurring in health service area resulting in intracranial injury, fractured neck of femur and other fractures.  
**Primary point of collection:** Patient medical record  
**Data Collection Source/System:** Admitted patient data collection  
**Primary data source for analysis:** Health Information Exchange (HIE)  
**Indicator definition:** A fall occurring in health service area resulting in intracranial injury, fractured neck of femur or other fracture as a rate per 1000 occupied bed days.  

**Numerator**  
**Numerator definition:** Number of completed acute or neonatal inpatient episodes within the reporting period with: a diagnosis code of intracranial injury, fractured neck of femur or other fractures in recorded as an additional diagnosis, and an external cause code of Fall, and a place of occurrence code of within the health facility, and a condition onset flag of ‘1’.

**Computation description:** Falls in hospital are identified using the following algorithm:

- Injuries resulting in intracranial injury, fractured neck of femur or other fracture with [ICD10-AM diagnosis codes](https://www.aihw.gov.au/search/), recorded as an additional diagnosis, AND
- Place of occurrence is either Y92.23 or Y92.24, AND
- Condition Onset Flag = ‘1’.
Strategy 2 KPIs: Provide World-Class Clinical Care Where Patient Safety is First

Numerator source: Heath Information Exchange (HIE)
Numerator availability: Available

**Denominator**
Denominator definition: The total number of acute or neonatal occupied bed days of all hospital inpatient episodes in NSW public hospitals within the reporting period. In this context, occupied bed days are the total days of all in scope episodes minus the leave days.

Denominator source: Heath Information Exchange (HIE)
Denominator availability: Available

**Inclusions**
- All acute and neonatal admitted patients in NSW public hospitals (Care types = 1 or 5)
- See [Full diagnosis code list](#) for the complete set of ICD codes that are included in this KPI.

**Exclusions**
Numerator and denominator exclusions:
- Sub-acute admitted patients
- Same-day chemotherapy - DRG V8: R63Z and admission date = separation date
- Same-day haemodialysis - DRG V8: L61Z and admission date = separation date
- Primary diagnosis mental health care - Major Diagnostic Category = 19 or 20
- Mental Health inpatient episodes - Care type = M
- Care type is ‘Hospital boarder’ - Care type = 0
- Care type is ‘Organ procurement-posthumous’ - Care type = 9

**Targets**
Target: < Risk adjusted target rate
- Performing: < target
- Not performing: >=23% of target rate
- Under performing: >=0% and <23% of target rate

<table>
<thead>
<tr>
<th>LHD</th>
<th>Target Rate (1,000 bed days)</th>
<th>Underperforming</th>
<th>Not Performing</th>
</tr>
</thead>
<tbody>
<tr>
<td>SCHN</td>
<td>&lt;0.026</td>
<td>&gt;=0.026 and &lt;0.031</td>
<td>&gt;=0.031</td>
</tr>
<tr>
<td>SVHN</td>
<td>&lt;0.13</td>
<td>&gt;=0.13 and &lt;0.15</td>
<td>&gt;=0.15</td>
</tr>
<tr>
<td>SYDLHD</td>
<td>&lt;0.11</td>
<td>&gt;=0.11 and &lt;0.14</td>
<td>&gt;=0.14</td>
</tr>
<tr>
<td>SWSLHD</td>
<td>&lt;0.11</td>
<td>&gt;=0.11 and &lt;0.13</td>
<td>&gt;=0.13</td>
</tr>
<tr>
<td>SESLHD</td>
<td>&lt;0.13</td>
<td>&gt;=0.13 and &lt;0.16</td>
<td>&gt;=0.16</td>
</tr>
<tr>
<td>ISLHD</td>
<td>&lt;0.17</td>
<td>&gt;=0.17 and &lt;0.22</td>
<td>&gt;=0.22</td>
</tr>
<tr>
<td>WSLHD</td>
<td>&lt;0.11</td>
<td>&gt;=0.11 and &lt;0.13</td>
<td>&gt;=0.13</td>
</tr>
<tr>
<td>NBMLHD</td>
<td>&lt;0.11</td>
<td>&gt;=0.11 and &lt;0.14</td>
<td>&gt;=0.14</td>
</tr>
</tbody>
</table>
Strategy 2 KPIs: Provide World-Class Clinical Care Where Patient Safety is First

### 2018-19 Service Performance Agreements

<table>
<thead>
<tr>
<th>Authority</th>
<th>Target</th>
<th>Achieved</th>
<th>Not Achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>NSLHD</td>
<td>&lt;0.16</td>
<td>&gt;=0.16</td>
<td>&lt;0.19</td>
</tr>
<tr>
<td>CCLHD</td>
<td>&lt;0.17</td>
<td>&gt;=0.17</td>
<td>&lt;0.21</td>
</tr>
<tr>
<td>HNELHD</td>
<td>&lt;0.13</td>
<td>&gt;=0.13</td>
<td>&lt;0.16</td>
</tr>
<tr>
<td>NNSWLHD</td>
<td>&lt;0.13</td>
<td>&gt;=0.13</td>
<td>&lt;0.16</td>
</tr>
<tr>
<td>MNCLHD</td>
<td>&lt;0.12</td>
<td>&gt;=0.12</td>
<td>&lt;0.15</td>
</tr>
<tr>
<td>SNSWLHD</td>
<td>&lt;0.17</td>
<td>&gt;=0.17</td>
<td>&lt;0.21</td>
</tr>
<tr>
<td>MLHD</td>
<td>&lt;0.15</td>
<td>&gt;=0.15</td>
<td>&lt;0.19</td>
</tr>
<tr>
<td>WNSWLHD</td>
<td>&lt;0.12</td>
<td>&gt;=0.12</td>
<td>&lt;0.15</td>
</tr>
<tr>
<td>FWLHD</td>
<td>&lt;0.22</td>
<td>&gt;=0.22</td>
<td>&lt;0.27</td>
</tr>
</tbody>
</table>


### Context

Monitoring falls in hospital resulting in harm is specific to aligning with the Australian Commission on Safety and Quality in Healthcare (ACSQHC), Hospital Acquired Complications List and the CEC Leading Better Value Care – Falls in hospital initiative.

### Related Policies/Programs

- PD2011_029 Falls - Prevention of Falls and Harm from Falls among Older People: 2011-2015
- National Safety and Quality Health Service Standard 10: Preventing Falls and Harm from Falls (ACSQHC)
- NSW Falls Prevention Program, Clinical Excellence Commission (CEC)

### Useable data available from

2015 (based on improvement in coding of condition onset flag in NSW)

### Frequency of Reporting

Monthly

### Time lag to available data

Admitted Patient Data Collection data for all admitted patients must be coded and queued for processing on the Ministry’s HIE by the 28th calendar day after the end of the week of separation (week ending each Friday).

### Business owners

- **Contact - Policy**: Executive Director, System Management Branch
- **Contact - Data**: Executive Director, System Information and Analytics Branch
  
  (hsipr@doh.health.nsw.gov.au)

### Representation

- **Data type**: Numeric
- **Form**: Number, presented as a rate per 1,000 bed days
- **Representational layout**: NN.NN
- **Minimum size**: 4
- **Maximum size**: 5
- **Data domain**
### 2018-19 Service Performance Agreements

**Strategy 2 KPIs: Provide World-Class Clinical Care Where Patient Safety is First**

<table>
<thead>
<tr>
<th>Date effective</th>
<th>1 July 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Related National Indicator</strong></td>
<td>AIHW and ACSQHC Hospital Acquired Complication list</td>
</tr>
</tbody>
</table>

Indicator sets and related indicators can be sourced from:
http://meteor.aihw.gov.au/content/index.phtml/itemid/401254
## INDICATOR: KQS205

**Hospital Acquired Pressure Injuries (Rate)**

### Previous IDs:
- Stage 3, 4, and Unspecified Deep Tissue pressure injuries - Rate (per 1,000 bed days)

### Shortened Title
Hospital Acquired Pressure Injuries

### Service Agreement Type
Key Performance Indicator

### Framework Strategy
Strategy 2: Provide World-Class Clinical Care Where Patient Safety is First

### Framework Objective
2.1 (Embed quality improvement to ensure safer patient care)

### Status
Final

### Version number
3.1

### Scope
All acute and neonatal admitted patients in NSW public hospitals

### Goal
To minimize the number and severity of hospital acquired pressure injuries in NSW public health facilities through promotion of a comprehensive, systematic approach to pressure injury prevention and management.

### Desired outcome
Improved quality and safety processes by timely risk assessment which guides prevention strategies and management of existing pressure injuries, resulting in a reduction in the number and severity of hospital acquired pressure injuries.

### Primary point of collection
Patient Medical Record

### Data Collection Source/System
Hospital PAS systems, Admitted Patient Data Collection

### Primary data source for analysis
HIE

### Indicator definition
The rate of completed inpatient episodes with stage 3 or 4 or unspecified hospital acquired pressure injuries per 1000 occupied bed days.

### Numerator
**Numerator definition**
The total number of acute or neonatal inpatient episodes with stage 3 or 4 or unspecified hospital acquired pressure injuries with episode end dates within the reporting period.

Stage 3, 4 and unspecified hospital acquired pressure injuries are identified where:
- ICD10AM 10th edition codes L89.2x, L89.3x, or L89.9x are recorded as an additional diagnosis only;
- AND a condition onset flag (COF) code of 1 (Condition with onset during the episode of admitted patient care)

**Numerator source**
HIE

**Numerator availability**
Available

### Denominator
**Denominator definition**
The total number of acute or neonatal occupied bed days of all hospital inpatient episodes in NSW public hospitals within the reporting period. In this context, occupied bed days are the total days of all in scope episodes minus the leave days.

**Denominator source**
HIE
Denominator availability

**Inclusions**
- All acute or neonatal admitted patients in NSW public hospitals.

**Exclusions**
- Numerator exclusions:
  - Episodes where an L89.2x, L89.3x, or L89.9x ICD10AM code has been recorded as a principal diagnosis.

**Numerator and denominator exclusions:**
- Sub-acute admitted patients
- Same-day chemotherapy - DRG V8: R63Z and admission date = separation date
- Same-day haemodialysis - DRG V8: L61Z and admission date = separation date
- Primary diagnosis mental health care - Major Diagnostic Category = 19 or 20
- Mental Health inpatient episodes - Care type = M
- Care type is ‘Hospital boarder’ - Care type = 0
- Care type is ‘Organ procurement-posthumous’ - Care type = 9

**Targets**

**Target**
- < Risk adjusted target rate
  - Performing: < target
  - Not performing: >=65% of target rate
  - Under performing: >=0% and <65% of target rate

<table>
<thead>
<tr>
<th>LHD</th>
<th>Target Rate (1,000 bed days)</th>
<th>Underperforming</th>
<th>Not Performing</th>
</tr>
</thead>
<tbody>
<tr>
<td>SCHN</td>
<td>&lt;0.39</td>
<td>&gt;=0.39 and &lt;0.65</td>
<td>&gt;=0.65</td>
</tr>
<tr>
<td>SVHN</td>
<td>&lt;0.24</td>
<td>&gt;=0.24 and &lt;0.39</td>
<td>&gt;=0.39</td>
</tr>
<tr>
<td>SYDLHD</td>
<td>&lt;0.24</td>
<td>&gt;=0.24 and &lt;0.39</td>
<td>&gt;=0.39</td>
</tr>
<tr>
<td>SWSLHD</td>
<td>&lt;0.20</td>
<td>&gt;=0.20 and &lt;0.32</td>
<td>&gt;=0.32</td>
</tr>
<tr>
<td>SESLHD</td>
<td>&lt;0.24</td>
<td>&gt;=0.24 and &lt;0.39</td>
<td>&gt;=0.39</td>
</tr>
<tr>
<td>ISLHD</td>
<td>&lt;0.25</td>
<td>&gt;=0.25 and &lt;0.42</td>
<td>&gt;=0.42</td>
</tr>
<tr>
<td>WSLHD</td>
<td>&lt;0.20</td>
<td>&gt;=0.20 and &lt;0.33</td>
<td>&gt;=0.33</td>
</tr>
<tr>
<td>NBMLHD</td>
<td>&lt;0.26</td>
<td>&gt;=0.26 and &lt;0.43</td>
<td>&gt;=0.43</td>
</tr>
<tr>
<td>NSLHD</td>
<td>&lt;0.27</td>
<td>&gt;=0.27 and &lt;0.44</td>
<td>&gt;=0.44</td>
</tr>
<tr>
<td>CCLHD</td>
<td>&lt;0.23</td>
<td>&gt;=0.23 and &lt;0.38</td>
<td>&gt;=0.38</td>
</tr>
<tr>
<td>HNELHD</td>
<td>&lt;0.21</td>
<td>&gt;=0.21 and &lt;0.34</td>
<td>&gt;=0.34</td>
</tr>
<tr>
<td>NNSWLHD</td>
<td>&lt;0.24</td>
<td>&gt;=0.24 and &lt;0.39</td>
<td>&gt;=0.39</td>
</tr>
<tr>
<td>MNCLHD</td>
<td>&lt;0.27</td>
<td>&gt;=0.27 and &lt;0.44</td>
<td>&gt;=0.44</td>
</tr>
<tr>
<td>SNSWLHD</td>
<td>&lt;0.20</td>
<td>&gt;=0.20 and &lt;0.34</td>
<td>&gt;=0.34</td>
</tr>
<tr>
<td>MLHD</td>
<td>&lt;0.26</td>
<td>&gt;=0.26 and &lt;0.42</td>
<td>&gt;=0.42</td>
</tr>
<tr>
<td>WNSWLHD</td>
<td>&lt;0.24</td>
<td>&gt;=0.24 and &lt;0.40</td>
<td>&gt;=0.40</td>
</tr>
<tr>
<td>FWLHD</td>
<td>&lt;0.26</td>
<td>&gt;=0.26 and &lt;0.42</td>
<td>&gt;=0.42</td>
</tr>
</tbody>
</table>

Context
The rate of hospital acquired pressure injury varies between patient populations. Facilities with a low hospital acquired pressure injury rate may be able to demonstrate good preventative practices; facilities with a high hospital acquired pressure injury rate may indicate a problem with clinical care and risk assessment processes.

Related Policies/Programs
- NSW Health Pressure Injury Prevention and Management policy PD 2014_007 sets out best practice for the prevention of pressure injuries
- NSQHSS – Standard 8 Preventing and Managing Pressure Injuries
- CEC Pressure Injury Prevention Project

Useable data available from
1 September 2015

Frequency of Reporting
Monthly

Time lag to available data
1 month

Business owners
Contact - Policy
Executive Director, System Management Branch

Contact - Data
Executive Director, System Information and Analytics Branch (hsipr@doh.health.nsw.gov.au)

Representation
Data type
Numeric

Form
Number, presented as a rate per 1,000 bed days

Representational layout
NN.NN

Minimum size
4

Maximum size
5

Data domain

Date effective
1 July 2015

Related National Indicator
### Healthcare Associated Infections

- **Indicator ID:** KS2110
- **Previous IDs:** Healthcare Associated Infections (Rate per 1,000 bed days)

#### Shortened Title
- Healthcare Associated Infections

#### Service Agreement Type
- Key Performance Indicator

#### Framework Strategy
- Strategy 2: Provide World-Class Clinical Care Where Patient Safety is First

#### Framework Objective
- 2.1 (Embed quality improvement to ensure safer patient care)

#### Status
- Final

#### Version number
- 1.1

#### Scope
- All acute and neonatal admitted patients in NSW public hospitals

#### Goal
- Improve post-surgical care and increase quality outcomes.

#### Desired outcome
- Reduction in the number of patients developing infections whilst an inpatient.

#### Primary point of collection
- Administrative and clinical patient data collected at admission and discharge

#### Data Collection Source/System
- Diagnosis codes / Hospital Patient Admission Systems (PAS), Admitted Patient Data Collection

#### Primary data source for analysis
- Health Information Exchange (HIE)

#### Indicator definition
- The rate of completed inpatient episodes where an infection has been recorded whose onset has occurred during the period of hospitalization per 1,000 occupied bed days.

#### Numerator
- **Definition:** Number of completed acute or neonatal inpatient episodes where an infection has been recorded as an additional diagnosis and whose onset has occurred during the period of hospitalization.

  Healthcare associated infections are identified where:
  - A relevant infection ICD10-AM diagnosis codes has been recorded as an additional diagnosis,
  - AND a condition onset flag (COF) code of 1 (Condition with onset during the episode of admitted patient care)

  **Source:** HIE
  **Availability:** HIE available monthly

#### Denominator
- **Definition:** The total number of acute or neonatal occupied bed days of all hospital inpatient episodes in NSW public hospitals within the reporting period. In this context, occupied bed days are the total days of all in scope episodes minus the leave days.
Denominator source: HIE
Denominator availability: Monthly

**Inclusions**
- All admitted acute or neonatal patients in NSW public hospitals.
- See Full diagnosis code list for the complete set of ICD codes that are included in this KPI.

**Exclusions**

**Numerator and denominator exclusions:**
- Sub-acute admitted patients
- Same-day chemotherapy - DRG V8: R63Z and admission date = separation date
- Same-day haemodialysis - DRG V8: L61Z and admission date = separation date
- Primary diagnosis mental health care - Major Diagnostic Category = 19 or 20
- Mental Health inpatient episodes - Care type = M
- Care type is 'Hospital boarder' - Care type = 0
- Care type is 'Organ procurement-posthumous' - Care type = 9

**Targets**

<table>
<thead>
<tr>
<th>LHD</th>
<th>Target Rate (1,000 bed days)</th>
<th>Underperforming</th>
<th>Not Performing</th>
</tr>
</thead>
<tbody>
<tr>
<td>SCHN</td>
<td>&lt;3.49</td>
<td>&gt;=3.49 and &lt;3.95</td>
<td>&gt;=3.95</td>
</tr>
<tr>
<td>SVHN</td>
<td>&lt;4.58</td>
<td>&gt;=4.58 and &lt;5.19</td>
<td>&gt;=5.19</td>
</tr>
<tr>
<td>SYDLHD</td>
<td>&lt;3.67</td>
<td>&gt;=3.67 and &lt;4.16</td>
<td>&gt;=4.16</td>
</tr>
<tr>
<td>SWSLHD</td>
<td>&lt;2.86</td>
<td>&gt;=2.86 and &lt;3.24</td>
<td>&gt;=3.24</td>
</tr>
<tr>
<td>SESLHD</td>
<td>&lt;3.92</td>
<td>&gt;=3.92 and &lt;4.45</td>
<td>&gt;=4.45</td>
</tr>
<tr>
<td>ISLHD</td>
<td>&lt;3.70</td>
<td>&gt;=3.70 and &lt;4.20</td>
<td>&gt;=4.20</td>
</tr>
<tr>
<td>WSLHD</td>
<td>&lt;3.00</td>
<td>&gt;=3.00 and &lt;3.39</td>
<td>&gt;=3.39</td>
</tr>
<tr>
<td>NBMLHD</td>
<td>&lt;3.34</td>
<td>&gt;=3.34 and &lt;3.78</td>
<td>&gt;=3.78</td>
</tr>
<tr>
<td>NSLHD</td>
<td>&lt;3.75</td>
<td>&gt;=3.75 and &lt;4.25</td>
<td>&gt;=4.25</td>
</tr>
<tr>
<td>CCLHD</td>
<td>&lt;3.47</td>
<td>&gt;=3.47 and &lt;3.94</td>
<td>&gt;=3.94</td>
</tr>
<tr>
<td>HNELHD</td>
<td>&lt;2.88</td>
<td>&gt;=2.88 and &lt;3.27</td>
<td>&gt;=3.27</td>
</tr>
<tr>
<td>NNSWLHD</td>
<td>&lt;2.39</td>
<td>&gt;=2.39 and &lt;2.71</td>
<td>&gt;=2.71</td>
</tr>
<tr>
<td>MNCLHD</td>
<td>&lt;2.64</td>
<td>&gt;=2.64 and &lt;2.99</td>
<td>&gt;=2.99</td>
</tr>
<tr>
<td>SNSWLHD</td>
<td>&lt;2.45</td>
<td>&gt;=2.45 and &lt;2.77</td>
<td>&gt;=2.77</td>
</tr>
<tr>
<td>MLHD</td>
<td>&lt;2.69</td>
<td>&gt;=2.69 and &lt;3.05</td>
<td>&gt;=3.05</td>
</tr>
<tr>
<td>WNSWLHD</td>
<td>&lt;2.63</td>
<td>&gt;=2.63 and &lt;2.98</td>
<td>&gt;=2.98</td>
</tr>
<tr>
<td>FWLHD</td>
<td>&lt;2.86</td>
<td>&gt;=2.86 and &lt;3.24</td>
<td>&gt;=3.24</td>
</tr>
</tbody>
</table>

The methodology for the target risk adjustment is as per the IHPA HAC NWAU.

Context
Related Policies/Programs
Useable data available from 2015
Frequency of Reporting Monthly
Time lag to available data 1 month

Business owners
Contact - Policy Executive Director, System Management Branch
Contact - Data Executive Director, Strategic Information and Analysis (sia@doh.health.nsw.gov.au)

Representation
Data type Numeric
Form Number, presented as a rate per 1,000 bed days
Representational layout NN.NN
Minimum size 4
Maximum size 5
Data domain
Date effective 1st July 2018

**INDICATOR:** SSQ120

<table>
<thead>
<tr>
<th>Previous IDs:</th>
<th>Hospital Acquired Venous Thromboembolism (Rate per 1000 bed days)</th>
</tr>
</thead>
</table>

**Shortened Title**
Hospital Acquired VTE Rate

**Service Agreement Type**
Key Performance Indicator

**Framework Strategy**
Strategy 2: Provide World-Class Clinical Care Where Patient Safety is First

**Framework Objective**
2.1 (Embed quality improvement to ensure safer patient care)

**Status**
Final

**Version number**
3.1

**Scope**
All adult or neonatal patients admitted to public hospitals in NSW

**Goal**
To provide an outcome measure for the effectiveness of the Venous Thromboembolism (VTE) Prevention program.

**Desired outcome**
Reduction in the number of patients developing hospital-acquired VTE through increasing the number of patients risk assessed within 24 hours of admission and provided appropriate VTE prophylaxis.

**Primary point of collection**
Administrative and clinical patient data collected at admission and discharge

**Data Collection Source/System**
Diagnosis codes / Hospital Patient Admission Systems (PAS), Admitted Patient Data Collection

**Primary data source for analysis**
HIE

**Indicator definition**
The rate of completed inpatient episodes with hospital-acquired VTE per 1000 occupied bed days.

Venous thromboembolism refers to either deep vein thrombosis or pulmonary embolism.

**Numerator**
Number of acute or neonatal patients who had hospital-acquired VTE during reference period.

Hospital-acquired VTEs are identified where:
- ICD-10AM 10th edition codes I26.0, I26.9, I80.1, I80.20, I80.21, I80.22, I80.23 and I80.42 are recorded as any additional diagnosis (i.e. NOT principal diagnosis);
- AND a Condition Onset Flag code of ‘1’

**Numerator source**
HIE

**Numerator availability**
Monthly

**Denominator**
Denominator definition
The total number of acute or neonatal occupied bed days of all hospital inpatient episodes in NSW public hospitals within the reporting period. In this context, occupied bed days are the total days of all in scope episodes minus the leave days.

Denominator source
HIE

Denominator availability
Monthly

Inclusions
- All acute or neonatal admitted patients in NSW public hospitals.

Exclusions
Numerator exclusions:
Patients with VTE on admission (ie, episodes where ICD-10AM 10th edition codes I26.0, I26.9, I80.1, I80.20, I80.21, I80.22, I80.23 and I80.42 are recorded as a principal diagnosis.

Numerator and denominator exclusions:
- Sub-acute admitted patients
- Same-day chemotherapy - DRG V8: R63Z and admission date = separation date
- Same-day haemodialysis - DRG V8: L61Z and admission date = separation date
- Primary diagnosis mental health care - Major Diagnostic Category = 19 or 20
- Mental Health inpatient episodes - Care type = M
- Care type is ‘Hospital boarder’ - Care type = 0
- Care type is ‘Organ procurement-posthumous’ - Care type = 9

Targets
Target < Risk adjusted target rate
- Performing: < target
- Not performing: >=46% of target rate
- Under performing: >=0% and <46% of target rate

<table>
<thead>
<tr>
<th>LHD</th>
<th>Target Rate (1,000 bed days)</th>
<th>Underperforming</th>
<th>Not Performing</th>
</tr>
</thead>
<tbody>
<tr>
<td>SCHN</td>
<td>&lt;0.07</td>
<td>&gt;=0.07 and &lt;0.11</td>
<td>&gt;=0.11</td>
</tr>
<tr>
<td>SVHN</td>
<td>&lt;0.33</td>
<td>&gt;=0.33 and &lt;0.47</td>
<td>&gt;=0.47</td>
</tr>
<tr>
<td>SYDLHD</td>
<td>&lt;0.28</td>
<td>&gt;=0.28 and &lt;0.41</td>
<td>&gt;=0.41</td>
</tr>
<tr>
<td>SWSLHD</td>
<td>&lt;0.18</td>
<td>&gt;=0.18 and &lt;0.27</td>
<td>&gt;=0.27</td>
</tr>
<tr>
<td>SESLHD</td>
<td>&lt;0.32</td>
<td>&gt;=0.32 and &lt;0.46</td>
<td>&gt;=0.46</td>
</tr>
<tr>
<td>ISLHD</td>
<td>&lt;0.22</td>
<td>&gt;=0.22 and &lt;0.32</td>
<td>&gt;=0.32</td>
</tr>
<tr>
<td>WSLHD</td>
<td>&lt;0.18</td>
<td>&gt;=0.18 and &lt;0.27</td>
<td>&gt;=0.27</td>
</tr>
<tr>
<td>NBMLHD</td>
<td>&lt;0.25</td>
<td>&gt;=0.25 and &lt;0.36</td>
<td>&gt;=0.36</td>
</tr>
<tr>
<td>NSLHD</td>
<td>&lt;0.26</td>
<td>&gt;=0.26 and &lt;0.38</td>
<td>&gt;=0.38</td>
</tr>
<tr>
<td>CCLHD</td>
<td>&lt;0.20</td>
<td>&gt;=0.20 and &lt;0.30</td>
<td>&gt;=0.30</td>
</tr>
<tr>
<td>HNELHD</td>
<td>&lt;0.18</td>
<td>&gt;=0.18 and &lt;0.27</td>
<td>&gt;=0.27</td>
</tr>
<tr>
<td>NNSWLHD</td>
<td>&lt;0.17</td>
<td>&gt;=0.17 and &lt;0.25</td>
<td>&gt;=0.25</td>
</tr>
<tr>
<td>MNCLHD</td>
<td>&lt;0.21</td>
<td>&gt;=0.21 and &lt;0.30</td>
<td>&gt;=0.30</td>
</tr>
</tbody>
</table>
Strategy 2 KPIs: Provide World-Class Clinical Care Where Patient Safety is First

<table>
<thead>
<tr>
<th>SNSWLHD</th>
<th>&lt;0.14</th>
<th>&gt;=0.14 and &lt;0.20</th>
<th>&gt;=0.20</th>
</tr>
</thead>
<tbody>
<tr>
<td>MLHD</td>
<td>&lt;0.22</td>
<td>&gt;=0.22 and &lt;0.33</td>
<td>&gt;=0.33</td>
</tr>
<tr>
<td>WNSWLHD</td>
<td>&lt;0.20</td>
<td>&gt;=0.20 and &lt;0.30</td>
<td>&gt;=0.30</td>
</tr>
<tr>
<td>FWLHD</td>
<td>&lt;0.13</td>
<td>&gt;=0.13 and &lt;0.19</td>
<td>&gt;=0.19</td>
</tr>
</tbody>
</table>


**Context**

Variation may exist in the assignment of ICD-10-AM codes, leading to under-reporting in post-operative or post-procedural period; in particular, the assignment of an additional code (I26.0, I26.9, I80.1 or I80.2) identifying the presence of the VTE as a post-operative or post-procedural complication is not a mandatory coding practice. Therefore coding practices may require evaluation to ensure consistency.

**Related Policies/Programs**

*PD2014_032 Prevention of Venous Thromboembolism*

**Useable data available from**

To be determined

**Frequency of Reporting**

Monthly

**Time lag to available data**

1 month

**Business owners**

- Contact - Policy: Executive Director, System Management Branch
- Contact - Data: Executive Director, System Information and Analytics

**Representation**

- **Data type**: Numeric
- **Form**: Number, presented as a rate per 1,000 bed days
- **Representational layout**: NN.NN
- **Minimum size**: 4
- **Maximum size**: 5
- **Data domain**: 1st July 2015

**Related National Indicator**

Hospital-Acquired Complications 10th edition, November 2017, ACSQHC

Australian Safety and Quality Goal 1.1.3 Adults experience fewer venous thromboembolisms associated with hospitalisation

National Quality Use of Medicines Indicators for Australian Hospitals

1.1 Percentage of hospitalised adult patients that are assessed for risk of venous thromboembolism

1.2 Percentage of hospitalised adult patients that receive venous
thromboembolism prophylaxis appropriate to their level of risk
**INDICATOR:** KS2111  
**Hospital Acquired Medication Complications (Rate per 1,000 bed days)**

<table>
<thead>
<tr>
<th>Shortened Title</th>
<th>HAC Medication Complications</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Service Agreement Type</strong></td>
<td>Key Performance Indicator</td>
</tr>
<tr>
<td><strong>Framework Strategy</strong></td>
<td>Strategy 2: Provide World-Class Clinical Care Where Patient Safety is First</td>
</tr>
<tr>
<td><strong>Framework Objective</strong></td>
<td>2.1 (Embed quality improvement to ensure safer patient care)</td>
</tr>
<tr>
<td><strong>Status</strong></td>
<td>Final</td>
</tr>
<tr>
<td><strong>Version number</strong></td>
<td>1.1</td>
</tr>
<tr>
<td><strong>Scope</strong></td>
<td>All acute or neonatal admitted patients in NSW public hospitals</td>
</tr>
<tr>
<td><strong>Goal</strong></td>
<td>Improve medication usage and increase quality outcomes.</td>
</tr>
<tr>
<td><strong>Desired outcome</strong></td>
<td>Reduction in the number of patients developing complications due to the intake of medications.</td>
</tr>
<tr>
<td><strong>Primary point of collection</strong></td>
<td>Patient medical record</td>
</tr>
<tr>
<td><strong>Data Collection Source/System</strong></td>
<td>Admitted patient data collection</td>
</tr>
<tr>
<td><strong>Primary data source for analysis</strong></td>
<td>Health Information Exchange (HIE)</td>
</tr>
<tr>
<td><strong>Indicator definition</strong></td>
<td>The rate of completed inpatient episodes within the reporting period where a medication complication has occurred in a public hospital per 1,000 occupied bed days.</td>
</tr>
</tbody>
</table>

**Numerator**

**Numerator definition**

Number of completed inpatient acute or neonatal episodes within the reporting period with: (i) drug related respiratory complications/ depression, or (ii) haemorrhagic disorder due to circulating anticoagulants, or (iii) hypoglycaemia recorded as an additional diagnosis and a condition onset flag of ‘1’.

**Computation description**

Medication complications are identified using the following algorithm:

- ICD-10-AM codes J96.00 or J96.01 or J96.09 or J96.90 or J96.91 or J96.99 or J98.1 as an additional diagnosis code AND a condition onset flag (COF) code of 1 (Condition with onset during the episode of admitted patient care) AND ANY external cause code of X41, X42, Y11, Y12, Y13, Y14, X43, X44, Y45.0, Y47.0-Y47.9 together with any Condition Onset Flag value assigned to the external cause codes; OR
- ICD-10-AM codes D68.3 or E10.64 or E11.64 or E13.64 or E14.64 or E16.0 or E16.1 or E16.2 as an additional diagnosis AND a condition onset flag (COF) code of 1 (Condition with onset during the episode of admitted patient care)
2018-19 Service Performance Agreements
Strategy 2 KPIs: Provide World-Class Clinical Care Where Patient Safety is First

Numerator source: Heath Information Exchange (HIE)
Numerator availability: Available

**Denominator**

Denominator definition: The total number of acute or neonatal occupied bed days of all hospital inpatient episodes in NSW public hospitals within the reporting period. In this context, occupied bed days are the total days of all in scope episodes minus the leave days.

Denominator source: Heath Information Exchange (HIE)
Denominator availability: Available

**Inclusions**

- All admitted acute or neonatal patients in NSW public hospitals.

**Exclusions**

Numerator exclusions:

- Episodes where the numerator diagnoses recorded as a principal diagnosis and where none of the other codes are present as additional diagnoses.

Numerator and denominator exclusions:

- Sub-acute admitted patients
- Same-day chemotherapy - DRG V8: R63Z and admission date = separation date
- Same-day haemodialysis - DRG V8: L61Z and admission date = separation date
- Primary diagnosis mental health care - Major Diagnostic Category = 19 or 20
- Mental Health inpatient episodes - Care type = M
- Care type is ‘Hospital boarder’ - Care type = 0
- Care type is ‘Organ procurement-posthumous’ - Care type = 9

**Targets**

Target < Risk adjusted target rate

- Performing: < target
- Not performing: >=32% of target rate
- Under performing: >=0% and <32% of target rate

<table>
<thead>
<tr>
<th>LHD</th>
<th>Target Rate (1,000 bed days)</th>
<th>Underperforming</th>
<th>Not Performing</th>
</tr>
</thead>
<tbody>
<tr>
<td>SCHN</td>
<td>&lt;0.39</td>
<td>&gt;=0.39 and &lt;0.52</td>
<td>&gt;=0.52</td>
</tr>
<tr>
<td>SVHN</td>
<td>&lt;1.15</td>
<td>&gt;=1.15 and &lt;1.53</td>
<td>&gt;=1.53</td>
</tr>
<tr>
<td>SYDLHD</td>
<td>&lt;0.89</td>
<td>&gt;=0.89 and &lt;1.18</td>
<td>&gt;=1.18</td>
</tr>
<tr>
<td>SWSLHD</td>
<td>&lt;0.82</td>
<td>&gt;=0.82 and &lt;1.08</td>
<td>&gt;=1.08</td>
</tr>
<tr>
<td>SESLHD</td>
<td>&lt;0.97</td>
<td>&gt;=0.97 and &lt;1.28</td>
<td>&gt;=1.28</td>
</tr>
<tr>
<td>ISLHD</td>
<td>&lt;1.04</td>
<td>&gt;=1.04 and &lt;1.38</td>
<td>&gt;=1.38</td>
</tr>
</tbody>
</table>
Strategy 2 KPIs: Provide World-Class Clinical Care Where Patient Safety is First

<table>
<thead>
<tr>
<th>WSLHD</th>
<th>&lt;0.88</th>
<th>&gt;=0.88 and &lt;1.17</th>
<th>&gt;=1.17</th>
</tr>
</thead>
<tbody>
<tr>
<td>NBMLHD</td>
<td>&lt;0.90</td>
<td>&gt;=0.90 and &lt;1.19</td>
<td>&gt;=1.19</td>
</tr>
<tr>
<td>NSLHD</td>
<td>&lt;0.90</td>
<td>&gt;=0.90 and &lt;1.20</td>
<td>&gt;=1.20</td>
</tr>
<tr>
<td>CCLHD</td>
<td>&lt;0.96</td>
<td>&gt;=0.96 and &lt;1.27</td>
<td>&gt;=1.27</td>
</tr>
<tr>
<td>HNELHD</td>
<td>&lt;0.76</td>
<td>&gt;=0.76 and &lt;1.01</td>
<td>&gt;=1.01</td>
</tr>
<tr>
<td>NNSWLHD</td>
<td>&lt;0.73</td>
<td>&gt;=0.73 and &lt;0.97</td>
<td>&gt;=0.97</td>
</tr>
<tr>
<td>MNCLHD</td>
<td>&lt;0.75</td>
<td>&gt;=0.75 and &lt;1.00</td>
<td>&gt;=1.00</td>
</tr>
<tr>
<td>SNSWLHD</td>
<td>&lt;0.66</td>
<td>&gt;=0.66 and &lt;0.87</td>
<td>&gt;=0.87</td>
</tr>
<tr>
<td>MLHD</td>
<td>&lt;1.07</td>
<td>&gt;=1.07 and &lt;1.42</td>
<td>&gt;=1.42</td>
</tr>
<tr>
<td>WNSWLHD</td>
<td>&lt;0.72</td>
<td>&gt;=0.72 and &lt;0.95</td>
<td>&gt;=0.95</td>
</tr>
<tr>
<td>FWLHD</td>
<td>&lt;0.65</td>
<td>&gt;=0.65 and &lt;0.86</td>
<td>&gt;=0.86</td>
</tr>
</tbody>
</table>


Context

Useable data available from 2015 (based on improvement in coding of condition onset flag in NSW)

Frequency of Reporting Monthly

Time lag to available data Admitted Patient Data Collection data for all admitted patients must be coded and queued for processing on the Ministry's HIE by the 28th calendar day after the end of the week of separation (week ending each Friday).

Business owners

Contact - Policy Executive Director, System Management Branch

Contact - Data Executive Director, Strategic Information and Analysis (sia@doh.health.nsw.gov.au)

Representation

Data type Numeric

Form Number, presented as a rate per 1,000 bed days

Representational layout NN.NN

Minimum size 4

Maximum size 5

Data domain

Date effective 1 July 2018

Related National Indicator AIHW and ACSQHC Hospital Acquired Complication list

Indicator sets and related indicators can be sourced from:
http://meteor.aihw.gov.au/content/index.phtml/itemid/401254
<table>
<thead>
<tr>
<th>Indicator</th>
<th>KS2112</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous IDs:</td>
<td>Surgical Complications Requiring Unplanned Return to Theatre (Rate per 1,000 bed days)</td>
</tr>
<tr>
<td>Shortened Title</td>
<td>HAC Return to Theatre</td>
</tr>
<tr>
<td>Service Agreement Type</td>
<td>Key Performance Indicator</td>
</tr>
<tr>
<td>Framework Strategy</td>
<td>Strategy 2: Provide World-Class Clinical Care Where Patient Safety is First</td>
</tr>
<tr>
<td>Framework Objective</td>
<td>2.1 (Embed quality improvement to ensure safer patient care)</td>
</tr>
<tr>
<td>Status</td>
<td>Final</td>
</tr>
<tr>
<td>Version number</td>
<td>1.1</td>
</tr>
<tr>
<td>Scope</td>
<td>All acute or neonatal admitted inpatients in NSW public hospitals</td>
</tr>
<tr>
<td>Goal</td>
<td>Improve post-surgical care and increase quality outcomes.</td>
</tr>
<tr>
<td>Desired outcome</td>
<td>Reduction in the number of patients developing surgical complications that require a return to theatre whilst an inpatient</td>
</tr>
<tr>
<td>Primary point of collection</td>
<td>Patient medical record</td>
</tr>
<tr>
<td>Data Collection Source/System</td>
<td>Admitted patient data collection</td>
</tr>
<tr>
<td>Primary data source for analysis</td>
<td>Heath Information Exchange (HIE)</td>
</tr>
<tr>
<td>Indicator definition</td>
<td>The rate of completed inpatient episodes within the reporting period where a surgical complication has occurred in a public hospital which resulted in an unplanned return to theatre, per 1,000 occupied surgical bed days.</td>
</tr>
<tr>
<td>Numerator</td>
<td>Number of completed inpatient acute or neonatal episodes within the reporting period with: (i) postoperative haemorrhage / haematoma requiring transfusion and/or return to theatre, (ii) surgical wound dehiscence, (iii) an Anastomotic leak, or (iv) vascular graft failure recorded as an additional diagnosis and a condition onset flag of ‘1’.</td>
</tr>
<tr>
<td>Numerator definition</td>
<td>Surgical complications requiring an unplanned return to theatre are identified using the following algorithm:</td>
</tr>
<tr>
<td>Computation description</td>
<td>- ICD-10-AM code T81.0 as an additional diagnosis code AND any of the following ACHI codes: 13706-01, 13706-02, 13706-03, 92060-00, 92061-00, 92062-00, 92063-00, 92064-00, 92206-00, 13306-00; OR</td>
</tr>
<tr>
<td>- ICD-10-AM codes T81.3 or O90.0 or O90.1 as an additional diagnosis code; OR</td>
<td></td>
</tr>
<tr>
<td>- ICD10AM codes K91.83 or K91.84 or N99.83 or T83.2 or T85.5 as an additional diagnosis AND external cause code: Y832; OR</td>
<td></td>
</tr>
<tr>
<td>- ICD-10-AM codes T82.2 or T82.3 as an additional diagnosis;</td>
<td></td>
</tr>
<tr>
<td>- AND a condition onset flag (COF) code of 1 (Condition with onset during...</td>
<td></td>
</tr>
</tbody>
</table>
the episode of admitted patient care)

Numerator source: Heath Information Exchange (HIE)
Numerator availability: Available

Denominator definition: The total number of acute or neonatal occupied bed days of all hospital inpatient episodes in NSW public hospitals within the reporting period. In this context, occupied bed days are the total days of all in scope episodes minus the leave days.

Denominator source: Heath Information Exchange (HIE)
Denominator availability: Available

Inclusions:
- All acute or neonatal admitted patients in NSW public hospitals.

Exclusions:

Numerator exclusions:
- Episodes where the numerator diagnoses recorded as a principal diagnosis and where none of the other codes are present as additional diagnoses.

Numerator and denominator exclusions:
- Sub-acute admitted patients
- Same-day chemotherapy - DRG V8: R63Z and admission date = separation date
- Same-day haemodialysis - DRG V8: L61Z and admission date = separation date
- Primary diagnosis mental health care - Major Diagnostic Category = 19 or 20
- Mental Health inpatient episodes - Care type = M
- Care type is ‘Hospital boarder’ - Care type = 0
- Care type is ‘Organ procurement-posthumous’ - Care type = 9

Targets:
Target < Risk adjusted target rate
- Performing: < target
- Not performing: >=26% of target rate
- Under performing: >=0% and <26% of target rate

<table>
<thead>
<tr>
<th>LHD</th>
<th>Target Rate (1,000 bed days)</th>
<th>Underperforming</th>
<th>Not Performing</th>
</tr>
</thead>
<tbody>
<tr>
<td>SCHN</td>
<td>&lt;0.55</td>
<td>&gt;=0.55 and &lt;0.69</td>
<td>&gt;=0.69</td>
</tr>
<tr>
<td>SVHN</td>
<td>&lt;1.03</td>
<td>&gt;=1.03 and &lt;1.29</td>
<td>&gt;=1.29</td>
</tr>
<tr>
<td>SYDLHD</td>
<td>&lt;0.84</td>
<td>&gt;=0.84 and &lt;1.06</td>
<td>&gt;=1.06</td>
</tr>
<tr>
<td>SWSLHD</td>
<td>&lt;0.49</td>
<td>&gt;=0.49 and &lt;0.62</td>
<td>&gt;=0.62</td>
</tr>
<tr>
<td>SESLHD</td>
<td>&lt;0.80</td>
<td>&gt;=0.80 and &lt;1.01</td>
<td>&gt;=1.01</td>
</tr>
</tbody>
</table>
### Strategy 2 KPIs: Provide World-Class Clinical Care Where Patient Safety is First

<table>
<thead>
<tr>
<th>ISLHD</th>
<th>&lt;0.54</th>
<th>&gt;=0.54 and &lt;0.68</th>
<th>&gt;=0.68</th>
</tr>
</thead>
<tbody>
<tr>
<td>WSLHD</td>
<td>&lt;0.54</td>
<td>&gt;=0.54 and &lt;0.68</td>
<td>&gt;=0.68</td>
</tr>
<tr>
<td>NBMLHD</td>
<td>&lt;0.61</td>
<td>&gt;=0.61 and &lt;0.77</td>
<td>&gt;=0.77</td>
</tr>
<tr>
<td>NSLHD</td>
<td>&lt;0.61</td>
<td>&gt;=0.61 and &lt;0.77</td>
<td>&gt;=0.77</td>
</tr>
<tr>
<td>CCLHD</td>
<td>&lt;0.59</td>
<td>&gt;=0.59 and &lt;0.74</td>
<td>&gt;=0.74</td>
</tr>
<tr>
<td>HNELHD</td>
<td>&lt;0.44</td>
<td>&gt;=0.44 and &lt;0.56</td>
<td>&gt;=0.56</td>
</tr>
<tr>
<td>NNSWLHD</td>
<td>&lt;0.36</td>
<td>&gt;=0.36 and &lt;0.45</td>
<td>&gt;=0.45</td>
</tr>
<tr>
<td>MNCLHD</td>
<td>&lt;0.45</td>
<td>&gt;=0.45 and &lt;0.56</td>
<td>&gt;=0.56</td>
</tr>
<tr>
<td>SNSWLHD</td>
<td>&lt;0.17</td>
<td>&gt;=0.17 and &lt;0.22</td>
<td>&gt;=0.22</td>
</tr>
<tr>
<td>MLHD</td>
<td>&lt;0.40</td>
<td>&gt;=0.40 and &lt;0.51</td>
<td>&gt;=0.51</td>
</tr>
<tr>
<td>WNSWLHD</td>
<td>&lt;0.38</td>
<td>&gt;=0.38 and &lt;0.48</td>
<td>&gt;=0.48</td>
</tr>
<tr>
<td>FWLHD</td>
<td>&lt;0.41</td>
<td>&gt;=0.41 and &lt;0.52</td>
<td>&gt;=0.52</td>
</tr>
</tbody>
</table>


### Context

#### Related Policies/Programs

Useable data available from 2015 (based on improvement in coding of condition onset flag in NSW)

#### Frequency of Reporting

Monthly

#### Time lag to available data

Admitted Patient Data Collection data for all admitted patients must be coded and queued for processing on the Ministry’s HIE by the 28th calendar day after the end of the week of separation (week ending each Friday).

### Business owners

- **Contact - Policy**: Executive Director, System Management Branch
- **Contact - Data**: Executive Director, Strategic Information and Analysis ([sia@doh.health.nsw.gov.au](mailto:sia@doh.health.nsw.gov.au))

### Representation

- **Data type**: Numeric
- **Form**: Number, presented as a rate per 1,000 bed days
- **Representational layout**: NN.NN
- **Minimum size**: 4
- **Maximum size**: 5
- **Data domain**
<table>
<thead>
<tr>
<th>Date effective</th>
<th>1 July 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Related National Indicator</td>
<td>AIHW and ACSQHC Hospital Acquired Complication list</td>
</tr>
</tbody>
</table>

Indicator sets and related indicators can be sourced from: http://meteor.aihw.gov.au/content/index.phtml/itemid/401254
<table>
<thead>
<tr>
<th>INDICATOR: MS2103</th>
<th><strong>3rd or 4th Degree Perineal Lacerations</strong> (Rate per 1,000 bed days)</th>
</tr>
</thead>
</table>
| Previous IDs:     | 3rd or 4th Degree Perineal Laceration Rate

**Shortened Title**: 3rd or 4th Degree Perineal Laceration Rate

**Service Agreement Type**: Improvement Measure

**Framework Strategy**: Strategy 2: Provide World-Class Clinical Care Where Patient Safety is First

**Framework Objective**: 2.1 (Embed quality improvement to ensure safer patient care)

**Status**: Final

**Version number**: 2.1

**Scope**: All acute or neonatal admitted inpatients in NSW public hospitals

**Goal**: Improve maternity safety and increase quality outcomes.

**Desired outcome**: Reduction in the number of patients developing 3rd or 4th degree perineal lacerations during the vaginal delivery of a newborn.

**Primary point of collection**: Administrative and clinical patient data collected at admission and discharge

**Data Collection Source/System**: Diagnosis codes / Hospital Patient Admission Systems (PAS), Admitted Patient Data Collection

**Primary data source for analysis**: HIE

**Indicator definition**: The rate of completed acute inpatient episodes where a 3rd and 4th degree perineal laceration has occurred during delivery, per 1000 occupied bed days.

**Numerator**

**Numerator definition**: Total number of vaginal deliveries that developed 3rd or 4th degree perineal lacerations during the vaginal delivery of a newborn during the reporting period.

3rd and 4th degree perineal laceration episodes are identified via the following:
- ICD-10AM 10th edition codes O70.2 and O70.3 as an additional diagnosis;
  - AND
- ICD-10AM 10th edition outcome of delivery codes beginning with Z37 is recorded; AND
- A Caesarean delivery was NOT recorded (ACHI procedure codes beginning with 16520)

**Numerator source**: HIE

**Numerator availability**: HIE available monthly

**Denominator**

**Denominator definition**: The total number of acute or neonatal occupied bed days of all hospital inpatient episodes in NSW public hospitals within the reporting period. In this context,
occupied bed days are the total days of all in scope episodes minus the leave days.

Denominator source: HIE
Denominator availability: Monthly

Inclusions
Numerator inclusions:
- All inpatient episodes in public hospitals that resulted in a vaginal birth
- Any Condition Onset Flag value

Exclusions
Numerator exclusions:
- Episodes where an O70.2 or O70.3 ICD10AM code has been recorded as a principal diagnosis.
- Episodes with a delivery via a Caesarean Section
- Episodes where the Source of Referral was ‘04’ (Hospital in same Local Health District / Specialist Network) or ‘05’ (Hospital in other Local Health District / Specialist Network)

Numerator and denominator exclusions:
- Sub-acute admitted patients
- Same-day chemotherapy - DRG V8: R63Z and admission date = separation date
- Same-day haemodialysis - DRG V8: L61Z and admission date = separation date
- Primary diagnosis mental health care - Major Diagnostic Category = 19 or 20
- Mental Health inpatient episodes - Care type = M
- Care type is ‘Hospital boarder’ - Care type = 0
- Care type is ‘Organ procurement-posthumous’ - Care type = 9

Targets
Target: < Risk adjusted target rate
- Performing: < target
- Not performing: >=37% of target rate
- Under performing: >=0% and <37% of target rate

<table>
<thead>
<tr>
<th>LHD</th>
<th>Target Rate (1,000 bed days)</th>
<th>Underperforming</th>
<th>Not Performing</th>
</tr>
</thead>
<tbody>
<tr>
<td>SYDLHD</td>
<td>&lt;0.35</td>
<td>&gt;=0.35 and &lt;0.49</td>
<td>&gt;=0.49</td>
</tr>
<tr>
<td>SWSLHD</td>
<td>&lt;0.44</td>
<td>&gt;=0.44 and &lt;0.60</td>
<td>&gt;=0.60</td>
</tr>
<tr>
<td>SESLHD</td>
<td>&lt;0.38</td>
<td>&gt;=0.38 and &lt;0.53</td>
<td>&gt;=0.53</td>
</tr>
<tr>
<td>ISLHD</td>
<td>&lt;0.31</td>
<td>&gt;=0.31 and &lt;0.43</td>
<td>&gt;=0.43</td>
</tr>
<tr>
<td>WSLHD</td>
<td>&lt;0.53</td>
<td>&gt;=0.53 and &lt;0.72</td>
<td>&gt;=0.72</td>
</tr>
<tr>
<td>NBMLHD</td>
<td>&lt;0.50</td>
<td>&gt;=0.50 and &lt;0.69</td>
<td>&gt;=0.69</td>
</tr>
<tr>
<td>NSLHD</td>
<td>&lt;0.32</td>
<td>&gt;=0.32 and &lt;0.44</td>
<td>&gt;=0.44</td>
</tr>
<tr>
<td>CCLHD</td>
<td>&lt;0.30</td>
<td>&gt;=0.30 and &lt;0.41</td>
<td>&gt;=0.41</td>
</tr>
<tr>
<td>HNELHD</td>
<td>&lt;0.34</td>
<td>&gt;=0.34 and &lt;0.46</td>
<td>&gt;=0.46</td>
</tr>
</tbody>
</table>
2018-19 Service Performance Agreements
Strategy 2 KPIs: Provide World-Class Clinical Care Where Patient Safety is First

<table>
<thead>
<tr>
<th></th>
<th>NNSWLHD</th>
<th>MNCLHD</th>
<th>SNSWLHD</th>
<th>MLHD</th>
<th>WNSWLHD</th>
<th>FWLHD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>&lt;0.30</td>
<td>&gt;=0.30 and &lt;0.41</td>
<td>&gt;=0.41</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>&gt;=0.28</td>
<td>&gt;=0.28 and &lt;0.39</td>
<td>&gt;=0.39</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>&lt;0.37</td>
<td>&gt;=0.37 and &lt;0.52</td>
<td>&gt;=0.52</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>&lt;0.32</td>
<td>&gt;=0.32 and &lt;0.44</td>
<td>&gt;=0.44</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>&lt;0.39</td>
<td>&gt;=0.39 and &lt;0.53</td>
<td>&gt;=0.53</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>&lt;0.23</td>
<td>&gt;=0.23 and &lt;0.32</td>
<td>&gt;=0.32</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


Context
Related Policies/Programs
Useable data available from 2015
Frequency of Reporting Monthly
Time lag to available data 1 month

Business owners
Contact - Policy Executive Director, System Management Branch
Contact - Data Executive Director, Strategic Information and Analysis (sia@doh.health.nsw.gov.au)

Representation
Data type Numeric
Form Number, presented as a rate per 1,000 bed days
Representational layout NN.NN
Minimum size 4
Maximum size 5
Data domain
Date effective 1st July 2017


National Core Maternity Indicators: PI 13—Third and fourth degree tears for (a) all
vaginal first births and (b) all vaginal births (2016)
### INDICATOR: KS2113

#### Hospital Acquired Neonatal Birth Trauma (Rate per 1,000 bed days)

#### Shortened Title
Neonatal Birth Trauma

#### Service Agreement Type
Key Performance Indicator

#### Framework Strategy
Strategy 2: Provide World-Class Clinical Care Where Patient Safety is First

#### Framework Objective
2.1 (Embed quality improvement to ensure safer patient care)

#### Status
Final

#### Version number
1.1

#### Scope
All acute or neonatal admitted patients in NSW public hospitals

#### Goal
Improve safety outcomes and increase quality outcomes.

#### Desired outcome
Reduction in the number of patients acquiring neonatal birth trauma.

#### Primary point of collection
Patient medical record

#### Data Collection Source/System
Admitted patient data collection

#### Primary data source for analysis
Health Information Exchange (HIE)

#### Indicator definition
The rate of completed inpatient newborn episodes within the reporting period where neonatal birth trauma has occurred in a public hospital, per 1,000 occupied bed days.

#### Numerator

**Numerator definition**
Number of completed inpatient newborn episodes within the reporting period with a neonatal birth trauma code recorded as any diagnosis with any condition onset flag.

**Computation description**

**Numerator source**
Health Information Exchange (HIE)

**Numerator availability**
Available

#### Denominator

**Denominator definition**
The total number of acute or neonatal occupied bed days of all hospital inpatient episodes in NSW public hospitals within the reporting period. In this context, occupied bed days are the total days of all in scope episodes minus the leave days.

**Denominator source**
Health Information Exchange (HIE)

**Denominator availability**
Available

#### Inclusions

**Numerator inclusions:**
All newborn episodes with a Care Type = 5 in NSW public hospitals.

**Exclusions**

**Numerator exclusions:**
- Preterm infants with birth weight less than 2,000 grams (identified with ICD10AM codes P07.0X, P07.1X, P07.2x or P07.3x)
- Cases with injury to brachial plexus (identified with ICD10AM codes P14.0, P14.1 or P14.3)
- Cases with osteogenesis imperfect (identified with an ICD10Am code of Q78.0)
- Episodes where the Source of Referral was '04' (Hospital in same Local Health District / Specialist Network) or '05' (Hospital in other Local Health District / Specialist Network)

**Numerator and denominator exclusions:**
- Sub-acute admitted patients
- Same-day chemotherapy - DRG V8: R63Z and admission date = separation date
- Same-day haemodialysis - DRG V8: L61Z and admission date = separation date
- Primary diagnosis mental health care - Major Diagnostic Category = 19 or 20
- Mental Health inpatient episodes - Care type = M
- Care type is 'Hospital boarder' - Care type = 0
- Care type is 'Organ procurement-posthumous' - Care type = 9

**Targets**

- Target < Risk adjusted target rate
  - Performing: < target
  - Not performing: >=43% of target rate
  - Under performing: >=0% and <43% of target rate

<table>
<thead>
<tr>
<th>LHD</th>
<th>Target Rate (1,000 bed days)</th>
<th>Underperforming</th>
<th>Not Performing</th>
</tr>
</thead>
<tbody>
<tr>
<td>SYDLHD</td>
<td>&lt;0.08</td>
<td>&gt;=0.08 and &lt;0.11</td>
<td>&gt;=0.11</td>
</tr>
<tr>
<td>SWSLHD</td>
<td>&lt;0.09</td>
<td>&gt;=0.09 and &lt;0.13</td>
<td>&gt;=0.13</td>
</tr>
<tr>
<td>SESLHD</td>
<td>&lt;0.08</td>
<td>&gt;=0.08 and &lt;0.12</td>
<td>&gt;=0.12</td>
</tr>
<tr>
<td>ISLHD</td>
<td>&lt;0.07</td>
<td>&gt;=0.07 and &lt;0.10</td>
<td>&gt;=0.10</td>
</tr>
<tr>
<td>WSLHD</td>
<td>&lt;0.11</td>
<td>&gt;=0.11 and &lt;0.16</td>
<td>&gt;=0.16</td>
</tr>
<tr>
<td>NBMLHD</td>
<td>&lt;0.11</td>
<td>&gt;=0.11 and &lt;0.16</td>
<td>&gt;=0.16</td>
</tr>
<tr>
<td>NSLHD</td>
<td>&lt;0.07</td>
<td>&gt;=0.07 and &lt;0.10</td>
<td>&gt;=0.10</td>
</tr>
<tr>
<td>CCLHD</td>
<td>&lt;0.07</td>
<td>&gt;=0.07 and &lt;0.09</td>
<td>&gt;=0.09</td>
</tr>
<tr>
<td>HNELHD</td>
<td>&lt;0.07</td>
<td>&gt;=0.07 and &lt;0.11</td>
<td>&gt;=0.11</td>
</tr>
<tr>
<td>NNSWLHD</td>
<td>&lt;0.06</td>
<td>&gt;=0.06 and &lt;0.09</td>
<td>&gt;=0.09</td>
</tr>
<tr>
<td>MNCLHD</td>
<td>&lt;0.06</td>
<td>&gt;=0.06 and &lt;0.09</td>
<td>&gt;=0.09</td>
</tr>
<tr>
<td>SNSWLHD</td>
<td>&lt;0.08</td>
<td>&gt;=0.08 and &lt;0.12</td>
<td>&gt;=0.12</td>
</tr>
</tbody>
</table>
2018-19 Service Performance Agreements
Strategy 2 KPIs: Provide World-Class Clinical Care Where Patient Safety is First

<table>
<thead>
<tr>
<th></th>
<th>MLHD</th>
<th>WNSWLHD</th>
<th>FWLHD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>&lt;0.07</td>
<td>&gt;=0.07 and &lt;0.10</td>
<td>&gt;=0.10</td>
</tr>
<tr>
<td></td>
<td>&lt;0.09</td>
<td>&gt;=0.08 and &lt;0.12</td>
<td>&gt;=0.12</td>
</tr>
<tr>
<td></td>
<td>&lt;0.05</td>
<td>&gt;=0.05 and &lt;0.07</td>
<td>&gt;=0.07</td>
</tr>
</tbody>
</table>


Context

Related Policies/Programs

Useable data available from 2015 (based on improvement in coding of condition onset flag in NSW)

Frequency of Reporting Monthly

Time lag to available data Admitted Patient Data Collection data for all admitted patients must be coded and queued for processing on the Ministry's HIE by the 28th calendar day after the end of the week of separation (week ending each Friday).

Business owners

Contact - Policy Executive Director, System Management Branch

Contact - Data Executive Director, Strategic Information and Analysis (sia@doh.health.nsw.gov.au)

Representation

Data type Numeric

Form Number, presented as a rate per 1,000 bed days

Representational layout NN.NN

Minimum size 4

Maximum size 5

Data domain

Date effective 1 July 2018

Related National Indicator

AIHW and ACSQHC Hospital Acquired Complication list

Indicator sets and related indicators can be sourced from: http://meteor.aihw.gov.au/content/index.phtml/itemId/401254
**Unplanned Hospital Readmissions**: all unplanned admissions within 28 days of separation (%):

- All persons (**SSQ106**)
- Aboriginal persons (**SSQ107**)

### Shortened Title
Unplanned Hospital Readmissions

### Service Agreement Type
Key Performance Indicator

### Framework Strategy
Strategy 2: Provide World-Class Clinical Care Where Patient Safety is First

### Framework Objective
2.1 (Embed quality improvement to ensure safer patient care)

### Scope
All patient admissions to public facilities in peer groups A1 – D1b.

### Goal
To identify and manage the number of unnecessary unplanned readmissions. To increase the focus on the safe transfer of care, coordinated care in the community and early intervention.

### Desired outcome
Improved efficiency, effectiveness, quality and safety of care and treatment, with reduced unplanned events.

### Primary point of collection
Administrative and clinical patient data collected at admission and discharge

### Data Collection Source/System
Admitted Patient Data Collection, Hospital Patient Admission Systems (PAS)

### Primary data source for analysis
HIE / IQ

### Indicator definition
The percentage of admissions that are an unplanned readmission to the same facility within 28 days following discharge for any purpose, disaggregated by Aboriginality status.

Note that Aboriginal persons include people who identify as Aboriginal and/or Torres Strait Islander.

### Numerator
- **Numerator definition**
  The total number of unplanned admissions (counted as stays not episodes) with admission date within reference period and patient previously discharged from same facility in previous 28 days for any purpose.

  Where: Unplanned is defined as Urgency of Admission (emergency_status) = 1.

  A readmission is defined as an admission with an admission_date within 28 days of the discharge_date of a previous stay for the same patient at the same facility (identified by MRN and facility_identifier).

- **Numerator source**
  HIE/ IQ

- **Numerator availability**
  HIE/ IQ Available monthly
Inclusions Readmissions that result in death

Exclusions Transfers in from other hospitals (source of referral = 4 or 5)
Transfers are not counted in the numerator as these are for the purposes of
this indicator as patients who are continuing their care in this new location.

**Denominator**

**Denominator definition**
SSQ106 & SSQ107: Total number of admissions (counted as stays not
episodes) with admission dates within the reference period.

**Denominator source**
HIE/ IQ

**Denominator availability**
HIE/ IQ Available monthly

Inclusions Transfers from other hospitals (source of referral = 4 or 5)
Transfers in are included in the denominator as these Stays can potentially
result in a patient readmission to the same hospital following discharge.

Exclusions Admissions that result in death

**Inclusions**
- each index/initial admission can have at most one readmission;
- a readmission can be an index/initial admission to another readmission.

**Exclusions**
- Additional episodes created through a change of care type;
- Hospital boarders and organ procurement (episode of care type 0 or 9);
- Facilities in peer groups below D1b.

**Targets**

**Target**
Reduction from previous year

- Performing: Reduction from previous year
- Under performing: No change from previous year
- Not performing: Increase on previous year.

**Comments**
- For this indicator, the focus is on the readmission – that is, the second
admission looking backwards across the reporting period.
- For the Aboriginal persons disaggregation, the presence of an
Aboriginal person in the numerator and denominator is dependent on
the recording of the value in both episodes. For instance, where a
person has two discharges within the same reporting period, in the
situation where the 1st episode is flagged as being for an Aboriginal
person, but not the readmission, then the 1st episode will be in the
denominator, but the readmission will not be in the numerator or
denominator.
- Patient deaths are excluded from the denominator but not the
numerator. If the patient dies during an admission they are unable to
readmit and therefore are excluded from the denominator. However, if
the patient dies during a readmission, the readmission is included in the
numerator (regardless of the outcome of the readmission). However, the
index admission prior to the readmission is counted in the denominator
provided that the admission date of the index admission falls within the
Further, there can be a readmission with no denominator. This is the case if a patient dies during their readmission and the index admission prior to the readmission occurs before the start of the reference period. In this case the readmission is counted in the numerator but not the denominator.

While the use of administrative data can be used to identify unplanned readmissions it cannot clearly identify that the unplanned readmission was either related to the previous admissions or unexpected or preventable.

This definition does not correspond with the ACHS Clinical Indicators which depends upon clinical decision on review;

Transfers from another hospital are not counted as readmissions as they can reasonably be seen as a continuation of a patient’s care in this new location and therefore excluded from the numerator. However these patients who transfer into a facility are still included in the denominator as at discharge the potential exists for these patients to represent for care after their care had previously been considered to be complete.

Context

A low readmission rate may indicate good patient management practices and post-discharge care; facilities with a high readmission rate may indicate a problem with a clinical care pathway.

Useable data available from

2001/02

Frequency of Reporting

- Monthly/Annual, financial year, biannual
- State Plan - quarterly

Time lag to available data

- HIE/IQ data have a 6 month lag, available December for previous financial year
- Availability depends on refresh frequency

Business owners

Contact - Policy
Executive Director, System Performance Support Branch

Contact - Data
Executive Director, System Information and Analytics Branch
(hsipr@doh.health.nsw.gov.au)

Representation

Data type
Numeric

Form
Number, presented as a percentage (%)

Representational layout
NNN.N%

Minimum size
4

Maximum size
6

Data domain
N/A
<table>
<thead>
<tr>
<th>Related National Indicator</th>
<th>National Healthcare Agreement: PI 23-Unplanned hospital readmission rates, 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><a href="http://meteor.aihw.gov.au/content/index.phtml/itemId/658485">http://meteor.aihw.gov.au/content/index.phtml/itemId/658485</a></td>
</tr>
</tbody>
</table>
## INDICATOR: KS2301

| Previous IDs: SSQ117, 9A20, 9A21 |

### Overall Patient Experience Index (Number)
- Patient Experience Survey index of adult admitted patients of four scored questions on overall rating of care, rating of staff, rating of organised care, and speaking highly of care to family and friends.

### Shortened Title
Patient Experience Index

### Service Agreement Type
Key Performance Indicator

### Framework Strategy
Strategy 2: Provide World-Class Clinical Care Where Patient Safety is First

### Framework Objective
2.3 (Improve the patient experience)

### Status
Final

### Version number
1.0

### Scope
Sample of adult patients who are admitted to hospitals in peer groups A1, A3, B1, B2, C1 and C2. These hospitals contribute to the LHD total in proportion to the total number of admitted patients for all A1, A3, B1, B2, C1 and C2 hospitals in that LHD.

### Goal
Improve patients' experience of care

### Desired outcome
Increase LHD results for an index of six patient-reported experience measures (PREMs) on provision of patient-centred care (maximum possible score 10)

### Primary point of collection
Postal survey of recent admitted patients, with up to two reminders and alternative completion online

### Data Collection Source/System
NSW Patient Survey Program data

### Primary data source for analysis
Weighted responses to Adult Admitted Patient Survey

### Indicator definition
The weighted average patient experience index across all patients with a valid response within the reporting period.

### Numerator
- Numerator definition
The sum of patient experience indices for all patients.

Calculated using the sum of scores to each of the four following questions divided by number of questions where a valid response was recorded for a patient:

- **How would you rate how well the health professionals worked together?**
  - Very good (10); Good (7.5); Neither good nor poor (5); Poor (2.5); Very poor (0)

- **How well organised was the care you received in hospital?**
  - Very well organised (10); Fairly well organised (5); Not well organised (0)

- **Overall, how would you rate the care you received while in hospital?**
  - Very good (10); Good (7.5); Neither good nor poor (5); Poor (2.5); Very poor (0)
**Strategy 2 KPIs: Provide World-Class Clinical Care Where Patient Safety is First**

- **If asked about your hospital experience by friends and family how would you respond?**
  
  I would speak highly of the hospital (10); I would neither speak highly nor be critical (5); I would be critical of the hospital (0).

  Missing values excluded from calculation. Respondent must have at least one valid response for the four questions.

  Data are weighted to represent the age and stay type (overnight or same day) profile of patients at each hospital.

<table>
<thead>
<tr>
<th>Numerator source</th>
<th>NSW Patient Survey Program data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator availability</td>
<td>Available</td>
</tr>
</tbody>
</table>

**Denominator**

Denominator definition

Total number of patients with at least one valid response for the four questions (as specified in the list of response options under 'numerator')

Data are weighted to represent the age and stay type (overnight or same day) profile of patients at each hospital.

<table>
<thead>
<tr>
<th>Denominator source</th>
<th>NSW Patient Survey Program data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator availability</td>
<td>Available</td>
</tr>
</tbody>
</table>

**Inclusions**

All patients surveyed during the target period.

- Facilities in peer groups A1, A3, B1, B2, C1 and C2
- Patients aged 17 years or older until Dec 2013, then 18 years or older from Jan 2014 onwards
- Valid Australian postal address

**Exclusions**

- As per inclusions above
- Same day admissions less than 3 hours
- Same day episodes with a mode of separation of transfer
- Maternity admissions (incl. stillbirths, miscarriages and termination of pregnancy procedures)
- Patients treated for contraceptive management
- Haemodialysis patients
- Admitted patients treated in a mental health setting
- Maltreatment codes (incl. sexual and physical abuse)
- Patients that have died

**Targets**

**Target**

Target score of 8.5 out of 10.0

- Not performing <=8.2
- Underperforming >8.2 to <8.5
- Performing - organisational score >=8.5

**Context**

Health services should not only be of good clinical quality but should also provide a positive experience for the patient.

**Related Policies/ Programs**
## Useable data available from
Quarterly data is available for January to March 2014 onwards.

## Frequency of Reporting
Quarterly reporting at LHD level

## Time lag to available data
Eight months from the end of each quarter

### Business owners
- **Contact - Policy**: Executive Director, System Purchasing Branch, Ministry of Health
- **Contact - Data**: Director, Data Analysis and Management, Bureau of Health Information (BHI-enq@health.nsw.gov.au)

### Representation
- **Data type**: Numeric
- **Form**: Number
- **Representational layout**: NN.N
- **Minimum size**: 3
- **Maximum size**: 4
- **Data domain**: 2018

### Related National Indicator
For other patient experience indicators, see the National Healthcare Agreement: PI 32 - Patient satisfaction/experience, 2018
http://meteor.aihw.gov.au/content/index.phtml/itemId/658467
INDICATOR: KS2302

Previous IDs:
- Patient Experience Survey index of adult admitted patients of six scored questions on Information provision, involvement in decisions on care and discharge, and continuity of care

Shortened Title
Compassionate Care Index

Service Agreement Type
Key Performance Indicator

Framework Strategy
Strategy 2: Provide World-Class Clinical Care Where Patient Safety is First

Framework Objective
2.3 (Improve the patient experience)

Status
Final

Version number
1.0

Scope
Sample of adult patients who are admitted to hospitals in peer groups A1, A3, B1, B2, C1 and C2. These hospitals contribute to the LHD total in proportion to the total number of admitted patients for all A1, A3, B1, B2, C1 and C2 hospitals in that LHD.

Goal
Improve patients’ experience of care

Desired outcome
Increase LHD results for an index of six patient-reported experience measures (PREMs) on provision of patient-centred care (maximum possible score 10)

Primary point of collection
Postal survey of recent admitted patients with up to two reminders and alternative completion online

Data Collection Source/System
NSW Patient Survey Program data

Primary data source for analysis
Weighted responses to Adult Admitted Patient Survey

Indicator definition
The weighted average compassionate care index across all patients with a valid response within the reporting period

Numerator
Numerator definition
The sum of compassionate care indices for all patients.

Calculated using the sum of scores of the following six questions divided by number of questions where a valid response was recorded for a patient:

- **During your stay in hospital, how much information about your condition was given to you?**
  - Not enough (0); The right amount (100); Too much (5)
- **Were you involved, as much as you wanted to be, in decisions about your care?**
  - Yes, definitely (10); Yes, to some extent (5); No (0)
- **Did you feel involved in decisions about your discharge from hospital?**
  - Yes, definitely (10); Yes, to some extent (5); No (0)
- **At the time you were discharged, did you feel that you were well enough to leave hospital?**
  - Yes (100); No (0)
• Were you given enough information about how to manage your care at home?
  Yes, completely (10); Yes, to some extent (5); No, I was not given enough (0)
• Did staff tell you who to contact if you were worried about your condition after you left?
  Yes (100); No (0).

Missing values excluded from calculation. Respondent must have at least one valid response in for the six questions.

Data are weighted to represent the age and stay type (overnight or same day) profile of patients at each hospital.

Numerator source: NSW Patient Survey Program data
Numerator availability: Available

Denominator
Denominator definition: Total number of patients with at least one valid response for the six questions (as specified in the list of response options under 'numerator')

Data are weighted to represent the age and stay type (overnight or same day) profile of patients at each hospital.

Denominator source: NSW Patient Survey Program data
Denominator availability: Available

Inclusions
All patients surveyed during the target period.
- Facilities in peer groups A1, A3, B1, B2, C1 and C2
- Patients aged 17 years or older until Dec 2013, then 18 years or older from Jan 2014 onwards
- Valid Australian postal address

Exclusions
• As per inclusions above
• Same day admissions less than 3 hours
• Same day episodes with a mode of separation of transfer
• Maternity admissions (incl. stillbirths, miscarriages and termination of pregnancy procedures)
• Patients treated for contraceptive management
• Haemodialysis patients
• Admitted patients treated in a mental health setting
• Maltreatment codes (incl. sexual and physical abuse)
• Patients that have died

Targets
Target: Target score of 8.5 out of 10.0
- Not performing <=8.2
- Underperforming >8.2 to <8.5 (non-exclusive)
- Performing - organisational score >=8.5

Context
Health services should facilitate the involvement and empowerment of patients and, where appropriate, partner with patients to achieve the best
possible experiences of care.

<table>
<thead>
<tr>
<th>Related Policies/ Programs</th>
<th>Strategy 2 KPIs: Provide World-Class Clinical Care Where Patient Safety is First</th>
</tr>
</thead>
<tbody>
<tr>
<td>Useable data available from</td>
<td>Quarterly data is available for January to March 2014 onwards.</td>
</tr>
<tr>
<td>Frequency of Reporting</td>
<td>Quarterly reporting at LHD level</td>
</tr>
<tr>
<td>Time lag to available data</td>
<td>Nine months from the end of each quarter</td>
</tr>
<tr>
<td>Business owners</td>
<td></td>
</tr>
<tr>
<td>Contact - Policy</td>
<td>Executive Director, System Purchasing Branch, Ministry of Health</td>
</tr>
<tr>
<td>Contact - Data</td>
<td>Director, Data Analysis and Management, Bureau of Health Information (<a href="mailto:BHI-enq@health.nsw.gov.au">BHI-enq@health.nsw.gov.au</a>)</td>
</tr>
<tr>
<td>Representation</td>
<td></td>
</tr>
<tr>
<td>Data type</td>
<td>Numeric</td>
</tr>
<tr>
<td>Form</td>
<td>Number</td>
</tr>
<tr>
<td>Representational layout</td>
<td>NN.N</td>
</tr>
<tr>
<td>Minimum size</td>
<td>3</td>
</tr>
<tr>
<td>Maximum size</td>
<td>4</td>
</tr>
<tr>
<td>Data domain</td>
<td></td>
</tr>
<tr>
<td>Date effective</td>
<td>2018</td>
</tr>
<tr>
<td>Related National Indicator</td>
<td>For other patient experience indicators, see the National Healthcare Agreement: PI 32 - Patient satisfaction/experience, 2018 <a href="http://meteor.aihw.gov.au/content/index.phtml/itemId/658467">http://meteor.aihw.gov.au/content/index.phtml/itemId/658467</a></td>
</tr>
</tbody>
</table>

Related Policies/ Programs

Useable data available from
Quarterly data is available for January to March 2014 onwards.

Frequency of Reporting
Quarterly reporting at LHD level

Time lag to available data
Nine months from the end of each quarter

Business owners

Contact - Policy
Executive Director, System Purchasing Branch, Ministry of Health

Contact - Data
Director, Data Analysis and Management, Bureau of Health Information (BHI-enq@health.nsw.gov.au)

Representation

Data type
Numeric

Form
Number

Representational layout
NN.N

Minimum size
3

Maximum size
4

Data domain

Date effective
2018

Related National Indicator
For other patient experience indicators, see the National Healthcare Agreement: PI 32 - Patient satisfaction/experience, 2018
http://meteor.aihw.gov.au/content/index.phtml/itemId/658467
### Elective Surgery Access Performance: Elective Surgery Patients Treated on Time (%)

- Category 1 (KSA103a)
- Category 2 (KSA103b)
- Category 3 (KSA103c)

Previously known as:
- “Planned surgery patients admitted on time”
- “Elective Surgery Patients Admitted Within Clinically Appropriate Time”
- National Elective Surgery Target Part 1: Elective Surgery Patients Treated on Time (%)

<table>
<thead>
<tr>
<th>Shortened Title</th>
<th>Elective Surgery Access Performance</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Service Agreement Type</th>
<th>Key Performance Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Framework Strategy</td>
<td>Strategy 2: Provide World-Class Clinical Care Where Patient Safety is First</td>
</tr>
<tr>
<td>Framework Objective</td>
<td>2.4 (Ensure timely access to care)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Status</th>
<th>Final</th>
</tr>
</thead>
<tbody>
<tr>
<td>Version number</td>
<td>1.6</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Scope</th>
<th>All elective surgery patients who are admitted and included in the NSW Ministry of Health Waiting Times Collection.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Goal</th>
<th>To ensure that elective surgical patients receive their surgery within the clinically recommended timeframe in NSW public hospitals.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Desired outcome</th>
<th>Better management of waiting lists to minimise waiting time for elective surgery.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Primary point of collection</th>
<th>Waiting List/Booking Clerk: Receipt of inbound Recommendation for Admission Form (RFA) to a public hospital for patient registration on waiting list.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Data Collection Source/System</th>
<th>Patient Admission System (PAS)/Waiting List Collection On-Line System (WLCOS)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Primary data source for analysis</th>
<th>WLCOS/Wait List /Scheduling Data Stream (via EDWARD)</th>
</tr>
</thead>
</table>

| Indicator definition | The percentage (%) of elective surgery patients on the NSW Ministry of Health Waiting Times Collection who were admitted within the timeframe recommended for their clinical urgency/priority category. |

<table>
<thead>
<tr>
<th>Numerator definition</th>
<th>Total number of elective surgery patients in the NSW Ministry of Health Waiting Times Collection who:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>have been admitted for treatment within the reporting period, (measured by removal from the waiting list removal with a status = 1, 2, 7, 8), and</td>
</tr>
<tr>
<td></td>
<td>were admitted within the timeframe recommended for their clinical urgency/priority category, where waiting time is measured from the last assigned clinical urgency/priority category or any other</td>
</tr>
</tbody>
</table>
Strategy 2 KPIs: Provide World-Class Clinical Care Where Patient Safety is First

previous equal to or higher clinical urgency/priority category.

Note: Includes:
- Staged patients Refer to Waiting Time and Elective Surgery Policy for management of staged patients
- Emergency admissions for their recorded waitlist procedure

Note on the transition to EDWARD: Whereas WLCOS receives the last 3 clinical urgency/priority category changes for a given booking, EDWARD receives all clinical urgency/priority category changes for a given booking. There are some instances where the WLCOS and EDWARD result will differ due to this limitation, with EDWARD reporting a more accurate value.

<table>
<thead>
<tr>
<th>Numerator source</th>
<th>WLCOS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator availability</td>
<td>Available Monthly</td>
</tr>
</tbody>
</table>

**Denominator**
- Denominator definition: Total number of surgical patients in the NSW Ministry of Health Waiting Times Collection who have been admitted for treatment within the reporting period.
- Denominator source: WLCOS
- Denominator availability: Available

**Inclusions**
- Surgical patients in the NSW Ministry of Health Waiting Times Collection who have been admitted for treatment, where the reason for removal is:
  - 1 Routine admission
  - 2 Emergency Admissions, where the patient has surgery for the waitlisted procedure
  - 7 Admission contracted to another hospital, OR
  - 8 Admission contracted to a private hospital/day procedure centre

**Exclusions**
- Patients whose Waiting List Category is not ‘Elective Surgery’
- Elective surgery patients with an Indicator Procedure Code of 277 (Peritonectomy)

**Targets**
- Category 1 Target (100.0%)
- Category 2 Target (>=97.0%; Not performing: (<93%); Underperforming: (>=93% and <97%))
- Category 3 Target (>=97.0%; Not performing: (<95%); Underperforming: (>=95% and <97%))

**Context**
- To ensure timely access to Elective Surgery.

**Related Policies and Programs**
- Waiting Time and Elective Surgery Policy 2012
- Agency for Clinical Innovation: Surgery, Anaesthesia and Critical Care Portfolio
Useable data available from: July 2005

Frequency of Reporting: Monthly/Weekly

Time lag to available data: Reporting required by the 10th day of each month, data available for previous month.

Business owners
- Contact - Policy: Executive Director, System Purchasing Branch
- Contact - Data: Executive Director, System Information and Analytics Branch (hsipr@doh.health.nsw.gov.au)

Representation
- Data type: Numeric
- Form: Number, presented as a percentage (%)
- Representational layout: NNN.NN
- Minimum size: 3
- Maximum size: 6
- Date effective: 1 July 2008

Related National Indicator
  Meteor ID: 658495
  Meteor ID: 658493
Overdue Elective Surgery Patients (Number)

- Category 1 Ready-for-care patients (RFC) > 30 days (SSA108)
- Category 2 Ready-for-care patients (RFC) > 90 days (SSA109)
- Category 3 Ready-for-care patients (RFC) > 365 days (SSA110)

Note: Previously known as Overdue planned surgical patients on list

Shortened Title
Overdue Elective Surgery Patients

Service Agreement Type
Key Performance Indicator

Framework Strategy
Strategy 2: Provide World-Class Clinical Care Where Patient Safety is First

Framework Objective
2.4 (Ensure timely access to care)

Status
Final

Version number
7.3

Scope
All ready for care patients currently on the NSW Health Waiting Times Collection for elective surgery.

Goal
To reduce waiting time for elective surgery in public hospitals.

Desired outcome
Better management of waiting lists to minimise waiting time for elective surgery.

Primary point of collection
Waiting List/Booking Clerk: Receipt of inbound Recommendation for Admission Form (RFA) to a public hospital patient registration Public hospital wait list management

Data Collection Source/System
Patient Admission System (PAS) / Waiting List Collection On–Line System (WLCOS).

Primary data source for analysis
WLCOS /Wait List / Scheduling Data Stream (via EDWARD).

Indicator definition
Number of elective surgical patients on the NSW Health Waiting Times Collection whose waiting time (last urgency/priority waiting time for categories 1 and 2, ready for care days for category 3) has exceeded the time recommended in the clinical urgency/priority category to which they have been assigned, where waiting time is measured from the last assigned clinical urgency/priority category or any other previous equal to or higher clinical urgency/priority category.

Numerator

Numerator definition
- **Number of Category 1 patients waiting >30 days**
Number of Category 1 elective surgical patients who have been waiting for admission greater than 30 days.

- **Number of Category 2 patients waiting >90 days**
Number of Category 2 elective surgical patients who have been waiting for admission greater than 90 days.

- **Number of Category 3 patients waiting >365 days**
Number of Category 3 elective surgical patients who have been waiting for admission greater than 365 days.
Note on the transition to EDWARD: Whereas WLCOS receives the last 3 clinical urgency/priority category changes for a given booking, EDWARD receives all clinical urgency/priority category changes for a given booking. There are some instances where the WLCOS and EDWARD result will differ due to this limitation, with EDWARD reporting a more accurate value. However, the OPERA reporting tool uses the same definition when reporting this indicator.

**Numerator source**  
WLCOS

**Numerator availability**  
Available Monthly

**Inclusions**  
Ready for Care patients (clinical urgency/priority categories 1, 2 and 3) on the elective surgical waiting list.

**Exclusions**  
- Not Ready for Care (NRFC) patients are excluded (clinical urgency/priority category 4).
- Elective surgery patients with an Indicator Procedure Code of 277 (Peritonectomy)

**Targets**

- Target  
  0 (Zero) for category 1 > 30 days per reporting period
  0 (Zero) for category 2 > 90 days per reporting period
  0 (Zero) for category 3 > 365 days per reporting period

**Comments**  
Patients should be admitted within the timeframe recommended for the assigned clinical urgency/priority category:

- **Category 1**: Procedures that are clinically indicated within 30 days.
- **Category 2**: Procedures that are clinically indicated within 90 days.
- **Category 3**: Procedures that are clinically indicated within 365 days.

**Context**  
Elective surgery: The numbers of overdue patients represent a measure of the hospital's performance of elective surgical care.

**Related Policies/ Programs**  
- Waiting Time and Elective Surgery Policy 2012
- Agency for Clinical Innovation: Surgery, Anaesthesia and Critical Care Portfolio
- Operating Theatre Efficiency Guidelines: A guide to the efficient management of operating theatres in New South Wales hospitals  

**Useable data available from**  
July 1994

**Frequency of Reporting**  
Monthly

**Time lag to available data**  
Reporting required by the 10th working day of each month, data available for previous month

**Business owners**  
System Purchasing Division

**Contact - Policy**  
Executive Director, System Purchasing Branch
### Representation

<table>
<thead>
<tr>
<th>Data type</th>
<th>Numeric</th>
</tr>
</thead>
<tbody>
<tr>
<td>Form</td>
<td>Number</td>
</tr>
<tr>
<td>Layout</td>
<td>NN,NNN</td>
</tr>
<tr>
<td>Minimum size</td>
<td>1</td>
</tr>
<tr>
<td>Maximum size</td>
<td>6</td>
</tr>
</tbody>
</table>

**Related National Indicator**

METeOR identifier: 613691 Elective surgery waiting list episode—overdue patient status, code N

### 2018-19 Service Performance Agreements

**Strategy 2 KPIs: Provide World-Class Clinical Care Where Patient Safety is First**

**INDICATOR:** KSA102  
**Previous IDs:** 9B3, 0086

<table>
<thead>
<tr>
<th><strong>Emergency Treatment Performance:</strong></th>
<th>Patients with Total time in ED &lt;= 4hrs (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previously known as:</td>
<td></td>
</tr>
<tr>
<td>• ED patients admitted, referred or discharged within 4 hours of presentation (%)</td>
<td></td>
</tr>
<tr>
<td>• Total Time in ED</td>
<td></td>
</tr>
<tr>
<td>• National emergency access target (NEAT): Patients with Total time in ED &lt;= 4hrs (%)</td>
<td></td>
</tr>
</tbody>
</table>

**Shortened Title**  
Emergency Treatment Performance

**Service Agreement Type**  
Key Performance Indicator

**Framework Strategy**  
Strategy 2: Provide World-Class Clinical Care Where Patient Safety is First

**Framework Objective**  
2.4 (Ensure timely access to care)

<table>
<thead>
<tr>
<th><strong>Status</strong></th>
<th>Final</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Version number</strong></td>
<td>4.2</td>
</tr>
</tbody>
</table>

**Scope**  
All emergency presentations where treatment has ceased

**Goal**  
To improve access to public hospital services

**Desired outcome**  
- Improved patient satisfaction
- Improved efficiency of Hospital services

**Primary point of collection**  
Emergency Department Clerk

**Data Collection Source/System**  
Emergency Department Data Collection

**Primary data source for analysis**  
HIE (ED_Visit)

**Indicator definition**  
The percentage of ED patients whose clinical care in the ED is complete and whose ED length of stay is <= 4 hours. ED length of stay is calculated as subtracting presentation date/time from ED departure date/time, where:

- **Presentation date/time in the ED** is the time and date of the first recorded contact with an emergency department staff member. The first recorded contact can be the commencement of the clerical registration or triage process, whichever happens first and;

- **Departure date/time** is measured using the following business rules:

  - If the patient is subsequently admitted to this hospital (either short stay unit, hospital-in-the-home or non-emergency department hospital ward), then record the time the patient leaves the emergency department to go to the admitted patient facility. For NSW, this corresponds to Mode of Separation codes ‘01’, ‘10’ or ‘11’, and is calculated using the “Actual Departure Date and Time” field in source systems.
  - If the service episode is completed without the patient being admitted, and the patient is referred to another hospital for admission, then record the time the patient leaves the emergency department. For NSW, this corresponds to Mode of Separation code ‘05’ and is calculated using the “Actual Departure Date and Time” field in source systems.
  - If the service episode is completed without the patient being admitted,
including where the patient is referred to another clinical location, then record the time the patient's emergency department non-admitted clinical care ended. For NSW, this corresponds to Mode of Separation codes '04' or '09' and is calculated using the earlier of "Departure Ready Date and Time", or "Actual Departure Date and Time" fields in source systems.

- If the patient did not wait, then record the time the patient leaves the emergency department or was first noticed as having left. For NSW, this corresponds to Mode of Separation code '06' and is calculated using the "Actual Departure Date and Time" field in source systems.
- If the patient leaves at their own risk, then record the time the patient leaves the emergency department or was first noticed as having left. For NSW, this corresponds to Mode of Separation codes '07' and is calculated using the "Actual Departure Date and Time" field in source systems.
- If the patient died in the emergency department, then record the time the body was removed from the emergency department. For NSW, this corresponds to Mode of Separation code '03' and is calculated using the "Actual Departure Date and Time" field in source systems.
- If the patient was dead on arrival, then record the time the body was removed from the emergency department. If an emergency department physician certified the death of the patient outside the emergency department, then record the time the patient was certified dead. For NSW, this corresponds to Mode of Separation code '08' and is calculated using the "Actual Departure Date and Time" field in source systems.

**NOTE:** For the purposes of this KPI, an ED presentation is defined as the totality of an ED visit, from the date and time of the first recorded contact with an emergency department staff member to the point where the visit has concluded and the clinical care in the ED has ceased.

**Numerator**

**Numerator definition**
All patients who have a length of stay from presentation time to departure time of less than or equal to 4 hours, where the actual_departure_date falls within the reporting period.

**Numerator source**
HIE (Emergency Department Data Collection)

**Numerator availability**
Available

**Denominator**

**Denominator definition**
The total number of emergency department presentations where the actual_departure_date falls within the reporting period

**Denominator source**
HIE (Emergency Department Data Collection)

**Denominator availability**
Available

**Inclusions**
- All patients presenting to the emergency department at facilities that currently provide patient episode data to the non-admitted patients ED minimum data collection
- All patients that departed during the reporting period
- Only records where “Presentation time” (i.e. triage or arrival time) and actual Departure date/time are present

**Exclusions**
- Records where total time in ED is missing, less than zero or greater than
99,998 minutes

- Visit type in (‘12’, ‘13’) i.e. Telehealth presentation, current admitted patient presentation
- Separation mode = ‘99’ i.e. Registered in error
- Duplicate with same facility, MRN, arrival date, arrival time and birth date

Targets

- The Emergency Treatment Performance state target is greater than or equal to 81%.
- Not performing: <71% of all presentations with a total time in ED <= 4 hours.
- Under performing: >=71% and <81% of all presentations with a total time in ED <= 4 hours.

Please note: The above refers to the state target ONLY. Individualised LHD monthly ETP targets have been set by the Ministry in consultation with the LHDs/SHNs and are monitored by the System Information and Analytics Branch.

Context

Improved public patient access to emergency department (ED) services by improving efficiency and capacity in public hospitals

Related Policies/ Programs

- Intergovernmental Agreement on Federal Financial Relations
- Whole of Hospital Program
- Centre for Health Care Redesign

Useable data available from

July 1996

Frequency of Reporting

Monthly

Time lag to available data

Reporting required by the 10th day of each month, data available for previous month

Business owners

- Contact - Policy: Executive Director, System Relationships Branch
- Contact - Data: Executive Director, System Information and Analytics Branch (hsipr@doh.health.nsw.gov.au)

Representation

- Data type: Numeric
- Form: Number, presented as a percentage (%)
- Representational layout: NNN.N
- Minimum size: 3
- Maximum size: 5
- Data domain
- Date effective: 1 July 2012

Related National Indicators

National Healthcare Agreement: PI 21b–Waiting times for emergency hospital care: proportion of patients whose length of emergency department stay is less than or equal to four hours, 2018
Meteor ID: 658489
2018-19 Service Performance Agreements
Strategy 2 KPIs: Provide World-Class Clinical Care Where Patient Safety is First

http://meteor.aihw.gov.au/content/index.phtml/itemId/658489

National Health Performance Authority, Hospital Performance: Waiting times for emergency hospital care: Percentage completed within four hours, 2014
Meteor ID: 558277
http://meteor.aihw.gov.au/content/index.phtml/itemId/558277

Components

Meteor ID 474181 Non-admitted patient emergency department service episode—service episode length, total minutes
The amount of time, measured in minutes, between when a patient presents at an emergency department, and when the non-admitted emergency department service episode has concluded
http://meteor.aihw.gov.au/content/index.phtml/itemId/474181

Meteor ID 471889 Emergency department stay—presentation time, hhmm
The time of patient presentation at the emergency department is the time of first recorded contact with an emergency department staff member. The first recorded contact can be the commencement of the clerical registration or triage process, whichever happens first
http://meteor.aihw.gov.au/content/index.phtml/itemId/471889
Strategy 2 KPIs: Provide World-Class Clinical Care Where Patient Safety is First

**INDICATOR: KSA101**

**Transfer of Care** – patients transferred from Ambulance to ED <= 30 minutes (%)

**Shortened Title**
Transfer of Care

**Service Agreement Type**
Key Performance Indicator

**Framework Strategy**
Strategy 2: Provide World-Class Clinical Care Where Patient Safety is First

**Framework Objective**
2.4 (Ensure timely access to care)

**Status**
Final

**Version number**
3.3

**Scope**
All patients arrived by NSW Ambulance to an Emergency Department.

**Goal**
Timely transfer of patients from ambulance to the emergency department, resulting in improved health outcomes and patient satisfaction, as well as improved ambulance operational efficiency

**Desired outcome**
- Ensure co-ordination between NSW Ambulance and emergency departments
- Improve ambulance availability
- Ensure timely access to hospital services for patients

**Primary point of collection**
Operator, Computer Aided Dispatch (CAD) system, ED staff

**Data Collection Source/System**
Ambulance Service, NSW (ASNSW) Operator, Computer Aided Dispatch (CAD) system, and Emergency Department System (EDIS, IPM ED, Cerner FirstNet, Health eCare and IBA)

**Primary data source for analysis**
Ambulance Transfer of Care Reporting System

**Indicator definition**
The percentage of patients arriving by ambulance whose care is transferred from ambulance paramedic to ED clinician within 30 minutes of arrival.

The 'Transfer of Care' time is the time interval measured in minutes between:
- Start time: the arrival time of the patient in the ambulance zone (recorded in the ambulance system as the start time) and
- End time: the arrival time of the patient in the ED treatment zone and their handover from ambulance paramedic to ED clinician (recorded in the ED IT system as treatment location arrival time)

**NOTE:** Triage of Ambulance patients arriving to the ED and the steps for Transfer of Care can be found in the Policy Directive PD2013_47.

Transfer of Care is defined as the transfer of accountability and responsibility for a patient from an ambulance paramedic to an ED clinician.

Transfer of Care is deemed complete only when clinical handover has occurred between hospital staff and paramedics, the patient has been offloaded from the ambulance stretcher and/or the care of the ambulance paramedics is no longer required.

**Ambulance Zone** = ambulance bay where ambulance vehicle arrives outside
2018-19 Service Performance Agreements
Strategy 2 KPIs: Provide World-Class Clinical Care Where Patient Safety is First

Hospital doors

**ED Treatment Zone** = bed/chair inside the ED (care assumed by ED clinician) or chair in the waiting room (care assumed by ED clinical staff managing the waiting room area).

**Numerator**

Numerator definition
Patients arrived by ambulance and waited less than or equal to 30 minutes for care to be transferred from an ambulance paramedic to an ED clinician.

End Time – Start Time ≤ 30 minutes

See indicator definition for Start time and End time.

Numerator source
NSW Ambulance Computer Aided Dispatch (CAD) system and Emergency Department System (EDIS, iPM ED, Cerner FirstNet, Health eCare and IBA)

Numerator availability
Available

Inclusions
Patients arriving in the emergency department & all visit types where the Ambulance Priority is either:

1A Emergency  
1B Emergency  
1C Emergency  
1CE Emergency  
2 Immediate  
2 Immediate ECP  
2A Emergency 30min  
2AE Emergency ECP 30min  
2Ah Emergency HAC 30min  
2AHE Emergency HAC/ECP 30min

**Exclusions**

Patients where the Ambulance Priority is either:

R4 Aeromedical  
R5 Treatments  
R6 After Treatment  
R7 Routine Transport  
R8 Sports / Special Events  
R9 Major Incident  
R10 Priority Error

- Ambulance records with no matching ED record (i.e. unmatched records)
- Incorrect data entered into ED system
- Missing ambulance data due to CAD outage
- NEPT booked transport
- Multiple patients in one ambulance – only one patient is matched

**Denominator**

Denominator definition
The total number of patients that arrived to the ED by ambulance

Denominator source
HIE, NSW Ambulance Computer Aided Dispatch (CAD) system and Emergency Department System (EDIS, iPM ED, Cerner FirstNet, Health eCare and IBA)

Denominator availability
Available

Inclusions
Patients arriving in the emergency department & all visit types where the Ambulance Priority is either:
Strategy 2 KPIs: Provide World-Class Clinical Care Where Patient Safety is First

1A Emergency       2B Emergency 60min
1B Emergency       2BE Emergency ECP 60min
1C Emergency       2Bh Emergency HAC 60min
1CE Emergency      2BHE Emergency HAC/ECP 60min
2 Immediate        2C Emergency 90min
2 Immediate ECP    2CE Emergency ECP 90min
2A Emergency 30min 2Ch Emergency HAC 90min
2AE Emergency ECP 30min 2CHE Emergency HAC/ECP 90min
2Ah Emergency HAC 30min  R3 Time Critical
2AHE Emergency HAC/ECP 30min

Exclusions
Patients where the Ambulance Priority is either:

- R4 Aeromedical
- R5 Treatments
- R6 After Treatment
- R7 Routine Transport
- R8 Sports / Special Events
- M9 Major Incident
- Priority Error

- Ambulance record with no matching ED record (i.e. unmatched records)
- Transfer of Care Time > 600 minutes
- Incorrect data entered into ED system
- Missing ambulance data due to CAD outage
- NEPT booked transport
- Multiple patients in one ambulance – only one patient is matched

Targets
Target: Greater than or equal to 90% within 30 minutes

Not performing: <80% within 30 minutes

Under performing: >= 80% and < 90% within 30 minutes

Context
Timely access to care in emergency departments can lead to better health outcomes for patients and reduce or avoid hospital stays. Better co-ordination of the handover process of patients between ambulance services and hospitals:

- contribute to the timeliness of ambulance patients accessing definitive care, and
- reduce the time taken for ambulance turnaround at hospital, improving resource availability

Related Policies/ Programs
- Whole of Health Program
- Centre for Health Care Redesign

Useable data available from 2011/12

Frequency of Reporting Monthly/Weekly

Time lag to available data
This ambulance system uses batched data extraction. Daily data is taken from both the ambulance system and the emergency department systems and then matched within the Transfer of Care Reporting System between 3am and 8am for the previous day's data. As there is a short turnaround for the data to be made available, there may be occasional operational issues that affect the availability of the data.
2018-19 Service Performance Agreements  
Strategy 2 KPIs: Provide World-Class Clinical Care Where Patient Safety is First

Business owners

| Contact - Policy               | Executive Director, System Management Branch, MOH |
| Contact – Ambulance Data       | Executive Director, Business Innovation and Planning, NSW Ambulance |
| Contact – ED Data              | Executive Director, System Information and Analytics Branch (hsipr@doh.health.nsw.gov.au) |

Representation

<table>
<thead>
<tr>
<th>Data type</th>
<th>Numeric</th>
</tr>
</thead>
<tbody>
<tr>
<td>Form</td>
<td>Number, presented as a percentage (%)</td>
</tr>
<tr>
<td>Representational layout</td>
<td>NNN.N</td>
</tr>
<tr>
<td>Minimum size</td>
<td>1</td>
</tr>
<tr>
<td>Maximum size</td>
<td>6</td>
</tr>
<tr>
<td>Data domain</td>
<td></td>
</tr>
<tr>
<td>Date effective</td>
<td>1 July 2016</td>
</tr>
</tbody>
</table>
STRATEGY 3 KPIs: Integrate Systems to Deliver Truly Connected Care

INDICATOR:  KS3101

### Aged Care Assessment Timeliness - Average time from ACAT referral to delegation - Admitted patients (Days)

**Previous IDs:**
- Aged Care Assessment Timeliness
- Aged Care Assessment Timeliness

**Shortened Title:**
Aged Care Assessment Timeliness

**Service Agreement Type:**
Key Performance Indicator

**Framework Strategy:**
Strategy 3: Integrate Systems to Deliver Truly Connected Care

**Framework Objective:**
3.1 (Drive system integration through agreements)

**Status:**
Final

**Version number:**
1.1

**Scope:**
All admitted patients in public and private hospitals referred for an ACAT assessment

**Goal:**
To ensure all inpatients who need an ACAT assessment are seen in a timely manner so that their eligibility for aged care services can be determined (for example, home care package, residential care)

**Desired outcome:**
Timely and efficient patient pathways so that hospital length of stay is not impacted negatively by a delay in completion of ACAT assessment.

**Primary point of collection:**
ACATs

**Data Collection Source/System:**
Australian Government MyAgedCare Assessor Portal

**Primary data source for analysis:**
MyAgedCare Business Intelligence Report MYAC004

**Indicator definition:**
The average number of patient bed days (calendar) from date of referral issued to ACAT to date of delegation during the reporting period. Number of days is calculated as delegation date minus referral date.

Average days is computed as:

\[
\frac{((\text{number of acute hospital referrals} \times \text{average days for acute hospital referrals}) + (\text{number of non-acute hospital referrals} \times \text{average days for non-acute hospital referrals}))}{\text{total number of acute and non-acute hospital referrals}}
\]

**Numerator**

- **Numerator definition:**
  
  \[
  ((\text{number of acute hospital referrals} \times \text{average days for acute hospital referrals}) + (\text{number of non-acute hospital referrals} \times \text{average days for non-acute hospital referrals}))
  \]

- **Numerator source:**
  MYAC004 Report

- **Numerator availability:**
  Fed to MYAC004 daily.

**Denominator**

- **Denominator definition:**
  The total number of acute and non-acute hospital referrals to ACAT with a delegation date during the reporting period.

- **Denominator source:**
  MYAC004 Report.

- **Denominator availability:**
  Fed to MYAC004 daily.
Inclusions
All admitted patients in acute/non-acute settings; public and private hospitals.

Exclusions
N/A

Targets
The average number of patient bed days (calendar) from date of referral issued to ACAT to date of delegation is ≤ 5 days.

Performing: <= 5 days
Under Performing: > 5 and <= 6 days
Not Performing: > 6 days

Context

Related Policies/ Programs
Aged Care Assessment Program (ACAP Guidelines)

Useable data available from
January 2017

Frequency of Reporting
Monthly

Time lag to available data
Delegation is implemented through the MyAgedCare system, data updated on a daily basis.

Business owners
Contact - Policy
Executive Director, Health and Social Policy Branch
Contact - Data
Manager, Aged Care Assessment Program Evaluation Unit, eHealth NSW

Representation
Data type
Numeric
Form
Number
Representational layout
NN.NN
Minimum size
3
Maximum size
5
Data domain
Floating Point
Date effective
01/07/2017

Related National Indicator
Contractual KPI's under the ACAP Agreements between the Commonwealth of Australia and States/Territories
### INDICATOR: KQS204

**Mental Health: Acute Post Discharge Community Care (%):**

- Acute Post Discharge follow-up within 7 days (%)

---

**Shortened Title**: Mental Health: Acute Post Discharge Community Care

**Service Agreement Type**: Key Performance Indicator

**Framework Strategy**: Strategy 3: Integrate Systems to Deliver Truly Connected Care

**Framework Objective**: 3.2 (Deliver mental health reforms)

**Status**: Final

**Version number**: 2.3

**Scope**: Mental health Services

**Goal**: Improve the effectiveness of an Area’s Inpatient discharge planning and integration of inpatient and Community Mental Health Services.

**Desired outcome**: Increase patient safety in the immediate post-discharge period and reduce the need for early readmission.

**Primary point of collection**: Administrative and clinical staff at designated Acute Mental Health facilities with mental health unit/beds, psychiatric hospitals, and Community Mental Health facilities.

**Data Collection Source/System**: Inpatient data: Patient Administration Systems. Community data: SCI-MHOAT, CHIME, CERNER, FISCH.

**Primary data source for analysis**: Admitted Patient Data Collection - HIE/IQ server; Community Mental Health Data Collection (MH-AMB) - HIE/IQ server; State Unique Patient Identifier (SUPI) - HIE/IQ server.

**Indicator definition**: Percentage of overnight separations from NSW acute mental health inpatient units which were followed by a public sector Community Mental Health contact, in which the consumer participated, within the seven days immediately following that separation.

#### Numerator

**Numerator definition**: Overnight separations from NSW Acute Mental Health inpatient units occurring within the reference period which were followed by a recorded public sector Community Mental Health contact, in which the consumer participated, within the seven days immediately following that separation.

**Numerator source**: Admitted Patient and MH-AMB data in HIE/IQ server, linked via the State Unique Patient Identifier.

**Numerator availability**: Admitted Patient data available; MH-AMB data available. Since 2007/2008, SUPI coverage has been close to 99% both for separations from NSW mental health inpatient units and for NSW Community Mental Health contacts.

#### Denominator

**Denominator definition**: Number of overnight separations from a NSW acute psychiatric inpatient unit(s) occurring within the reference period.
Note: Separations are selected from NSW HIE Inpatient tables, where Ward Identifier = designated MH units and Unit Type=MH bed types, from Mental Health Service Entity Register (MH-SER) ward tables.

Denominator source Admitted Patient Data Collection in HIE/IQ server.
Denominator availability Available.

Inclusions
Includes only overnight separations where the last ward is a designated acute mental health unit.
Uses only separations with SUPI to link the separation of inpatients from acute mental health units with contacts recorded in the community.
Includes all financial subprograms (Child & Adolescent, Adult General, Forensic, and Older Persons).
Mental Health Ambulatory service contacts delivered to any registered client who participated in the contact; these may include:
- Consultation and liaison to non-mental health inpatients
- Outpatient and community clients
- Groups of identified clients.

NB. This definition of ambulatory contacts is not comparable to NAPOOS.

Exclusions
Excludes same-day separations and separations where the mode of separation is death (6, 7); discharge own risk (2); transfer to another acute or psychiatric inpatient hospital (4, 5); type change (9). Post-discharge contacts do not include:
- Inpatient events in a mental health inpatient unit by inpatient staff
- Community contacts on the day of separation.
- Community residential events in a community residential facility by community residential staff
- Non client-related events
- Travel time Contacts by non mental health program or NGO service providers.

Targets
On average expect 70% of overnight separations from NSW acute mental health units to be followed by a recorded community contact within 7 days of discharge.

Target Performing: >= 70%
Under Performing: >= 50% and < 70%
Not Performing: <50%

Comment
Community follow-up can be detected only if a community contact has been recorded in the Area clinical information system. Low community contact recording will result in an apparently low follow-up rate.

A person needs to be accurately identified in both inpatient and ambulatory data collections to enable the SUPI process to link their
records. Errors or omissions in the data, making this linkage less efficient, will result in an apparently low follow-up rate. Some separations are appropriately followed up by GP, private psychiatrist or contracted NGO and will not be captured within this indicator.


Context

The majority of people with chronic and recurring mental illness are cared for in the community. Continuity of care (follow up and support by professionals and peers) in the community settings for psychiatric patients discharged from a hospital leads to an improvement in symptoms severity, readmission rate, level of functioning and patient assessed quality of life. Early and consistent follow up in the community reduces suicide among hospital discharged mental health patients with high suicide risk and history of self-harm.


Related Policies/ Programs

The NSW Health Policy Directive “Transfer of Care from Mental Health Inpatient Services” (PD2012_060), articulates the roles and responsibilities for safe, efficient and effective transfer of care between inpatient settings and from hospital to the community. The policy aims to address two key state targets to improve mental health outcomes:

- Reduce re–admissions within 28 days to any facility
- Increase the rate of community follow–up within 7 days from a NSW public mental health unit

Useable data available from


Frequency of Reporting

Monthly: HSP report; Quarterly: NSW MH Performance Report;

Time lag to available data

Admitted Patient reporting is required by the 13th calendar day of each month for previous month. Data available in HIE/IQ Server by following Tuesday.
Community Mental Health data is fed to HIE weekly, but data entry into source systems may be several months late.

Business owners

Contact - Policy Executive Director, Mental Health Branch (Tel: 02 9391 9262)
Contact - Data Manager Performance and Reporting, InforMH (8877 5120)
### Representation

<table>
<thead>
<tr>
<th>Representation</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data type</td>
<td>Numeric</td>
</tr>
<tr>
<td>Form</td>
<td>Number, presented as a percentage (%)</td>
</tr>
<tr>
<td>Representational layout</td>
<td>NNN</td>
</tr>
<tr>
<td>Minimum size</td>
<td>1</td>
</tr>
<tr>
<td>Maximum size</td>
<td>3</td>
</tr>
<tr>
<td>Data domain</td>
<td>HIRD (Health Information Resource Directory), Indicator specifications in Technical Paper (noted in comment)</td>
</tr>
<tr>
<td>Date effective</td>
<td>2005/2006</td>
</tr>
</tbody>
</table>

### Related National Indicator

 KPis for Australian Public Mental Health Services: PI 12J – Rate of post-discharge community care, 2017

[http://meteor.aihw.gov.au/content/index.phtml/itemId/663838](http://meteor.aihw.gov.au/content/index.phtml/itemId/663838)

Meteor ID: 663838
<table>
<thead>
<tr>
<th><strong>INDICATOR:</strong></th>
<th>KQS203</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Previous IDs:</strong></td>
<td>0008, 9A9</td>
</tr>
</tbody>
</table>

### Mental Health: Acute Readmission - within 28 days (%)

**Shortened Title**
Mental Health: Acute Readmissions

**Service Agreement Type**
Key Performance Indicator

**Framework Strategy**
Strategy 3: Integrate Systems to Deliver Truly Connected Care

**Framework Objective**
3.2 (Deliver mental health reforms)

**Status**
Final

**Version number**
3.2

**Scope**
Mental health services

**Goal**
To reduce the number of acute public sector mental health readmissions to same or another public sector acute mental health unit within 28 days of discharge.

**Desired outcome**
Improved mental health and well-being through effective inpatient care and adequate and proper post-discharge follow up in the community.

**Primary point of collection**
Administrative and clinical staff at designated facilities (including stand-alone psychiatric hospitals) with mental health units/beds.

**Data Collection Source/System**
Inpatient data: Patient Administration Systems.

**Primary data source for analysis**
Admitted Patient Data Collection (NSW HIE).

**Indicator definition**
Percentage of overnight separations from a NSW acute Mental Health unit followed by an overnight readmission to any NSW acute Mental Health unit within 28 days.

#### Numerator

**Numerator definition**
Overnight separations from a NSW mental health acute psychiatric inpatient unit(s) occurring within the reference period, that are followed by an overnight readmission to the same or another acute psychiatric inpatient unit within 28 days.

**Numerator source**
Admitted Patient Data Collection (NSW HIE).

**Numerator availability**
Availability of Admitted Patient data is good; however, time must be allowed for readmissions to occur and be recorded in systems. Numerator is therefore only available after a lag of 3 months, e.g. a June report will measure readmissions following separations in March. Since 2007/2008, SUPI coverage has been close to 99% for separations from NSW mental health inpatient units.

#### Denominator

**Denominator definition**
Number of overnight separations from a NSW acute psychiatric inpatient unit(s) occurring within the reference period.
Note: Separations are selected from NSW HIE Inpatient tables, where Ward Identifier = designated MH units and Unit Type=MH bed types, from Mental Health Service Entity Register (MH-SER) ward tables.

Denominator source: Admitted Patient Data Collection in HIE/IQ server.
Denominator availability: Available.

**Inclusions**

**Numerator:** Overnight separations, where the last ward is a designated acute mental health unit, which are followed by an overnight admission to any designated acute mental health unit within 28 days.

- **Note:** Each admission can only have one readmission within 28 days for the reporting period. Any subsequent readmission within the reporting period is only counted as a readmission against the admission immediately preceding it.

**Denominator:** Separations following overnight acute care where the last ward is a designated acute mental health unit.

**Exclusions**

- Excludes separations where “mode of separation” = death (6, 7), discharge at own risk (2) transfer (4, 5) or type change (9).
- Excludes same day separations. This exclusion applies to each separation in the denominator and any subsequent readmission.
- Separations where the purpose of admission was for maintenance ECT and length of stay is one night only. This exclusion applies to each separation in the denominator and any subsequent readmission.

**Target**

Less than or equal to 13% (10% for readmission to same facility and 3% readmission to other facility/Area).

Performing: <= 13%

Under Performing: > 13% and < 20%

Not Performing: >= 20%

**Comment**

The methodology for constructing this indicator was revised in August 2008. The revision was followed by the publication of a Technical Report describing the rationale and methodology for the revised indicator which was distributed widely in AHS and the Department (MHDAO).

An electronic copy of the report, “Technical Paper: Transition to a Revised 28 Day Readmission Indicator for Mental Health, November 2008”, based on the definitions and methodology published in the National Mental Health KPIs (November 2004), is available from Associate Director Performance Analysis and Reporting, InforMH (Tel: 02 8877 5121).

Context

Readmission to Hospital within 28 days of discharge has become one of the most widely used Key Performance Indicators in Australian health care.

Within mental health care, 28 Day Readmission is reported in all Australian jurisdictions. The Australian national mental health KPI set includes the indicator in the domains of effectiveness and continuity, stating "high levels of readmissions within a short timeframe are widely regarded as reflecting deficiencies in inpatient treatment and/or follow-up care and point to inadequacies in the functioning of the overall system".


Related Policies/ Programs

The NSW Health Policy Directive “Transfer of Care from Mental Health Inpatient Services” (PD2012_060), articulates the roles and responsibilities for safe, efficient and effective transfer of care between inpatient settings and from hospital to the community. The policy aims to address two key state targets to improve mental health outcomes:

- Reduce re-admissions within 28 days to any facility
- Increase the rate of community follow-up within 7 days from a NSW public mental health unit

Useable data available from

Financial year 2002/03

Frequency of Reporting


Time lag to available data

Admitted Patient reporting is required by the 13th calendar day of each month for previous month. Data available in HIE/IQ Server by following Tuesday.

Business owners

Contact - Policy Director, Mental Health Branch (Tel: 02 9391 9262)

Contact - Data Manager Performance and Reporting, InforMH (8877 5120)

Representation

Data type Numeric
Form Number, presented as a percentage (%)
<table>
<thead>
<tr>
<th>Representational layout</th>
<th>NNN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum size</td>
<td>1</td>
</tr>
<tr>
<td>Maximum size</td>
<td>3</td>
</tr>
<tr>
<td>Data domain</td>
<td>HIRD (Health Information Resource Directory), Indicator specifications in Technical Paper (noted in comment)</td>
</tr>
<tr>
<td>Date effective</td>
<td>2002/2003</td>
</tr>
</tbody>
</table>

**Related National Indicator**

KPIs for Australian Public Mental Health Services: PI 02J – 28 day readmission rate, 2017

[http://meteor.aihw.gov.au/content/index.phtml/itemId/663806](http://meteor.aihw.gov.au/content/index.phtml/itemId/663806)

Meteor ID: 663806
**INDICATOR:** KQS206  

**Previous IDs:** Mental Health: Acute Seclusion Occurrence

- Number of acute seclusion episodes as a rate per 1000 bed days

**Shortened Title**  
Acute Seclusion Occurrence

**Service Agreement Type**  
Key Performance Indicator

**Framework Strategy**  
Strategy 3: Integrate Systems to Deliver Truly Connected Care

**Framework Objective**  
3.2 (Deliver mental health reforms)

<table>
<thead>
<tr>
<th>Status</th>
<th>Version number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Final</td>
<td>1.2</td>
</tr>
</tbody>
</table>

**Scope**  
Mental health public hospital acute services

**Goal**  
To reduce the use of seclusion in public sector mental health services

**Desired outcome**  
The reduction, and where possible, elimination of seclusion in mental health services

**Primary point of collection**  
Administrative and clinical staff in NSW public hospitals (including stand-alone psychiatric hospitals) with mental health units/beds.

**Data Collection Source/System**  
Inpatient data; Patient Administration Systems and local seclusion registers

**Primary data source for analysis**  
Inpatient data: Admitted Patient Data Collection – HIE/IQ server; Local seclusion registers

**Indicator definition**  
The number of seclusion episodes per 1000 bed days in acute mental health units

**Numerator**

- **Numerator definition**  
  Number of seclusion episodes in acute mental units within the reporting period

- **Numerator source**  
  Seclusion Collection (Manual)

- **Numerator availability**  
  Data available since the statewide collection commenced in January 2008

**Denominator**

- **Denominator definition**  
  Number of bed days in acute mental units within the reporting period

- **Denominator source**  
  HIE/IQ server

- **Denominator availability**  
  Available

**Inclusions**
- All acute mental health units

**Exclusions**
- Leave days are excluded from the denominator

**Targets**

- **Target**  
  Target: <5.1  
  Performing: <5.1  
  Not performing: >=5.1
Under performing: N/A

Context
Rate of seclusion is one of the indicators in the Key Performance Indicators for the Australian Public Mental Health Services, 3rd Edition published in 2013.
Seclusion data is manually reported by LHDs. Apparent differences in rate between units may be due to local differences in counting or reporting.

Related Policies/ Programs
Annual National Mental Health Seclusion and Restraint forums convened by the Safety and Quality Partnership Standing Committee (SQPSC).

Useable data available from
Data have been available since January 2008.

Frequency of Reporting
Quarterly

Time lag to available data
Admitted Patient reporting is required by the 13th calendar day of each month for previous month. Data available in HIE/IQ Server by following Tuesday.
Submission of local seclusion data may take up to one month after the end of reporting period.

Business owners
Health System Information Performance & Reporting, Ministry of Health
Contact - Policy
Director, Mental Health Branch (Tel: 02 9391 9262)
Contact - Data
Manager Performance and Reporting, InforMH (8877 5120)

Representation
Data type
Numeric
Form
Number, presented as a rate per 1,000
Representational layout
NNN.N
Minimum size
2
Maximum size
6
Data domain

Date effective
2015

Related National Indicator
Meteor ID 663842 KPIs for Australian Public Mental Health Services: PI 15J – Rate of seclusion, 2017
Number of seclusion events per 1,000 patient days within public acute admitted patient specialised mental health service units.
http://meteor.aihw.gov.au/content/index.phtml/itemId/663842

Meteor ID 558083 Specialised mental health service—number of seclusion events, total number N[NNN]
The total number of seclusion events occurring within the reference period for a specialised mental health service.
http://meteor.aihw.gov.au/content/index.phtml/itemId/558083

Meteor ID 286770 Establishment—accrued mental health care days, total
N(N7)
The total number of accrued mental health care days provided by admitted patient care services and residential mental health care services within the reference period. 
http://meteor.aihw.gov.au/content/index.phtml/itemId/286770

Key Performance Indicators for Australian Public Mental Health Services, 3rd edition, 2013.
### Emergency Department Extended Stays: Mental Health Presentations staying in ED > 24 hours (number)

**Previously known as:**
- Mental Health Access Block - Emergency department to inpatient unit - Presentations staying in ED > 24 hours (Number)
- ED Presentations staying in ED > 24 hours (Mental Health)
- Presentations staying in ED > 24 hours (Mental Health)

**Shortened Title**
MH ED Extended Stays > 24 hrs

**Service Agreement Type**
Key Performance Indicator

**Framework Strategy**
Strategy 3: Integrate Systems to Deliver Truly Connected Care

**Framework Objective**
3.2 (Deliver mental health reforms)

**Status**
Final

**Version number**
2.51

**Scope**
Emergency Department mental health patients.

**Goal**
To improve access to mental health inpatient services (where this is required) from Emergency Department.

**Desired outcome**
Improve patient satisfaction and availability of services with reduced waiting time for admission to acute patient care in a Mental Health unit from the Emergency Department and to improve the availability of Emergency Department services for other patients.

**Primary point of collection**
Emergency Department clerk

**Data Collection Source/System**
Emergency Department Information System (EDIS)/Cerner First Net/other electronic Emergency Department Information Systems

**Primary data source for analysis**
HIE (Table ED_Visit_mrn, ED_diagnosis_mrn, ED_diagnosis_sct_mrn)

**Indicator definition**
Number of Mental Health presentations where the patient's stay in ED from Presentation time to actual departure is longer than 24 hours, where the actual_departure_date falls within the reporting period.

Where:
- **Presentation time in the ED** is the triage time. If the triage time is missing it is the arrival time and;
- **Departure time** is the earliest of departure ready date/time or actual departure date/time for non-admitted patients with a mode of separation 2, 4 or 9; otherwise it is the actual departure date/time.

Mental health patients are identified using ED principal diagnosis codes as follows:

**ICD9CM:**
- First three characters "294"-"301" or "306"-"314";
- whole codes "V71.01"-"V71.09";
- whole code "799.2";
- whole codes "E950.00"-"E959.99".

**ICD10AM:**

---

**Page 124**
Strategy 3 KPIs: Integrate Systems to Deliver Truly Connected Care

- First three characters "F20"-"F51" or "F53"-"F63" or "F65"-"F69" or "F80"-"F99" or "R44"-"R45" or "X60"-"X84";
- For codes with first two characters "F1", include only those of form "F1n.5" where n is an integer 0-9.

SNOMED CT (mapped to ICD10AM V10), using the NWAU_CLINICAL_CODE_MAP table as stored here: 

**NOTE:** For the purposes of this Measure, an ED presentation is defined as the totality of an ED visit, from the date and time of Triage (or arrival time if missing) to the point where the visit has concluded and the clinical care in the ED has ceased.

**Data Availability**
Available. Note that some EDIS systems include the decimal point in the ICD9 diagnosis code and some do not.

**Inclusions**
Mental health patients as identified using ED principal diagnosis codes ICD 9, ICD 10 and SNOMED CT. Emergency type visits (type of visit codes 1, 3 and 11).

**Exclusions**
Excludes:
- Departure status was Did not wait, Left at own risk or Dead on arrival i.e. Modes of separation 6, 7, 8, and 99.
- Records with negative or missing length of stay.

**Targets**
Target: 0 (zero / nil) presentations during a month
Not performing: >5 presentations during a month
Under performing: Between 1 and 5 presentations during a month.

**Lower /upper age limit**
All ages

**Context**
Timely admission to a hospital bed, for those Emergency Department patients who require inpatient treatment, contributes to patient comfort and improves outcomes and the availability of Emergency Department services for other patients.

**Related Policies/ Programs**
- Clinical Services Redesign Program
- Whole of Health program

**Useable data available from**
July 2006

**Frequency of Reporting**
Monthly

**Time lag to available data**
Reporting required by the 10th day of each month, data available for previous month

**Business owners**
Mental Health Branch

**Contact - Policy**
Executive Director, Mental Health Branch

**Contact - Data**
Executive Director, System Information and Analytics Branch (hsipr@doh.health.nsw.gov.au)

**Representation**
<table>
<thead>
<tr>
<th>Data type</th>
<th>Numeric</th>
</tr>
</thead>
<tbody>
<tr>
<td>Form</td>
<td>Number</td>
</tr>
<tr>
<td>Representational layout</td>
<td>NNNN</td>
</tr>
<tr>
<td>Minimum size</td>
<td>1</td>
</tr>
<tr>
<td>Maximum size</td>
<td>4</td>
</tr>
</tbody>
</table>

**Related National Indicator**

**Components**

Meteor ID 474181 Non-admitted patient emergency department service episode—service episode length, total minutes NNNNN

The amount of time, measured in minutes, between when a patient presents at an emergency department, and when the non-admitted emergency department service episode has concluded

[http://meteor.aihw.gov.au/content/index.phtml/itemId/474181](http://meteor.aihw.gov.au/content/index.phtml/itemId/474181)

Meteor ID 471889 Emergency department stay—presentation time, hhmm

The time of patient presentation at the emergency department is the time of first recorded contact with an emergency department staff member. The first recorded contact can be the commencement of the clerical registration or triage process, whichever happens first

[http://meteor.aihw.gov.au/content/index.phtml/itemId/471889](http://meteor.aihw.gov.au/content/index.phtml/itemId/471889)
## Mental Health: Acute Seclusion Duration – Average (Hours)

- **Average hours per seclusion episode**

### Shortened Title
Acute Seclusion Duration

### Service Agreement Type
Key Performance Indicator

### Framework Strategy
Strategy 3: Integrate Systems to Deliver Truly Connected Care

### Framework Objective
3.2 (Deliver mental health reforms)

### Status
Final

### Version number
1.2

### Scope
Mental health public hospital acute services

### Goal
To reduce the use of seclusion in public sector mental health services

### Desired outcome
The reduction, and where possible, elimination of seclusion in mental health services

### Primary point of collection
Administrative and clinical staff in NSW public hospitals (including stand-alone psychiatric hospitals) with mental health units/beds.

### Data Collection Source/System
Seclusion Collection (Manual)

### Primary data source for analysis
Seclusion Collection (Manual)

### Indicator definition
The average duration in hours of seclusion episodes occurring in the reporting period

#### Numerator
- **Numerator definition**
  Total duration of seclusion episodes in acute mental health units within the reporting period
- **Numerator source**
  Seclusion Collection (Manual)
- **Numerator availability**
  Data available since the statewide collection commenced in January 2008

#### Denominator
- **Denominator definition**
  Number of seclusion episodes in acute mental units within the reporting period
- **Denominator source**
  Seclusion Collection (Manual)
- **Denominator availability**
  Data available since the statewide collection commenced in January 2008

### Inclusions
Acute mental health units in facilities with seclusion rooms/facilities

### Exclusions

### Targets
- **Target**
  - Performing: < 4 hours
  - Under performing: >= 4 hours and <= 5.5 hours
  - Not performing: > 5.5 hours
2018-19 Service Performance Agreements
Strategy 3 KPIs: Integrate Systems to Deliver Truly Connected Care

Context
All seclusion data is manually reported by LHDs. Apparent differences in rate between units may be due to local differences in counting or reporting.

Related Policies/ Programs
Annual National Mental Health Seclusion and Restraint forums convened by the Safety and Quality Partnership Standing Committee (SQPSC).

Useable data available from
Data have been available since January 2008.

Frequency of Reporting
Quarterly

Time lag to available data
Submission of local seclusion episodes data may take up to one month after the end of reporting period.

Business owners
Health Systems Information Performance & Reporting, Ministry of Health
Contact - Policy
Director, Mental Health Branch (Tel: 02 9391 9262)
Contact - Data
Manager Performance and Reporting, InforMH (8877 5120)

Representation
Data type
Numeric
Form
Number
Representational layout
NNN.N
Minimum size
2
Maximum size
6
Data domain

Related National Indicator
Meteor ID 558083 Specialised mental health service—number of seclusion events, total number N[NNN]
The total number of seclusion events occurring within the reference period for a specialised mental health service.
http://meteor.aihw.gov.au/content/index.phtml/itemId/558083

Meteor ID 573910 Specialised mental health service—seclusion duration, total hours NNNNN
The total amount of time mental health consumers spent in seclusion within the reference period for a specialised mental health service.
http://meteor.aihw.gov.au/content/index.phtml/itemId/573910
**INDICATOR:** SSQ127  

**Previous IDs:**  
Mental Health: Involuntary Patients Absconded – From an inpatient mental health unit – Incident Types 1 and 2 (Number)

**Shortened Title**  
Involuntary Patients Absconded

**Service Agreement Type**  
Key Performance Indicator

**Framework Strategy**  
Strategy 3: Integrate Systems to Deliver Truly Connected Care

**Framework Objective**  
3.2 (Deliver mental health reforms)

**Status**  
Final

**Version number**  
1.3

**Scope**  
Mental health public hospital inpatient services

**Goal**  
Improved monitoring and treatment of involuntary patients

**Desired outcome**  
Reduce the number of involuntary mental health patients who abscond

**Primary point of collection**  
All health service staff that report or notify an incident.

**Data Collection Source/System**  
Incident Information Management System (IIMS)

**Primary data source for analysis**  
RIB Database, Clinical Excellence Commission

**Indicator definition**  
The number of Type 1 and 2 incidents reported where involuntary patients absconded from a mental health inpatient unit.

**Numerator**  
Numerator definition  
The number of Type 1 and 2 incidents reported where involuntary patients absconded from a mental health inpatient unit.

Numerator source  
RIB Database, Clinical Excellence Commission

Numerator availability  
TBA

**Denominator**  
Denominator definition  
N/A

<table>
<thead>
<tr>
<th>Inclusions</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Exclusions</th>
</tr>
</thead>
</table>

**Targets**  
Target  
0 (Zero) per reporting period

Performing: 0 (Zero) per reporting period

Not performing: > 0 (Zero) per reporting period

**Context**  

**Related Policies/ Programs**  
N/A

**Useable data available from**  
N/A
### Frequency of Reporting
Quarterly

### Time lag to available data
TBA

### Business owners
Mental Health Branch, MoH

- **Contact - Policy**: Executive Director, Mental Health Branch
- **Contact - Data**: Manager Performance and Reporting, InforMH (8877 5120)

### Representation

<table>
<thead>
<tr>
<th>Data type</th>
<th>Numeric</th>
</tr>
</thead>
<tbody>
<tr>
<td>Form</td>
<td>Number</td>
</tr>
<tr>
<td>Representational layout</td>
<td>N{NNN}</td>
</tr>
<tr>
<td>Minimum size</td>
<td>1</td>
</tr>
<tr>
<td>Maximum size</td>
<td>4</td>
</tr>
<tr>
<td>Data domain</td>
<td></td>
</tr>
<tr>
<td>Date effective</td>
<td>01/07/2016</td>
</tr>
</tbody>
</table>

### Related National Indicator
N/A
**INDICATOR:** KS3202  
**Previous IDs:** Mental Health Consumer Experience  
**Shortened Title:** Mental Health Consumer Experience  
**Service Agreement Type:** Key Performance Indicator  
**Framework Strategy:** Strategy 3: Integrate Systems to Deliver Truly Connected Care  
**Framework Objective:** 3.2 (Deliver mental health reforms)  
**Status:** Final  
**Version number:** 1.01  

**Scope:** NSW public specialized inpatient and community mental health services.  
**Goal:** To improve experience and outcomes in mental health care  
**Desired outcome:** More than 80% of mental health consumers report a Very Good or Excellent overall experience.  
**Primary point of collection:** Your Experience of Service (YES) questionnaire  
**Data Collection Source/System:** NSW YES surveys distributed by LHDs/SNHs reported to NSW YES Collection maintained by InforMH, System Information and Analytics Branch  
**Primary data source for analysis:** NSW YES collection  
**Indicator definition:** NSW or LHD/SNH percentage is the average of percentages calculated separately for inpatient and community settings. Within each setting, score is the average of Percent of completed YES questionnaires with overall Experience score in the Very Good to Excellent range.  

**Calculation method is:** \[ 100 \times \frac{\text{Numerator 1}}{\text{Denominator 1}} + \frac{\text{Numerator 2}}{\text{Denominator 2}}/2. \]

**Numerator**  
**Numerator definition:**  
1. The number of valid YES questionnaires with overall Experience score in the Very Good to Excellent range (\( \geq 8/10 \)) in inpatient settings  
2. The number of valid YES questionnaires with overall Experience score in the Very Good to Excellent range (\( \geq 8/10 \)) in community settings  

Overall Experience score is the average score of validly completed YES questions 1-22, expressed as a score out of 10.  

**Numerator source:** YES Collection  
**Numerator availability:** Quarterly  

**Denominator**  
**Denominator definition:**  
1. The total number of valid YES questionnaires received in inpatient settings.  
2. The total number of valid YES questionnaires received in community settings.
Strategy 3 KPIs: Integrate Systems to Deliver Truly Connected Care

### Community Settings

**Denominator source**  
YES Collection

**Denominator availability**  
Quarterly

#### Inclusions

All YES questionnaires included in reference period

#### Exclusions

- No valid service identification.
- YES questionnaires where <12 of questions 1-22 were completed.
- LHD/SHN service settings (inpatient/community) with <10 YES questionnaires returned in the quarter.

#### Targets

<table>
<thead>
<tr>
<th>Target</th>
<th>Performing</th>
<th>Underperforming</th>
<th>Not performing</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>&gt;= 80%</td>
<td>&gt;= 70% and &lt;80%</td>
<td>&lt;70%</td>
</tr>
</tbody>
</table>

#### Context

**Related Policies/Programs**

Useable data available from  
July 2015

**Frequency of Reporting**  
Quarterly

**Time lag to available data**  
One quarter

**Business owners**

- **Contact - Policy**  
  Executive Director, Mental Health Branch
- **Contact - Data**  
  Executive Director, System Information and Analytics Branch

**Representation**

- **Data type**  
  Numeric
- **Form**  
  Number, expressed as a percentage
- **Representational layout**  
  N[NN]
- **Minimum size**  
  1
- **Maximum size**  
  3
- **Data domain**
- **Date effective**  
  1 July 2018

**Related National Indicator**

Page 132
**INDICATOR:** KS3201  
**Previous IDs:** KMH201

<table>
<thead>
<tr>
<th><strong>Mental Health: Pathways to Community Living –</strong> People transitioned to the community (Number)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Previously called People comprehensively assessed under the Pathways to Community Living Initiative</td>
</tr>
</tbody>
</table>

**Shortened Title**  
Pathways to Community Living

**Service Agreement Type**  
Key Performance Indicator

**Framework Strategy**  
Strategy 3: Integrate Systems to Deliver Truly Connected Care

**Framework Objective**  
3.2 (Deliver mental health reforms)

**Status**  
Final

**Version number**  
1.1

**Scope**  
The six key Local Health Districts that have a significant number of patients with a length of stay greater than 365 days – these are Northern Sydney LHD, Western Sydney LHD, Hunter New England LHD, Western NSW LHD, Sydney LHD and South Western Sydney LHD.

**Goal**  
To ensure continued progress on the Pathways to Community Living (PCLI) initiative, which will ultimately lead to people living in more appropriate community settings

**Desired outcome**  
Greater accountability for driving the PCLI initiative

**Primary point of collection**  
LHD PCLI database

**Data Collection Source/System**  
LHD PCLI databases

**Primary data source for analysis**  
N/A

**Indicator definition**  
The total number of people (cumulative since project commencement) transitioned under the Pathways to Community Living Initiative

**Numerator**

| Numerator definition | The total number of people (cumulative since project commencement) reported as transitioned from an inpatient unit to the community under the Pathways to Community Living Initiative |
| --- |
| Numerator source | Reports generated from the LHD PCLI database |
| Numerator availability | Quarterly |

**Denominator**

| Denominator definition | N/A |
| --- |
| Denominator source | N/A |
| Denominator availability | N/A |

**Inclusions**

- Northern Sydney LHD
- Western Sydney LHD
- Hunter New England LHD
2018-19 Service Performance Agreements
Strategy 3 KPIs: Integrate Systems to Deliver Truly Connected Care

- Western NSW LHD
- Sydney LHD
- South Western Sydney LHD

**Exclusions**
LHDs and SHNs not listed in the inclusions

**Targets**

- **Target**
  - Performing: Increase on previous quarter
  - Not performing: Decrease from previous quarter
  - Under performing: No change on previous quarter

**Context**

**Related Policies/ Programs**
- NSW Mental Health Reform 2014-2024 – Living Well
- Pathways to Community Living Initiative

**Useable data available from**
1 July 2017

**Frequency of Reporting**
Quarterly

**Time lag to available data**
30th day of the month following each quarterly period

**Business owners**
Mental Health Branch

- **Contact - Policy**
  - Robyn Murray, PCLI Project Manager, Mental Health Branch

- **Contact - Data**
  - Manager, Performance and Reporting, InforMH (8877 5120)

**Representation**

- **Data type**
  - Numeric

- **Form**
  - Number

- **Representational layout**
  - N{NN}

- **Minimum size**
  - 1

- **Maximum size**
  - 3

**Date effective**
1 July 2017

**Related National Indicator**
N/A
<table>
<thead>
<tr>
<th>INDICATOR:</th>
<th>KMH202</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Previous IDs:</strong></td>
<td><strong>Mental Health Peer Workforce Employment</strong> – Full time equivalents (FTEs) (Number)</td>
</tr>
<tr>
<td>Shortened Title</td>
<td>Mental Health Peer Workforce Employment</td>
</tr>
<tr>
<td>Service Agreement Type</td>
<td>Key Performance Indicator</td>
</tr>
<tr>
<td>Framework Strategy</td>
<td>Strategy 3: Integrate Systems to Deliver Truly Connected Care</td>
</tr>
<tr>
<td>Framework Objective</td>
<td>3.2 (Deliver mental health reforms)</td>
</tr>
<tr>
<td>Status</td>
<td>Final</td>
</tr>
<tr>
<td>Version number</td>
<td>1.2</td>
</tr>
<tr>
<td>Scope</td>
<td>Staff employed by the Local Health District/Specialty Health Networks</td>
</tr>
</tbody>
</table>
| Goal | • Identify opportunities to expand the scope and size of the Peer and Carer workforce across the NSW mental health system  
• Develop strategies and implement frameworks for capacity building to support, expand, enhance and define the Peer and Carer workforce across the NSW mental health system  
• Ensure recruitment for vacant positions occurs within each quarter |
| Desired outcome | Increase the number of skilled, competent and qualified peer workers (consumer or carer workers) in the NSW mental health system to support better experience of care for consumers |
| Primary point of collection | NSW Mental Health Peer Workforce Coordinator, MHDAO |
| Data Collection Source/System | Manual collection by NSW Mental Health Peer Workforce Coordinator, MHDAO |
| Primary data source for analysis | Peer Workforce Data Collection spreadsheet |
| Indicator definition | The total number of Full Time Equivalent (FTE) mental health staff employed in a peer worker capacity (consumer or carer workers). |
| **Numerator** | The total number of Full Time Equivalent (FTE) mental health staff employed in a peer worker capacity (consumer or carer workers) using the following definitions: |
| **Numerator definition** | Consumer / Peer workers: Persons employed (or engaged via contract) on a part-time or full-time paid basis, where the person is specifically employed for the expertise developed from their lived experience of mental illness. |
| | Mental health consumer workers include the job titles of, but not limited to, consumer consultants, peer support workers, peer specialists, consumer companions, consumer advocates, consumer representatives, consumer project officers and recovery support workers. |
| | Carer workers: Persons employed (or engaged via contract) on a part-time or full-time paid basis, where the person is specifically employed for |
Strategy 3 KPIs: Integrate Systems to Deliver Truly Connected Care

the expertise developed from their experience as a mental health carer.

Mental health carer workers include the job titles of, but not limited to, carer consultants, carer support workers, carer representatives and carer advocates.

Numerator source: Manual collection - Peer Workforce Data Collection spreadsheet
Numerator availability: Quarterly

**Denominator**

Denominator definition: N/A

Denominator source
Denominator availability

**Inclusions**

N/A

**Exclusions**

N/A

**Targets**

Target: Increase in FTE profile for each quarterly reporting period

- Performing: Increase in FTE profile for each reporting period
- Under-performing: No change to FTE profile in reporting period
- Not performing: Decrease in FTE profile in each reporting period

**Context**

Related Policies/ Programs: NSW Mental Health Reform 2014-2024 – Living Well

Useable data available from: 1 August 2016

Frequency of Reporting: Quarterly

Time lag to available data: 10th day of the month following each quarterly period

Business owners: Mental Health Branch, System Management

Contact - Policy: NSW Mental Health Peer Workforce Coordinator, Mental Health

Contact - Data: NSW Mental Health Peer Workforce Coordinator, Mental Health

**Representation**

Data type: Numeric
Form: Number
Representational layout: NN.N
Minimum size: 2
Maximum size: 3
Data domain

Page 136
2018-19 Service Performance Agreements
Strategy 3 KPIs: Integrate Systems to Deliver Truly Connected Care

<table>
<thead>
<tr>
<th>Date effective</th>
<th>01/07/2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Related National Indicator</td>
<td>N/A</td>
</tr>
<tr>
<td>INDICATOR: KSA205</td>
<td><strong>Electronic Discharge Summaries Completed:</strong> (%)</td>
</tr>
<tr>
<td>------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>Previous IDs:</td>
<td>• Percentage of discharge summaries lodged electronically to HealtheNet Clinical Repository</td>
</tr>
</tbody>
</table>

Shortened Title: Electronic Discharge Summaries Completed

Service Agreement Type: Key Performance Indicator
Framework Strategy: Strategy 3: Integrate Systems to Deliver Truly Connected Care
Framework Objective: 3.5 (Leverage information & analytics to connect care across the system)

Status: Final
Version number: 1.2

Scope: All completed admitted inpatient stays
Goal: All inpatient stays to have an electronic discharge summary completed after the patient has received care as a hospital inpatient.
Desired outcome: To improve patient health outcomes

Primary point of collection: Cerner, iPM, CorePAS, Clinical Applications Portal
Data Collection Source/System: HealtheNet Clinical Repository
Primary data source for analysis: HealtheNet Statewide Infrastructure, Rhapsody, Enterprise Service Bus, Clinical Repository Databases

Indicator definition: The percentage of unique discharge summaries lodged electronically with HealtheNet Clinical Repository over the total number of discharged inpatient stays.

**Numerator**
- Numerator definition: Total YTD number of unique electronic discharge summaries lodged with HealtheNet Clinical Repository.
- Numerator source: HealtheNet Statewide Infrastructure, Rhapsody, Enterprise Service Bus, Clinical Repository Databases
- Numerator availability: Monthly

**Denominator**
- Denominator definition: Total number of admitted inpatient stays within a financial year.
- Denominator source: HealtheNet Clinical Repository/HIE
- Denominator availability: Monthly

**Inclusions**
- Admitted inpatient stays with a separation (end) date within the reporting period.
2018-19 Service Performance Agreements
Strategy 3 KPIs: Integrate Systems to Deliver Truly Connected Care

- Day-only episodes

**Exclusions**

N/A

**Targets**

<table>
<thead>
<tr>
<th>Target</th>
<th>Increase in YTD percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performing: Increase in YTD percentage</td>
<td></td>
</tr>
<tr>
<td>Not performing: No change in YTD percentage</td>
<td></td>
</tr>
<tr>
<td>Under performing: Decrease in YTD percentage</td>
<td></td>
</tr>
</tbody>
</table>

**Context**

**Related Policies/ Programs**

Useable data available from 1 July 2015

**Frequency of Reporting**

Monthly

**Time lag to available data**

System Performance Support Branch

**Business owners**

- Executive Director, System Performance Support Branch

**Contact - Policy**

Executive Director, System Performance Support Branch

**Contact - Data**

Executive Director, System Information and Analytics Branch (hsipr@doh.health.nsw.gov.au)

**Representation**

- Data type: Numeric
- Form: Number, expressed as a percentage
- Representational layout: NNN.N
- Minimum size: 3
- Maximum size: 5
- Data domain
- Date effective: 1 July 2016

**Related National Indicator**
**INDICATOR:** KF-005

**Previous ID:**

**Domestic Violence Routine Screening** – Routine Screens conducted (%)

**Shortened Title**

Domestic Violence Routine Screening

**Service Agreement Type**

Key Performance Indicator

**Framework Strategy**

Strategy 3: Integrate Systems to Deliver Truly Connected Care

**Framework Objective**

3.6 (Support vulnerable people)

**Status**

Final

**Version number**

1.21

**Scope**

All women attending Child and Family services, and women aged 16 years and over in Drug and Alcohol and Mental Health Services.

**Goal**

Ensure domestic violence routine screening is conducted on eligible women.

**Desired outcome**

Identify and respond to women experiencing domestic violence.

**Primary point of collection**

Data Collection Source/System

Local Health Districts: Cerner/eMR, CHIME

**Primary data source for analysis**

Cerner/eMR, CHIME

**Indicator definition**

The percentage of Domestic Violence Routine Screens conducted for women attending Child and Family Health services, and women aged 16 years and over in Drug and Alcohol and Mental Health Services as a percentage of eligible women.

**Numerator**

Numerator definition

Number of Domestic Violence Routine Screens conducted for women attending Child and Family Health services, and women aged 16 years and over in Drug and Alcohol and Mental Health Services.

Numerator source

Cerner/eMR, CHIME

Numerator availability

Quarterly

**Denominator**

Denominator definition

Number of eligible women presenting to Child and Family Health, Drug and Alcohol and Mental Health Services

Denominator source

Cerner/eMR, CHIME

Denominator availability

Quarterly

**Inclusions**

All women attending Child and Family Health services, and women aged 16 years and over in Drug and Alcohol and Mental Health Services.

Screening completed within reporting period.

**Exclusions**

- Children of women attending Child and Family Health services, Drug and Alcohol and Mental Health Services.
- Women presenting to Antenatal services, as an extract is currently unavailable from eMaternity.

**Targets**

70%
Performing: >= 70%

Under Performing: >= 60% and < 70%

Not Performing: < 60%

Context

Routine Screening for domestic violence for every woman who visits Antenatal and Early Childhood services, all women aged 16 + years who visit Drug & Alcohol - Mental Health Services provided by the LHD or their agent.

A 100% target is not feasible for the Domestic Violence Routine Screens program as this would likely detract from the quality of screening and ensuing outcomes. Nor would it take into account situation where it would be reasonable not to screen including:

- Whether the client is well enough to be screened (i.e. client may be presenting to a Mental Health service for first time and is psychotic)
- Whether it is safe to screen client (i.e. partner may be present)

Related Policies/ Programs

NSW Health Policy and Procedures for Identifying and Responding to Domestic Violence

Useable data available from

July 2018

Frequency of Reporting

Quarterly

Time lag to available data

2 weeks

Business owners

Government Relations Branch

Contact - Policy

Director, Prevention and Response to Violence, Abuse and Neglect Unit

Contact - Data

Senior Analyst, Data Management (PARVAN)

Representation

Data type

Numeric

Form

Number, presented as a percentage (%)

Representational layout

NN.N

Minimum size

3

Maximum size

4

Data domain

N/A

Date effective

July 2018

Related National Indicators

Indicator: N/A
2018-19 Service Performance Agreements
Strategy 3 KPIs: Integrate Systems to Deliver Truly Connected Care

<table>
<thead>
<tr>
<th>INDICATOR:</th>
<th>KF-007</th>
<th><strong>Out of Home Care Health Pathway Program</strong> - Children and young people completing a primary health assessment (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous ID:</td>
<td></td>
<td>Out of Home Care Health Pathway Program</td>
</tr>
<tr>
<td>Shortened Title</td>
<td></td>
<td>Out of Home Care Health Pathway Program</td>
</tr>
<tr>
<td>Service Agreement Type</td>
<td></td>
<td>Key Performance Indicator</td>
</tr>
<tr>
<td>Framework Strategy</td>
<td></td>
<td>Strategy 3: Integrate Systems to Deliver Truly Connected Care</td>
</tr>
<tr>
<td>Framework Objective</td>
<td></td>
<td>3.6 (Support vulnerable people)</td>
</tr>
<tr>
<td>Status</td>
<td></td>
<td>Final</td>
</tr>
<tr>
<td>Version number</td>
<td></td>
<td>1.2</td>
</tr>
<tr>
<td>Scope</td>
<td></td>
<td>All children and young people entering statutory out of home care</td>
</tr>
<tr>
<td>Goal</td>
<td></td>
<td>Children and young people entering statutory out of home care receive appropriate health care assessment and follow up.</td>
</tr>
<tr>
<td>Desired outcome</td>
<td></td>
<td>That all children and young people who enter statutory Out Of Home Care receive a timely, coordinated assessment of their health, development and wellbeing, a health management plan and interventions and reviews as identified through the Health Pathway Program process.</td>
</tr>
<tr>
<td>Primary point of collection</td>
<td></td>
<td>NSW Health Out of Home Care service providers in Local Health Districts</td>
</tr>
<tr>
<td>Data Collection Source/System</td>
<td></td>
<td>Local Health Districts: CHOC, CHIME</td>
</tr>
<tr>
<td>Primary data source for analysis</td>
<td></td>
<td>Out of Home Care Pathway Report</td>
</tr>
<tr>
<td>Indicator definition</td>
<td></td>
<td>Percentage of eligible children and young people (in Statutory Out of Home Care) referred onto the Out of Home Care Health Pathway Program that complete a primary health assessment.</td>
</tr>
</tbody>
</table>

**Numerator**

- Numerator definition: Number of eligible referrals to the Health Pathway Program that complete a primary (2a) health assessment in the reporting period (‘the reporting period’ refers to a standard reporting quarter i.e. Q1 Jul-Sept, Q2 Oct-Dec, Q3 Jan-Mar, Q4 Apr-June)
- Numerator source: Out of Home Care Pathway Report
- Numerator availability: Quarterly

**Denominator**

- Denominator definition: Number of eligible referrals to the OOHC Health Pathway Program received by the LHD in the reporting period (this is a count of referrals received 30 days prior to the quarterly reporting period i.e. in Q1 Jul-Sept count referrals received from 1 June - 31 Aug, Q2 Oct-Dec count referrals received 1 Sept to 30 Nov, Q3 Jan-Mar count referrals received 1 Dec to 28 Feb (leap year 29 Feb), Q4 Apr-June count referrals received 1 Mar 31 May).  
- Denominator source: Out of Home Care Pathway Report
- Denominator availability: Quarterly

**Inclusions**

- All eligible referrals received by the LHD for children and young people entering Statutory Out of Home Care to the Health Pathway Program
Exclusions

Children and young people who are not in Statutory Out of Home Care

Targets

100%
- Performing: 100%
- Under Performing: >= 90% and < 100%
- Not Performing: < 90%

Context

The Out of Home Care model pathway, the agreed state-wide framework for providing timely and coordinated health services for children and young people in OOHC, states that all children and young people entering the pathway should receive a primary health assessment (2a). This is consistent with the "National Clinical Assessment Framework for children and young people in Out of Home Care".

Related Policies/ Programs

NSW Health Out of Home Care Health Pathway Program

Useable data available from

Office of Kids and Families Data Warehouse

Frequency of Reporting

Quarterly

Time lag to available data

8 weeks

Business owners

Health and Social Policy Branch
Contact - Policy
Manager Child and Family Health Unit, Health and Social Policy Branch
Contact - Data
Manager Child and Family Health Unit, Health and Social Policy Branch

Representation

Data type
Numeric
Form
Number presented as percentage (%)
Representational layout
NNN.N
Minimum size
2
Maximum size
4
Data domain
N/A
Date effective
July 2010

Related National Indicators

Indicator: N/A
<table>
<thead>
<tr>
<th>INDICATOR: KF-009</th>
<th><strong>Sexual Assault Services Initial Assessments</strong> – Referrals for victims of sexual assault receiving an initial psychosocial assessment (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Previous ID:</strong></td>
<td>Sexual Assault Services Initial Assessments</td>
</tr>
<tr>
<td><strong>Shortened Name</strong></td>
<td>Sexual Assault Services Initial Assessments</td>
</tr>
<tr>
<td><strong>Service Agreement Type</strong></td>
<td>Key Performance Indicator</td>
</tr>
<tr>
<td><strong>Framework Strategy</strong></td>
<td>Strategy 3: Integrate Systems to Deliver Truly Connected Care</td>
</tr>
<tr>
<td><strong>Framework Objective</strong></td>
<td>3.6 (Support vulnerable people)</td>
</tr>
<tr>
<td><strong>Status</strong></td>
<td>Final</td>
</tr>
<tr>
<td><strong>Version number</strong></td>
<td>1.21</td>
</tr>
<tr>
<td><strong>Scope</strong></td>
<td>All sexual assault victims referred to NSW Health Sexual Assault Services.</td>
</tr>
<tr>
<td><strong>Goal</strong></td>
<td>Ensure that NSW Health Sexual Assault Services provide an initial psychosocial assessment to high priority referrals.</td>
</tr>
<tr>
<td><strong>Desired outcome</strong></td>
<td>Victims of sexual assault are provided an initial psychosocial assessment including current safety and support needs.</td>
</tr>
<tr>
<td><strong>Primary point of collection</strong></td>
<td>NSW Health Sexual Assault Services</td>
</tr>
<tr>
<td><strong>Data Collection Source/System</strong></td>
<td>NSW Health Sexual Assault Services/JIRT Senior Health Clinicians Data Collection</td>
</tr>
<tr>
<td><strong>Primary data source for analysis</strong></td>
<td>Kids and Families Data Warehouse</td>
</tr>
<tr>
<td><strong>Indicator definition</strong></td>
<td>Percentage of new referrals for victims of sexual assault to Sexual Assault Services who receive an initial psychosocial assessment. An initial psychosocial assessment can be provided in-person or by telephone to assess victim's current circumstance, including safety.</td>
</tr>
<tr>
<td><strong>Numerator</strong></td>
<td>Number of referrals for victims of sexual assault received at Sexual Assault Services who receive an initial psychosocial assessment.</td>
</tr>
<tr>
<td><strong>Numerator definition</strong></td>
<td>Number of referrals for victims of sexual assault received at Sexual Assault Services who receive an initial psychosocial assessment.</td>
</tr>
<tr>
<td><strong>Numerator source</strong></td>
<td>Kids and Families Data Warehouse</td>
</tr>
<tr>
<td><strong>Numerator availability</strong></td>
<td>Monthly</td>
</tr>
<tr>
<td><strong>Denominator</strong></td>
<td>Number of referrals for victims of sexual assault received at Sexual Assault Services.</td>
</tr>
<tr>
<td><strong>Denominator definition</strong></td>
<td>Number of referrals for victims of sexual assault received at Sexual Assault Services.</td>
</tr>
<tr>
<td><strong>Denominator source</strong></td>
<td>Kids and Families Data Warehouse</td>
</tr>
<tr>
<td><strong>Denominator availability</strong></td>
<td>Monthly</td>
</tr>
<tr>
<td><strong>Inclusions</strong></td>
<td>Client types: Sexual assault victims</td>
</tr>
<tr>
<td><strong>Exclusions</strong></td>
<td>Client types: Non-offending family member/partner; Other</td>
</tr>
</tbody>
</table>
Strategy 3 KPIs: Integrate Systems to Deliver Truly Connected Care

Targets

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>80%</td>
<td></td>
</tr>
<tr>
<td>Performing: &gt;= 80%</td>
<td></td>
</tr>
<tr>
<td>Under Performing: &gt;= 70% and &lt; 80%</td>
<td></td>
</tr>
<tr>
<td>Not Performing: &lt; 70%</td>
<td></td>
</tr>
</tbody>
</table>

Context

NSW Health’s 55 Sexual Assault Services offer holistic specialist assistance to adult and child victims of sexual assault including supporting their psycho-social, emotional and cultural wellbeing. Free information, counselling, court support, medical treatment and forensic examinations are available for anyone who has recently been sexually assaulted in NSW. A 100% target is not feasible as some clients may decline the assessment, are unable to participate, or are unable to be contacted.

Related Policies/ Programs

Sexual Assault Services Policy and Procedure Manual (Adult) - PD2005_607

Useable data available from

July 2017

Frequency of Reporting

Monthly

Time lag to available data

2 weeks

Business owners

Government Relations Branch

Contact - Policy
Director, Prevention and Response to Violence, Abuse and Neglect Unit

Contact - Data
Senior Analyst, Data Management (PARVAN)

Representation

Data type
Numeric

Form
Number, presented as a percentage (%)

Representational layout
NN.N

Minimum size
3

Maximum size
5

Data domain
N/A

Date effective
July 2017

Related National Indicators

Indicator: N/A
<table>
<thead>
<tr>
<th>INDICATOR:</th>
<th>KF-0061, KF-0062</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous IDs:</td>
<td>KF-006A, KF-006B</td>
</tr>
<tr>
<td><strong>Sustaining NSW Families Programs:</strong></td>
<td></td>
</tr>
<tr>
<td>Shortened Title(s):</td>
<td>Sustaining NSW Families Programs (Completed) Sustaining NSW Families Programs (Enrolled)</td>
</tr>
<tr>
<td>Service Agreement Type:</td>
<td>Improvement Measure</td>
</tr>
<tr>
<td>Framework Strategy:</td>
<td>Strategy 3: Integrate Systems to Deliver Truly Connected Care</td>
</tr>
<tr>
<td>Framework Objective:</td>
<td>3.6 (Support vulnerable people)</td>
</tr>
<tr>
<td>Status:</td>
<td>Final</td>
</tr>
<tr>
<td>Version number:</td>
<td>1.1</td>
</tr>
<tr>
<td>Scope:</td>
<td>Families enrolled in the Sustaining NSW Families Program</td>
</tr>
<tr>
<td>Goal:</td>
<td>Families complete the full course of structured home visits</td>
</tr>
<tr>
<td>Desired outcome:</td>
<td>Children have better health and development outcomes. Parents have improved parenting capacity.</td>
</tr>
<tr>
<td>Primary point of collection:</td>
<td>Funded Sustaining NSW Families services</td>
</tr>
<tr>
<td>Data Collection Source/System:</td>
<td>Excel spreadsheet</td>
</tr>
<tr>
<td>Primary data source for analysis:</td>
<td>Excel spreadsheet</td>
</tr>
<tr>
<td>Indicator definition:</td>
<td><strong>KF-0061</strong>: The proportion of families enrolled in the program from 2016/17 that completed the program when their child reached two years of age in the reporting period. <strong>KF-0062</strong>: The proportion of families enrolled in the program from 2016/17 in the reporting period, and who will be continuing into the 2019/20 reporting year.</td>
</tr>
<tr>
<td><strong>Numerator</strong></td>
<td></td>
</tr>
<tr>
<td>Numerator definition:</td>
<td><strong>KF-0061</strong>: The number of families enrolled in the program from 2016/17 that completed the program when their child reached two years of age in the reporting period. <strong>KF-0062</strong>: The number of families enrolled in the program from 2016/17 in the reporting period, and who will be continuing into the 2019/20 reporting year.</td>
</tr>
<tr>
<td>Numerator source:</td>
<td>Excel spreadsheet (point of service provision)</td>
</tr>
<tr>
<td>Numerator availability:</td>
<td>Monthly</td>
</tr>
<tr>
<td><strong>Denominator</strong></td>
<td></td>
</tr>
<tr>
<td>Denominator definition:</td>
<td><strong>KF-0061 and KF-0062</strong>: The number of families enrolled in the program from 2016/17 in the reporting period.</td>
</tr>
<tr>
<td>Denominator source:</td>
<td>Excel spreadsheet (point of service provision)</td>
</tr>
</tbody>
</table>
Denominator availability

Monthly

**Inclusions**
Families enrolled in the program (who have been referred and assessed against program criteria)

**Exclusions**
Families not eligible according to criteria, or eligible but declining an offer of a place.

**Targets**

**KF-0061:** At least 50% of families who enrolled in the program in 16/17 completed the program (ie remained in the program until the child turned two years of age).

- Performing: >=50%
- Under Performing: >=45% and <50%
- Not Performing: <45%

NOTE: Indicator KF-006A applies to: CCLHD; HNELHD; NNSWLHD; SESLHD; SWSLHD (Site 1, Fairfield/Liverpool only)

**KF-0062:** At least 65% of families enrolled by 30 Jun 2019.

- Performing: >=65%
- Under Performing: >=55% and <65%
- Not Performing: <55%

NOTE: Indicator KF-006B applies to: SLHD; WSLHD, SWSLHD (Site 2, Campbelltown only).

**Context**
Program dosage is linked to child and parent outcomes. This indicator is a function of enrolments into the program, and retention for the duration of the program. The benchmark of greater than 50per cent retention at child’s age of two years is in line with literature on sustained nurse home visiting programs.

Sustaining NSW Families provides intensive structured health home visiting to vulnerable families to support parent-child relationships and optimise child health, development and wellbeing.

**Related Policies/ Programs**
PD2010_017 Maternal and Child Health Primary Health Care Policy

**Useable data available from**
Over three years in established sites

**Frequency of Reporting**
Monthly

**Time lag to available data**
Two weeks

**Business owners**
Health and Social Policy Branch

**Contact - Policy**
Child and Family Health Team

**Contact - Data**
Child and Family Health Team

**Representation**
Data type: Numeric
<table>
<thead>
<tr>
<th>Form</th>
<th>Number, presented as a percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Representational layout</td>
<td>NNN.N</td>
</tr>
<tr>
<td>Minimum size</td>
<td>3</td>
</tr>
<tr>
<td>Maximum size</td>
<td>5</td>
</tr>
<tr>
<td>Data domain</td>
<td></td>
</tr>
<tr>
<td>Date effective</td>
<td>1 July 2015</td>
</tr>
</tbody>
</table>

**Related National Indicator**
## STRATEGY 4 KPIs: Develop and Support our People & Culture

<table>
<thead>
<tr>
<th>INDICATOR:</th>
<th>SPC110</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Previous IDs:</strong></td>
<td><strong>Staff Engagement: People Matter Survey Engagement Index - Variation from previous year (%)</strong></td>
</tr>
</tbody>
</table>

**Shortened Title**
Staff Engagement

**Service Agreement Type**
Key Performance Indicator

**Framework Strategy**
Strategy 4: Develop and Support our People and Culture

**Framework Objective**
4.1 (Achieve a ‘Fit for Purpose’ workforce)

**Status**
Final

**Version number**
2.3

**Scope**
All LHD staff who respond to the survey.

**Goal**
Improved response rates, and staff engagement

**Desired outcome**
To achieve a higher response rates and higher staff engagement index than achieved in the previous People Matter survey.

**Primary point of collection**
Staff completion and submission of survey

**Data Collection Source/System**
External survey provider: Public Service Commission

**Primary data source for analysis**
External survey provider: Public Service Commission

**Indicator definition**
Percentage variation in the Engagement index in the current survey against last year’s survey.

### Numerator

**Numerator definition**
Current % survey score formulated from questions in survey determined by external provider.

**Numerator source**
Survey data from external provider

**Numerator availability**
External provider.

### Denominator

**Denominator definition**
% survey score formulated from questions in survey determined by external provider for the previous survey.

**Denominator source**
Survey data from external provider

**Denominator availability**
External provider.

| **Inclusions** | All staff who complete the survey |
| **Exclusions** | Nil |

**Targets**
Target: >0% increase on previous year
Performing: Increase or no change from previous year
Under Performing: <5% decrease from previous year
Not Performing: >=5% decrease from previous year

Context

Related Policies/ Programs: NSW Health Workplace Culture Framework
Useable data available from: Expected to be available August 2017 from external provider
Frequency of Reporting: Annual-ongoing
Time lag to available data

Business owners: Workforce Planning and Development
  Contact - Policy: Director, Workforce Strategy & Culture
  Contact - Data: Michelle McNally (Workforce Planning and Development)

Representation
  Data type: Numeric
  Form: Percentage
  Representational layout: NNN
  Minimum size: 1
  Maximum size: 3
  Data domain: External provider
  Date effective: 2011

Related National Indicator: N/A
**INDICATOR:** KPC201

**Staff Performance Reviews - Within the last 12 months (%)**

- The percentage of total eligible staff with performance reviews completed within the last 12 months.

**Previous IDs:**
- Staff Performance Reviews
  - Within the last 12 months (%)

**Shortened Title**
- Staff Performance Reviews

**Service Agreement Type**
- Key Performance Indicator

**Framework Strategy**
- Strategy 4: Develop and Support our People and Culture

**Framework Objective**
- 4.1 (Achieve a ‘Fit for Purpose’ workforce)

**Status**
- Final

**Version number**
- 1.4

**Scope**
- Achievement of Public Service Commission mandatory requirements for performance reviews.

**Goal**
- To ensure eligible staff have a formal performance review, at least once a year.

**Desired outcome**
- To ensure all eligible staff receive formal feedback on their performance, have a clear understanding of their individual performance objectives, and understand the capabilities they are required to demonstrate in their role.

**Primary point of collection**

**Data Collection Source/System**
- Stafflink/other

**Primary data source for analysis**
- All Health cluster agencies

**Indicator definition**
- The number of eligible staff who have had a performance review, within the last 12 months, as a percentage of the total eligible staff.

**Numerator**

<table>
<thead>
<tr>
<th>Numerator definition</th>
<th>Total number of eligible staff who have had a performance review within the last 12 months.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator source</td>
<td>StaffLink/other</td>
</tr>
<tr>
<td>Numerator availability</td>
<td>Available</td>
</tr>
</tbody>
</table>

**Denominator**

<table>
<thead>
<tr>
<th>Denominator definition</th>
<th>Total number of eligible staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator source</td>
<td>StaffLink/other</td>
</tr>
<tr>
<td>Denominator availability</td>
<td>Available</td>
</tr>
</tbody>
</table>

**Inclusions**

- All permanent and temporary staff (fixed term contracts)
- SES/HES
- Staff on secondment (to and from the agency). The seconded staff members home agency should report the staff member if it pays 51% or more of their employment-related costs. The receiving agency should report the staff member if it pays 51% or more.
2018-19 Service Performance Agreements
Strategy 4 KPIs: Develop and Support our People & Culture

- Apprentices, trainees and cadets
- Staff specialists
- Staff on leave (paid or unpaid), excluding extended periods of leave such as maternity leave or long service leave if that would preclude a performance review taking place.

**Exclusions**

The following are excluded from the definition of eligible staff:
- Visiting Practitioners and other contractors and consultants
- Casual/sessional and seasonal staff
- Contingent labour
- Volunteers
- Students/work experience
- Staff separated from the agency prior to the reference period even if they received a payment during the reference period
- Staff absent from the workplace in the 6 months before the consensus date

**Targets**

Target: 100% of eligible staff have a formal performance review at least annually.

Not performing: <85%

Under performing: >=85% and <90%

Performing: >=90%

**Context**

**Related Policies/ Programs**


**Useable data available from**

StaffLink/other

**Frequency of Reporting**

Quarterly

**Time lag to available data**

As a minimum it must be available by the end of each quarter.

**Business owners**

Workplace Relations Branch

Contact - Policy: Jutta Sund, Senior Workplace Relations Advisor, Workplace Relations Branch

Contact - Data: Director, Workforce Planning and Performance Unit, Workforce Planning and Development Branch

**Representation**

- Data type: Numeric
- Form: Percentage
- Representational layout: NNN.NN
- Minimum size: 3
- Maximum size: 6
<p>| Data domain | A unique count of the date field related to performance review that has been undertaken by eligible staff in the proceeding 12 month period. This would be sourced from the source Human Resource Information System (StaffLink or other) and reported through State Management Reporting Tool (SMRT). |
| Date effective | 01/07/2014 |
| Related National Indicator | Nil |</p>
<table>
<thead>
<tr>
<th>Shortened Title</th>
<th>Aboriginal Workforce Participation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Agreement Type</td>
<td>Key Performance Indicator</td>
</tr>
<tr>
<td>Framework Strategy</td>
<td>Strategy 4: Develop and Support our People and Culture</td>
</tr>
<tr>
<td>Framework Objective</td>
<td>4.3 (Strengthen the culture within Health to reflect CORE values)</td>
</tr>
<tr>
<td>Status</td>
<td>Final</td>
</tr>
<tr>
<td>Version number</td>
<td>1.5</td>
</tr>
<tr>
<td>Scope</td>
<td>Staff employed within NSW Health Workforce</td>
</tr>
</tbody>
</table>
| Goals                   | • Identify opportunities to recruit Aboriginal people across the breadth and depth of the health service through the strategic use of Identified and Targeted recruitment practices  
• Develop strategies for capacity building to support career opportunities for Aboriginal people across the breadth and depth of the health service  
• Increase the retention of Aboriginal people in the health service through:  
  • Maximising the number of NSW Health staff who have completed both components of the Respecting the Difference training  
  • Ensure that the Aboriginal workforce has access to ongoing professional development opportunities through education and training and that clear career pathways are established for Aboriginal staff  
  • Providing traineeships, cadetships and scholarships for Aboriginal people to work within health services  
  • Increasing the response rates to EEO questions across the health service. |
| Desired outcome         | Increase the number of skilled, competent and qualified Aboriginal staff in the NSW Health workforce and create a working environment that respects Aboriginal heritage and cultural values. |
| Primary point of collection | StaffLink                        |
| Data Collection Source/System | Public Service Commission Workforce Profile via the State Management Reporting Service (SMRS) |
| Primary data source for analysis | Public Service Commission Workforce Profile via the State Management Reporting Service (SMRS) |
| Indicator definition    | The percentage of Aboriginal staff employed in health workforce (i) within all salary bands and (ii) within all occupations  
The June 2017 salary bands are as follows:  
• 0 – 45,800  
• 45,801 – 60,154 |
2018-19 Service Performance Agreements
Strategy 4 KPIs: Develop and Support our People & Culture

- 60,155 – 67,248
- 67,249 – 85,098
- 85,099 – 110,046
- 110,047 – 137,557
- 137,558 – 153,915
- >=153,916

Occupations categories are as specified via Treasury Groupings:
- Medical
- Nursing
- Allied Health Professionals
- Other Prof & Para Professionals & Clinical Support Staff
- Scientific & Technical Clinical Support Staff
- Oral Health Practitioners & Support Workers
- Ambulance Staff
- Clinical Support and Corporate Services
- Hotel Services
- Maintenance & Trades
- Other

Note that Aboriginal people include people who identify as Aboriginal and/or Torres Strait Islander.

**Numerator**

Numerator definition: Total number of staff employed that indicate they are Aboriginal staff.
Numerator source: Public Service Commission Workforce Profile via the State Management Reporting Service (SMRS)
Numerator availability: Annual

**Denominator**

Denominator definition: Total number of eligible staff employed in health workforce
Denominator source: Public Service Commission Workforce Profile via the State Management Reporting Service (SMRS)
Denominator availability: Quarterly/Annual

**Inclusions**

This information shows the number of employed staff who responded to the EEO questions, in relation to the question on Aboriginal staff with either "yes" or "no" response. A percentage of staff employed does not respond to this section of the EEO form.

**Exclusion**

Department of Premiers and Cabinet applies a weighting to the base staff employed figures to derive an estimate of the representation of the number of Staff employed that are Aboriginal to account for non-respondents.

**Reporting**

Reporting required by: NSW Ministry of Health
2018-19 Service Performance Agreements
Strategy 4 KPIs: Develop and Support our People & Culture

Indicators reported to

Next report due Annual

**Targets**

Target 1.8% representation of Aboriginal staff across all salary levels (bands) and occupational groups in the NSW Health workforce by 2021

Performing: Increase on previous year

Under Performing: Nil increase on previous year

Not Performing: Overall decrease from previous year

Time frame for target

Lower /upper age limit N/A

Sex N/A

Geographical area of interest Whole State//Local Health District/ Pillars / Networks / Specialty Services

Comments

**Context**

- PD2016_053 Good Health – Great Jobs Aboriginal Workforce Strategic Framework 2016 - 2020
- PD2011_069 Respecting the Difference An Aboriginal Cultural Training Framework for NSW Health
- NSW Aboriginal Health Plan 2013-2023
- National Partnership Agreement on Indigenous Economic Participation (COAG agreement)
- National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework (2016–2023)
- The Government Sector Employment Rule 26, Employment of eligible persons

**Related Policies/ Programs**

PD2016_053 / PD2011_069
Stepping Up online recruitment resource

**Useable data available from**

Public Service Commission Workforce Profile via the State Management Reporting Service (SMRS)

**Frequency of Reporting**

Annually

**Time lag to available data**

3 months from end of quarter

**Business owners**

Workforce Planning and Development Branch

**Contact - Policy**

Executive Director, Workforce Planning and Development Branch

**Contact - Data**

Director, Workforce Planning and Performance Unit, Workforce Planning and Development Branch
<table>
<thead>
<tr>
<th>Representation</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Data type</td>
<td>Numeric</td>
</tr>
<tr>
<td>Form</td>
<td>percentage</td>
</tr>
<tr>
<td>Representational layout</td>
<td>NNN.NN</td>
</tr>
<tr>
<td>Minimum size</td>
<td>3</td>
</tr>
<tr>
<td>Maximum size</td>
<td>6</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Documentation of indicator</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Source</td>
<td>Public Service Commission Workforce Profile via the State Management Reporting Service (SMRS)</td>
</tr>
<tr>
<td>Source identification</td>
<td></td>
</tr>
<tr>
<td>Publisher</td>
<td></td>
</tr>
<tr>
<td>Planned review date</td>
<td>Annual</td>
</tr>
<tr>
<td>Date effective</td>
<td>30/06/2017</td>
</tr>
</tbody>
</table>
INDICATOR: KS4401

**Compensable Workplace Injury - Claims (Number)**

- Reduction in the number of compensable injury claims.

Previous ID:

**Shortened Title**

Compensable Workplace Injury Claims

**Service Agreement Type**

Key Performance Indicator

**Framework Strategy**

Strategy 4: Develop and Support our People and Culture

**Framework Objective**

4.5 (Improve health, safety and wellbeing at work)

**Status**

Final

**Version number**

1.1

**Scope**

All NSW Health employees including emergency and non-emergency employees

**Goal**

To measure the success of proactive programs aimed at increasing personal safety awareness and reducing injuries in the workplace for NSW Health employees.

**Desired outcome**

An indicative improvement in the actual number of compensable injuries suffered and reported.

**Primary point of collection**

iCare self insurance Treasury Managed Fund data warehouse

**Data Collection Source/System**

iCare self insurance Treasury Managed Fund data warehouse

**Primary data source for analysis**

iCare self insurance Treasury Managed Fund data warehouse

**Indicator definition**

Number of NSW Health employees who have lodged a claim as a result of a workplace injury by the end of the current financial year compared to the previous financial year.

**Numerator**

Numerator definition

The number of claims reported year to date compared to the number of claims reported for the previous year to date.

Numerator source

iCare self insurance Treasury Managed Fund data warehouse

Numerator availability

Not currently available

**Denominator**

Denominator definition

N/A

Denominator source

Denominator availability

**Inclusions**

The number of compensable claims reported each month.

**Exclusions**

Claims reported excludes null claims
Strategy 4 KPIs: Develop and Support our People & Culture

Targets

<table>
<thead>
<tr>
<th>Target</th>
<th>10% decrease</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Performing: &gt;=10% decrease</td>
</tr>
<tr>
<td></td>
<td>• Under performing: &gt;=0% and &lt;10% decrease</td>
</tr>
<tr>
<td></td>
<td>• Not performing: increase</td>
</tr>
</tbody>
</table>

Comments

Context
To monitor whether overall levels of active claims are changing over time.

Related Policies/Programs
Injury Management and Return To Work Policy PD2013_006

Useable data available from
Baseline data for the 2016/17 financial year by month, quarter and annual.

Frequency of Reporting
Monthly, Quarterly and Annual.

Time lag to available data
Reporting available 1 week after the conclusion of the month.

Business owners

<table>
<thead>
<tr>
<th>Contact - Policy</th>
<th>Executive Director, Workplace Relations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact - Data</td>
<td>Manager Insurance &amp; Risk, Finance Division</td>
</tr>
</tbody>
</table>

Representation

<table>
<thead>
<tr>
<th>Data type</th>
<th>Numeric</th>
</tr>
</thead>
<tbody>
<tr>
<td>Form</td>
<td>Number</td>
</tr>
<tr>
<td>Representational layout</td>
<td>NNN,NNN</td>
</tr>
<tr>
<td>Minimum size</td>
<td>3</td>
</tr>
<tr>
<td>Maximum size</td>
<td>6</td>
</tr>
<tr>
<td>Date Effective</td>
<td>1 July 2016</td>
</tr>
</tbody>
</table>

Related National Indicator
STRATEGY 5 KPIs: Support and Harness Health & Medical Research and Innovation

INDICATOR: KS5303
Previous ID: KS5301

Ethics Application Approvals - By the Human Research Ethics Committee within 45 calendar days - Involving more than low risk to participants (%)

Shortened Title
Ethics Application Approvals

Service Agreement Type
Key Performance Indicator

Framework Strategy
Strategy 5: Support and Harness Health & Medical Research and Innovation

Framework Objective
5.4 (Enable the research environment)

Status
Final

Version number
1.1

Scope

Goal
To assess the efficiency of the HREC's processes and to drive process improvement.

Desired outcome

Primary point of collection

Data Collection Source/System
AU RED; then REGIS when implemented

Primary data source for analysis
AU RED; then REGIS when implemented

Indicator definition
The proportion of applications (excluding LNR) approved by the reviewing HREC within 45 calendar days from the meeting submission closing date, with a final written notification date (final clock stop date) within the reporting period.

Numerator

Numerator definition
Total number of applications (excluding LNR) approved by the reviewing HREC within 45 calendar days from the meeting submission closing date, with a final written notification date (final clock stop date) within the reporting period.

Numerator source
AU RED; then REGIS when implemented

Numerator availability

Denominator

Denominator definition
Total number of applications (excluding LNR) approved by the reviewing HREC with a final written notification date (final clock stop date) within the reporting period.

Denominator source
AU RED; then REGIS when implemented mid-year.

Denominator availability

Inclusions
- Application Type = Single Site or Multi Site
- LNR = NoCurrent Decision = Approved and Approved with Further information response approved
2018-19 Service Performance Agreements
Strategy 5 KPIs: Support and Harness Health & Medical Research and Innovation

Exclusions
- Application Type = Site Specific Assessment
- LNR = Yes
- Current Decision = Not approved; Invalid application; not requiring review by HREC; further information/ modification requested; no opinion pending consultation with referee; invalid application

Targets
95%
Performing: >= 95%
Under Performing: >= 75% and < 95%
Not Performing: < 75%

Context
The measure will account for clock stops in accordance with the NHMRC Certification Handbook. Where a valid application is received, the clock starts on the submission closing date for the HREC meeting at which an application will be reviewed. The clock stops when a request for further information or clarification is requested from the applicant. The clock recommences when the requested information or clarification has been received. The clock is finally stopped when the HREC formally notifies the applicant of the final decision.

Related Policies/ Programs

Useable data available from

Frequency of Reporting
Annually

Time lag to available data

Business owners
Office for Health and Medical Research
Contact - Policy
Executive Director, Office for Health and Medical Research
Contact - Data
Executive Director, Office for Health and Medical Research

Representation
Data type
Numeric
Form
Number, presented as a percentage (%)
Representational layout
NNN.N
Minimum size
3
Maximum size
5
Data domain
N/A
Date effective

Related National Indicators
Indicator
Source
<table>
<thead>
<tr>
<th>INDICATOR: KS5304</th>
<th>Research Governance Application Authorisations – Site specific Within 15 calendar days - Involving more than low risk to participants (%)</th>
</tr>
</thead>
</table>

**Shortened Title**

Research Governance Application Authorisations

**Service Agreement Type**

Key Performance Indicator

**Framework Strategy**

Strategy 5: Support and Harness Health & Medical Research and Innovation

**Framework Objective**

5.4 (Enable the research environment)

**Status**

Final

**Version number**

1.0

**Scope**

**Goal**

To assess the efficiency of the site authorisation process and to drive process improvement.

**Desired outcome**

**Primary point of collection**

**Data Collection Source/System**

AU RED; then REGIS when implemented

**Primary data source for analysis**

AU RED; then REGIS when implemented

**Indicator definition**

The proportion of site specific assessment (SSA) applications (excluding LNR) authorised by the RGO within 15 calendar days, authorised within the reporting period.

**Numerator**

**Numerator definition**

Total number of SSA applications (excluding LNR) authorised by the RGO within 15 calendar days, authorised (final SSA decision letter provided) within the reporting period.

**Numerator source**

AU RED; then REGIS when implemented

**Numerator availability**

**Denominator**

**Denominator definition**

Total number of SSA applications (excluding LNR) authorised (final SSA decision letter provided) by the RGO within the reporting period.

**Denominator source**

AU RED; then REGIS when implemented

**Denominator availability**

**Inclusions**

- Application Type = Site Specific Assessment
- LNR = No
- Current Decision = Authorised; authorised with conditions; further information response authorised

**Exclusions**

- Application Type = Single Site or Multi Site
- LNR = Yes
- Current Decision = Invalid application; not authorised; Request for further
2018-19 Service Performance Agreements
Strategy 5 KPIs: Support and Harness Health & Medical Research and Innovation

information/ modification; not requiring review by Research Organisation; further information response not authorised; further information response not complete.

**Targets**

95%

Performing: >= 95%

Under Performing: >= 75% and < 95%

Not Performing: < 75%

**Context**

The Improvement Measure will account for clock stops. The SSA application received date is the date the RGO or designee receives an SSA application from a researcher regardless of whether or not it is complete and/or deemed valid. The interim clock stop dates represent when a request for further information or clarification is requested from the applicant. The clock recommences (interim clock start dates) when the requested information or clarification has been received. The clock is finally stopped when the final SSA decision letter is provided to the site principal investigator.

**Related Policies/ Programs**


**Useable data available from**

**Frequency of Reporting**

Annually

**Time lag to available data**

**Business owners**

Office for Health and Medical Research

- Contact - Policy
  - Executive Director, Office for Health and Medical Research

- Contact - Data
  - Executive Director, Office for Health and Medical Research

**Representation**

- Data type: Numeric
- Form: Number, presented as a percentage (%)
- Representational layout: NNN.N
- Minimum size: 3
- Maximum size: 5
- Data domain: N/A
- Date effective: 

**Related National Indicators**

- Indicator:
Source
## STRATEGY 7 KPIs: Deliver Infrastructure & System Capability

<table>
<thead>
<tr>
<th>INDICATOR:</th>
<th>KS7301</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Capital Variation:</strong> Against Approved Budget: (%)</td>
<td></td>
</tr>
</tbody>
</table>

| Previous IDs: | Capital Variation Against Budget |

<table>
<thead>
<tr>
<th>Shortened Title</th>
<th>Capital Variation Against Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Service Agreement Type:</strong></td>
<td>Key Performance Indicator</td>
</tr>
<tr>
<td><strong>Framework Strategy:</strong></td>
<td>Strategy 7: Deliver Infrastructure &amp; System Capability</td>
</tr>
<tr>
<td><strong>Framework Objective:</strong></td>
<td>7.1 (Deliver agreed infrastructure on time and budget)</td>
</tr>
</tbody>
</table>

| **Scope:** | Financial management and monitoring of capital projects |
| **Goal:** | Health Entities operate within approved capital budget allocation |
| **Desired outcome:** | Health Entities achieve an on budget result or the variation is within acceptable limit. |

| **Primary point of collection:** | Health Entities |
| **Data Collection Source/System:** | Oracle Accounting System for Actuals / BTS for Budget |
| **Primary data source for analysis:** | SMRS for Actuals and Budget. |
| **Indicator definition:** | Year to date – YTD Actual capital expenditure compared to YTD Budget capital expenditure. |

### Numerator

<table>
<thead>
<tr>
<th>Numerator definition</th>
<th>YTD Actual = July to end current month actual capital expenditure.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator source</td>
<td>SMRS</td>
</tr>
<tr>
<td>Numerator availability</td>
<td>Available</td>
</tr>
</tbody>
</table>

### Denominator

<table>
<thead>
<tr>
<th>Denominator definition</th>
<th>YTD Budget = July to end current month phased budget capital expenditure.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator source</td>
<td>SMRS</td>
</tr>
<tr>
<td>Denominator availability</td>
<td>Available</td>
</tr>
</tbody>
</table>
Strategy 7 KPIs: Deliver Infrastructure & System Capability

Inclusions

Exclusions

Targets

Target

Target: < 10% above or below budget.

Not performing: > 10.0% above or below budget.

Context

Health Entities are expected to operate within the capital budget.

Related Policies/ Programs

Service Level Agreement

Useable data available from

Available on monthly basis

Frequency of Reporting

Monthly

Time lag to available data

Available 3 working days after Financial Management Information System (FMIS) close

Business owners

MOH Finance Branch

Contact - Policy

Finance (Harshal Naik - 9391 9745)

Contact - Data

Contact for data inquiries: Treasury and Capital Reporting Team.

Email: capitalreporting@doh.health.nsw.gov.au

Representation

Data type

Numeric

Form

Number, presented as a percentage (%)

Representational layout

NNN.NN

Minimum size

3

Maximum size

6

Data domain

NA

Date effective

July 2017

Related National Indicator

NA

Indicator sets and related indicators can be sourced from:

http://meteor.aihw.gov.au/content/index.phtml/itemId/401254
**2018-19 Service Performance Agreements**  
**Strategy 7 KPIs: Deliver Infrastructure & System Capability**

**INDICATOR:**  DSR_7401

**Previous IDs:**  
Asset Maintenance Expenditure – as a proportion of asset replacement value (%)

**Shortened Title**  
Asset Maintenance Expenditure

**Service Agreement Type**  
Key Performance Indicator

**Framework Strategy**  
Strategy 7: Deliver Infrastructure & System Capability

**Framework Objective**  
7.3 (Build asset management capability)

**Status**  
Final

**Version number**  
1.1

**Scope**  
Maintenance expense includes all costs incurred in planning, supervising, managing or executing works involved in or related to maintaining capitalised assets owned or controlled by Public Health Organisations and extends to maintenance for buildings, plant and equipment (including medical equipment) recognized on the balance sheet.

**Goal**  
To minimise asset maintenance related risks and obtain expected economic benefits of assets.

**Desired outcome**  
Better management of required maintenance levels to ensure compliant, safe, and fit for purpose assets.

**Primary point of collection**  
General ledger, maintenance expense and gross carrying amounts.

**Data Collection Source/System**  
Maintenance Expense:
- Maintenance contracts
- Repairs & Maintenance / Non Contract
- Other Maintenance expenses
- Maintenance Expense – Contracted Labour and Other (Non-Employee Related)
- Employee Related Expense
- EXCLUDING: New and Replacement Equipment under $10,000

Asset Replacement Value (ARV) through Asset Gross Carrying amounts for:
- Buildings (excluding Works In Progress)
- Plant & Equipment (excluding Works In Progress)

**Primary data source for analysis**  
Oracle Stafflink

**Indicator definition**  
The amount of money spent within a Financial Year maintaining assets, divided by the Asset Replacement Value (ARV) of the assets being maintained, expressed as a percentage

\[
\text{Maintenance Expense ($)} \div \text{Asset Replacement Value ($)} \times 100\%
\]

*or in other words*

Maintenance Expense ($) as a percentage (%) of Asset Replacement Value ($)

---

Page 169
or in mathematical terms

Maintenance Expense per Asset Replacement Value (%) = Total Maintenance Expense ($) x 100 / Total Asset Replacement Value ($) (\$)

**Numerator**

**Numerator definition**
Total maintenance expense (excluding new and replacement equipment under $10,000) across PHOs per quarter (quarter of Financial Year) for building and plant and equipment assets (including medical equipment) that is recognised on the balance sheet

**Numerator source**
Maintenance Expense accounts

**Numerator availability**
Available monthly, reported quarterly

**Denominator**

**Denominator definition**
Total value of building and plant and equipment assets (including medical equipment) recognised on the balance sheet across PHOs.

**Denominator source**
The PPE Reconciliation Note in the Financial Statements

**Denominator availability**
Available monthly, reported quarterly

**Inclusions**

Included PHOs:
- All Local Health Districts
- HealthShare
- Ambulance Service of NSW
- Sydney Children’s Hospital Network
- NSW Pathology
- Plus: ‘Total of included entities’

Capitalised building and plant and equipment assets (including medical equipment) recognised on balance sheet.

Maintenance expenses include labour and materials for maintenance works.

**Exclusions**

Excluded from calculations of ARV:
- Work In Progress
- New and replacement equipment under $10,000

Excluded from calculations of Maintenance Expense
- Major inspection costs of capitalized assets where costs are recognised in the carrying amount of the asset
- Maintenance costs for non-capitalised assets.

**Targets**

Target
>=10% increase from last financial year
Strategy 7 KPIs: Deliver Infrastructure & System Capability

- Not Performing: <5% increase from last financial year
- Under Performing: >=5% and <10% increase from last financial year
- Performing: >=10% increase from last financial year

**Context**

The indicator allows comparisons of the expenditures for maintenance between Public Health Organisations, as well as to performance in last Financial Year’s quarter.

The ARV is used in the denominator to normalise the measurement given that asset portfolios vary in size and value.

This indicator will also be used as a Whole-of-Government indicator under Treasury’s Financial Management Transformation (FMT) program as well as an indicator under Property NSW’s Property Asset Utilisation Taskforce (PAUT) Phase II reforms.

**Related Policies/ Programs**

- Health Asset Management reform program
- Financial Management Transformation (FMT) program
- Property Asset Utilisation Taskforce (PAUT) Phase II reforms

**Useable data available from**

FY 2016-17 (and several years retrospective if required)

**Frequency of Reporting**

Quarterly year to date

**Time lag to available data**

Upon availability of end of quarter financial data

**Business owners**

MOH Financial Services and Asset Management Division

Contact - Policy

Jan Schmidt, Director Asset Management, Financial Services and Asset Management Division

Contact - Data

Chris Schneider, Director, Financial Accounting, Financial Services and Asset Management Division

**Representation**

- Data type: Numeric
- Form: Number, presented as a percentage (%)
- Representational layout: N.NN
- Minimum size: 3
- Maximum size: 3
- Data domain
- Date effective: 30 June 2017

**Related National Indicator**

N/A
STRATEGY 8 KPIs: Build Financial Sustainability and Robust Governance

INDICATOR: AI-001

Purchased Activity Volumes – Variance: Acute Admitted – NWAU (%)

Previous IDs:

Shortened Title
Purchased Activity Variance: Acute Admitted

Service Agreement Type
Key Performance Indicator

Framework Strategy
Strategy 8: Build Financial Sustainability and Robust Governance

Framework Objective
8.1 (Secure a long term sustainable financial position)

Status
Final

Version number
1.4

Scope
Acute admitted episodes in 2018-19 ABF in-scope hospitals, excluding mental health services provided in designated units, Emergency Department only episodes.

Goal
Greater certainty concerning the amount of activity to be performed in a year.

Desired outcome
• To improve operating efficiency by enhancing the capacity to manage costs and monitor performance by creating an explicit relationship between funds allocated and services provided
• To achieve greater accountability for management of resources and performance

Primary point of collection
Patient Medical Record

Data Collection Source/System
Hospital PAS, Admitted Patient Data Collection, LHD Activity Targets

Primary data source for analysis
HIE

Indicator definition
Variation of year to date acute weighted activity (NWAU) from the year to date acute activity target.

Numerator

Numerator definition
Acute Episode Funding activity for the year to date NWAU separations with an [episode_end_date] within the financial year. Includes an estimate for the NWAU of uncoded activity, based on the average NWAU for that type of case at that hospital

Less

Acute Episode Funding activity target for the year to date in NWAU separations.

NWAU version is 2018-19 for DRG 9.0 (NWAU 18).

Numerator source
HIE

Numerator availability
Available 2 months after the end of the period of measurement.
### 2018-19 Service Performance Agreements
#### Strategy 8 KPIs: Build Financial Sustainability and Robust Governance

<table>
<thead>
<tr>
<th><strong>Denominator</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Denominator definition</strong></td>
<td>Acute Episode Funding activity target for the year to date in NWAU separations.</td>
</tr>
<tr>
<td><strong>Denominator source</strong></td>
<td>LHD Activity Targets</td>
</tr>
<tr>
<td><strong>Denominator availability</strong></td>
<td>Available when targets finalised</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Inclusions</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute episodes (care type 1 or 5)</td>
<td></td>
</tr>
<tr>
<td>Episode end date within the period</td>
<td></td>
</tr>
<tr>
<td>Facilities in scope of ABF in 2018-19</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Exclusions</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Episodes with any days in a designated psychiatric unit, i.e. ([\text{days_in_psych_unit}] &gt; 0) (for historical time series purposes only)</td>
<td></td>
</tr>
<tr>
<td>ED only episodes, i.e. ([\text{ed_status}] = 1) or ‘4’ (for historical time series purposes only)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Targets</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Target</strong></td>
<td>Target: Individual targets 1.0% above or below negotiated activity target.</td>
</tr>
<tr>
<td>Not performing: &gt;2.0% above or below negotiated activity target.</td>
<td></td>
</tr>
<tr>
<td>Under performing: Between 1.0% and 2.0% above or below negotiated activity target.</td>
<td></td>
</tr>
</tbody>
</table>

### Context

<table>
<thead>
<tr>
<th><strong>Related Policies/ Programs</strong></th>
<th>Activity Based Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Useable data available from</strong></td>
<td>2009/10</td>
</tr>
<tr>
<td><strong>Frequency of Reporting</strong></td>
<td>Quarterly</td>
</tr>
<tr>
<td><strong>Time lag to available data</strong></td>
<td>6 – 7 weeks</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Business owners</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Contact - Policy</strong></td>
<td>Executive Director, System Purchasing Branch</td>
</tr>
<tr>
<td><strong>Contact - Data</strong></td>
<td>Executive Director, System Information and Analytics Branch</td>
</tr>
</tbody>
</table>

### Representation

<table>
<thead>
<tr>
<th><strong>Data type</strong></th>
<th>Numeric</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Form</strong></td>
<td>Number, presented as a percentage (%)</td>
</tr>
<tr>
<td><strong>Representational layout</strong></td>
<td>NNN.N</td>
</tr>
<tr>
<td><strong>Minimum size</strong></td>
<td>3</td>
</tr>
<tr>
<td><strong>Maximum size</strong></td>
<td>4</td>
</tr>
<tr>
<td><strong>Data domain</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Date effective</strong></td>
<td>July 2009</td>
</tr>
<tr>
<td>Related National Indicator</td>
<td>National Efficient Price Determination 2018-19</td>
</tr>
<tr>
<td>---------------------------</td>
<td>---------------------------------------------</td>
</tr>
</tbody>
</table>
INDICATOR: ED-001

Purchased Activity Volumes – Variance:
Emergency Department - NWAU (%)

Previous ID:

Shortened Title
Purchased Activity Variance: ED

Service Agreement Type
Key Performance Indicator

Framework Strategy
Strategy 8: Build Financial Sustainability and Robust Governance

Framework Objective
8.1 (Secure a long term sustainable financial position)

Status
Final

Version number
1.4

Scope
All Emergency Department presentations in 2018-19 ABF in-scope hospitals.

Goal
Greater certainty concerning the amount of activity to be performed in a year.

Desired outcome

• To improve operating efficiency by enhancing the capacity to manage costs and monitor performance by creating an explicit relationship between funds allocated and services provided

• To achieve greater accountability for management of resources and performance

Primary point of collection
Emergency Department clerk

Data Collection Source/System
Emergency Department Data Collection - Emergency Department Information System (EDIS)/Cerner First Net/other electronic Emergency Department Information Systems & iPM ED (for all HNE LHDs).

Primary data source for analysis
HIE (Table ED_Visit), and summary ED data for those ABF in scope EDs with no patient level data provided to HIE.

Indicator definition
Variation of year to date ED service activity (NWAU) from the year to date activity target.

Numerator

Numerator definition
ED activity for the year to date NWAU presentations in EDs of ABF in-scope hospitals, with a [departure_date] within the financial year (adjusted with summary level data only EDs), less ED activity target for the year to date in NWAU presentations in ABF in-scope EDs.

NWAU version for 2018-19 is URG 1.4 or UDG 1.3

Numerator source
HIE

Numerator availability
Available

Denominator

Denominator definition
ED activity target for the year to date in NWAU presentations in 2018-19 ABF in-scope EDs.

Denominator source
HIE
### Denominator availability
Available

### Inclusions
All patients presenting to emergency department at ABF in scope facilities.

### Exclusions
- Mode of separation = 99 (registered in error)
- Type of visit = 12 (Telehealth Presentation) or 13 (Current Admitted Patient Presentation).

### Targets
- **Target**: Individual targets 1.0% above or below negotiated activity target.
- **Not performing**: >2.0% above or below negotiated activity target.
- **Under performing**: Between 1.0% and 2.0% above or below negotiated activity target.

### Related Policies/Programs
Activity Based Funding

### Useable data available from
July 1996

### Frequency of Reporting
Monthly

### Time lag to available data
Reporting required by the 10th day of each month, data available for previous month

### Business owners
- **Contact - Policy**: Executive Director, System Purchasing Branch
- **Contact - Data**: Executive Director, System Information and Analytics Branch

### Representation
- **Data type**: Numeric
- **Form**: Number, presented as a percentage (%)
- **Representational layout**: NNN.N
- **Minimum size**: 3
- **Maximum size**: 5
- **Date effective**: July 2013

### Related National Indicator
National Efficient Price Determination 2018-19
**INDICATOR: NA-001**

**Purchased Activity Volumes – Variance:** Non-admitted Patient - NWAU (%)

**Previous IDs:**

<table>
<thead>
<tr>
<th>Shortened Title</th>
<th>Purchased Activity Variance: Non-admitted</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Service Agreement Type</strong></td>
<td>Key Performance Indicator</td>
</tr>
<tr>
<td><strong>Framework Strategy</strong></td>
<td>Strategy 8: Build Financial Sustainability and Robust Governance</td>
</tr>
<tr>
<td><strong>Framework Objective</strong></td>
<td>8.1 (Secure a long term sustainable financial position)</td>
</tr>
</tbody>
</table>

**Status**
- Final

**Version number**
- 2.5

**Scope**

This scope of this indicator covers:

- NSW Health hospitals and community health services that are recognised as in scope of NSW Activity Based Funded in 2018-19, and
- Non-admitted patient service units of the above hospitals and community health services with NSW Establishment Types that are mapped to national Tier 2 Clinic Type Version 5.0 categories that are recognised as in scope of NSW Activity Based Funding in 2018-19.

Services outsourced by a Local Health District / Specialist Health Network under a fee for service or sessional service contract to an external organisation, individual professional health care provider or other Local Health District, that would have met the inclusion criteria had the service not been outsourced, are in-scope.

**Goal**

Provide greater certainty concerning the volume and complexity mix of non-admitted patient services provided to patients.

**Desired outcome**

- To improve operating efficiency by enhancing the capacity to manage costs and demand by creating an explicit relationship between volume and complexity mix of services provided and the funding allocation.
- To achieve greater transparency and accountability of resource management, service delivery and performance.

**Primary point of collection**

- Registration and classification of non-admitted patient service units
- Scheduling non-admitted patient appointments
- Recording non-admitted patient service attendances
- Notating service provision details in patient medical records

**Data Collection Source/System**

- NSW Non-admitted Patient Data Collection 2018-19
- HERO Organisation Service Provider Data Set
- LHD Activity Targets agreed for 2018-19

Non-admitted patient activity is recorded in a wide range of source systems, some of which address the needs specific clinical specialties.

The strategic source systems from which the majority of activity is expected are HNA Millennium / eMR (Cerner), IPM and CHIME.

HERO (Health Establishment Registration On-line system) is the source system used by LHDs / SHNs to register non-admitted patient service units, indicate their parent hospital / community health service and classify them by
Primary data source for analysis: EDWARD Non-admitted Patient Data Mart

Note: The data mart acquires its data from the following sources:
- EDWARD (activity)
- HERO (service unit details)
- MDS Master Data Services (NWAU weights)

Indicator definition: Percentage variation of year to date actual non-admitted patient national weighted activity (NWAU 2018-19) from the year to date target.

**Numerator**

- Numerator definition: Total Final Non-Admitted Patient National Weighted Activity Unit (NWAU 2018-19) for services delivered from 1 July 2018 to the year to date Minus Non-Admitted Patient National Weighted Activity Unit (NWAU 2018-19) Target for services delivered from 1 July 2018 to the year to date.

- Numerator source: HERO and EDWARD Non-admitted Patient Data Mart
- Numerator availability: Available 2 months after the end of the period of measurement.

**Denominator**

- Denominator definition: Non-Admitted Patient National Weighted Activity Unit (NWAU 2018-19) Target for services delivered from 1 July 2018 to the year to date.

- Denominator source: Service Volume for Non-admitted Patient Services in the LHD / SHN Performance Agreement for 2018-19
- Denominator availability: June 2015

**Inclusions**


There are, however, NSW Health scope variations to those outlined in the IHPA determination. Specific details of record inclusions criteria for this performance indicator and the national weighted activity unit allocation process are outlined in the "Non-admitted Patient Activity Post Load Reporting Compendium for 2018-19" published on the Ministry of Health Intranet at:


Non-admitted patient services included in this measure must meet all of the following criteria:

- The service must contain clinical / therapeutic content that warrants a clinical note being made in the patient’s medical record.
The service must be a direct service provided to the patient (i.e. the patient (or his/her proxy), participated in the service either via face to face attendance, telephone, Telehealth / video-conference or other technology that enables interactive participation).

• The patient must be a non-charge patient and principal funding source of the service must be the NSW State Health budget, or activity funded via a NSW Health bulk purchasing agreement with Department of Veterans’ Affairs, the NSW Motor Accident Authority, NSW Work Cover, or the Disability Support Scheme.

• The service unit that delivered the service must be registered in HERO and classified to an establishment type category that maps to a NSW ABF funded national Tier 2 Service Type (Version 5.0) for the 2018-19 Service Agreement.

• The service unit must have a parent hospital or community health service, as recorded in HERO, that the LHD / SHN and MOH has agreed to fund on an ABF basis for the 2018-19 Service Agreement.

Selected home based services are also included in this measure, as reported as indicated by the service unit's classification to one of the following NSW Service Unit Establishment Type categories:

- 21.04 Total Parenteral Nutrition - Home Delivered - Procedure Unit
- 21.05 Enteral Nutrition - Home Delivered - Procedure Unit
- 34.09 Haemodialysis - Home Delivered Procedure Unit
- 34.10 Peritoneal Dialysis - Home Delivered Procedure Unit
- 36.23 Invasive Ventilation - Home Delivered Procedure Unit

**Exclusions**

The following non-admitted patient services are excluded:

- Non-admitted patient services that are funded via revenue collected by the Local Health District / Specialist Health Network (such as privately referred non-admitted patients and direct federal funding program agreements), or direct revenue from a compensation fund or DVA that is not covered by a NSW Health bulk purchasing agreement.

- Non-admitted patient support services (services that do not contain clinical / therapeutic content, or do not warrant a note being made in the patient's medical record, or were provided by someone who was not a health care professional).

- Non-admitted patient services provided by hospitals or community health services that the LHD / SHN and MOH has agreed to fund on a block funding basis for the 2018-19 Service Agreement. Note: This list differs from the national NWAU determination.

- Non-admitted patient services provided by diagnostic service units, as indicated by the service unit's classification to one of the following NSW
Service Unit Establishment Type categories:

- 13.01 Pathology (Microbiology, Haematology, Biochemistry) Unit
- 13.03 Radiology / General Imaging Diagnostic Unit
- 13.04 Sonography / Ultrasonography Diagnostic Unit
- 13.05 Computerised Tomography (CT) Diagnostic Unit
- 13.06 Magnetic Resonance Imaging (MRI) Diagnostic Unit
- 13.07 Nuclear Medicine Diagnostic Unit
- 13.08 Positron Emission Tomography (PET) Diagnostic Unit
- 13.14 Public Health Laboratory Service Unit
- 13.15 Clinical Measurement - Respiratory Diagnostic Unit
- 13.16 Clinical Measurement - Cardiology Diagnostic Unit
- 13.17 Clinical Measurement - Neurology Diagnostic Unit
- 13.18 Clinical Measurement - Urology Diagnostic Unit
- 13.19 Clinical Measurement - Renal Diagnostic Unit
- 13.20 Clinical Measurement - Ophthalmology Diagnostic Unit
- 13.21 Clinical Measurement - Vascular Diagnostic Unit
- 13.22 Clinical Measurement - Bone Mineral Density Diagnostic Unit
- 13.23 Clinical Measurement - Endocrine Diagnostic Unit
- 13.24 Clinical Measurement - Gastroenterology Diagnostic Unit
- 13.26 Clinical Measurement - Sleep Diagnostic Unit
- 13.99 Clinical Measurement - Diagnostic Unit, NEC
- 15.04 Mammography / Breast Screen Diagnostic Unit

- Non-admitted patient services provided by service units funded under the Mental Health funding program, as indicated by the service unit's classification to the following NSW Service Unit Establishment Type categories:
  - 26.01 Mental Health Acute Unit
  - 26.02 Mental Health Consultation Liaison Unit
  - 26.03 Mental Health Emergency Care Unit
  - 26.04 Mental Health Early Intervention Unit
  - 26.05 Mental Health Promotion / Illness Prevention Unit
  - 26.06 Mental Health Research Unit
  - 26.07 Mental Health General Service Unit
  - 26.08 Mental Health Rehabilitation Unit
  - 26.09 Mental Health Extended Care Unit
  - 26.10 Mental Health Non-Acute Care Unit
  - 26.15 Specialist Mental Health Allied Health/Nursing Unit
  - 26.16 Mental Health Carer Support Service Allied Health / Nursing Unit
  - 26.17 Eating Disorders Mental Health Unit

- Non-admitted patient services provided by service units purchase via a Dental Weight Activity Unit (DWAU), as indicated by the service unit's classification to the following NSW Service Unit Establishment Type categories:
  - 28.01 Oral Health / Dental, nfd Procedure Unit
  - 28.02 Oral Health / Adult Dental Procedure Unit
2018-19 Service Performance Agreements
Strategy 8 KPIs: Build Financial Sustainability and Robust Governance

- 28.03 Oral Health / Child Dental Procedure Unit
- 28.04 Oral Health / Combined Adult and Child Dental Procedure Unit
- 28.05 Maxillofacial Surgery Medical Consultation Unit

- Non-admitted patient services provided by service units classified to one of the following NSW Service Unit Establishment Type categories:
  - 13.02 Pharmacy Dispensing Unit
  - 14.01 Business Unit, nfd
  - 14.02 Administration Service Unit
  - 14.03 Biomedical Engineering Service Unit
  - 14.04 Business Development / Planning Service Unit
  - 14.05 Catering Service Unit
  - 14.06 Cleaning Service Unit
  - 14.07 Facility & Asset Management Service Unit
  - 14.08 Finance / Billing Service Unit
  - 14.09 Human Resource Service Unit
  - 14.10 Information Management Service Unit
  - 14.11 Information Technology & Communication Service Unit
  - 14.12 Linen Service Unit
  - 14.13 Quality & Safety Service Unit
  - 14.14 Staff Transport Service / Fleet
  - 18.01 Emergency Department - Level 1
  - 18.02 Emergency Department - Level 2
  - 18.03 Emergency Department - Level 3
  - 18.04 Emergency Department - Level 4
  - 18.05 Emergency Department - Level 5
  - 18.06 Emergency Department - Level 6
  - 18.07 Emergency Medical Unit
  - 18.08 Rural Emergency Medicine Unit
  - 24.01 Health Service Intake Unit - Administrative
  - 24.03 Health Service Contact Centre (w or w/o Intake service)
  - 24.05 Aboriginal & Torres Strait Islander Liaison and Referral Support Service
  - 25.01 Intensive Care Unit
  - 25.07 High Dependency Unit
  - 25.08 Coronary Care Unit
  - 25.09 Neonatal Intensive Care Unit
  - 25.10 Neonatal Special Care Nursery
  - 32.20 Interpreter Services Unit
  - 32.32 Staff Health Unit
  - 32.43 Social/Support/Recreation/Neighbourhood Aid Service Unit
  - 39.21 Health Transport Unit (Patient)
  - 39.22 Pastoral Care Unit
  - 41.01 Home Modification/Maintenance Service Unit
  - 41.02 Meals - Home Delivered Service Unit
  - 43.01 Admitted Patient Burns Unit
  - 43.02 Admitted Patient Severe Burns Unit

- Any Service Unit which is assigned to an expired NSW Service Unit Establishment Type
2018-19 Service Performance Agreements
Strategy 8 KPIs: Build Financial Sustainability and Robust Governance

- Any service provider where the client / patient (or his / her proxy) did not interact with the health care provider (e.g. case conferences, case planning and case review services).
- Services provided to patients that are an admitted patient of a NSW Health hospital or under the care of a NSW Health Emergency Department at the time the service was provided.

<table>
<thead>
<tr>
<th>Targets</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target: Individual targets 1.0% above or below negotiated activity target.</td>
</tr>
<tr>
<td>Not performing: &gt;2.0% above or below negotiated activity target.</td>
</tr>
<tr>
<td>Under performing: Between 1.0% and 2.0% above or below negotiated activity target.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Related Policies/Programs</th>
<th>Activity Based Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Useable data available from</td>
<td>1 July 2015</td>
</tr>
<tr>
<td>Frequency of Reporting</td>
<td>Monthly</td>
</tr>
<tr>
<td>Time lag to available data</td>
<td>6 – 7 weeks</td>
</tr>
<tr>
<td>Business owners</td>
<td>System Purchasing Branch</td>
</tr>
<tr>
<td>Contact - Policy</td>
<td>Executive Director, System Purchasing Branch</td>
</tr>
<tr>
<td>Contact - Data</td>
<td>Executive Director, Health System Information and Performance Reporting</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Representation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data type</td>
</tr>
<tr>
<td>Form</td>
</tr>
<tr>
<td>Representational layout</td>
</tr>
<tr>
<td>Minimum size</td>
</tr>
<tr>
<td>Maximum size</td>
</tr>
<tr>
<td>Data domain</td>
</tr>
<tr>
<td>Date effective</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Related National Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>There is no national equivalent indicator</td>
</tr>
</tbody>
</table>
National components  METeOR ID 652528
Non-admitted patient service event—non-admitted service type, code (Tier 2 v5.0) NN.NN
http://meteor.aihw.gov.au/content/index.phtml/itemId/652528
<table>
<thead>
<tr>
<th>INDICATOR: SA-001</th>
<th><strong>Purchased Activity Volumes – Variance:</strong> Sub and non-acute admitted - NWAU (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Previous IDs:</strong></td>
<td>purchased activity volumes – variance: sub &amp; non-acute</td>
</tr>
<tr>
<td><strong>Shortened Title</strong></td>
<td>Purchased Activity Variance: Sub &amp; Non-acute</td>
</tr>
<tr>
<td><strong>Service Agreement Type</strong></td>
<td>Key Performance Indicator</td>
</tr>
<tr>
<td><strong>Framework Strategy</strong></td>
<td>Strategy 8: Build Financial Sustainability and Robust Governance</td>
</tr>
<tr>
<td><strong>Framework Objective</strong></td>
<td>8.1 (Secure a long term sustainable financial position)</td>
</tr>
<tr>
<td><strong>Status</strong></td>
<td>Final</td>
</tr>
<tr>
<td><strong>Version number</strong></td>
<td>1.4</td>
</tr>
<tr>
<td><strong>Scope</strong></td>
<td>Sub and non acute admitted episodes in 2018-19 ABF in-scope hospitals, excluding mental health services provided in designated units, Emergency Department only episodes.</td>
</tr>
<tr>
<td><strong>Goal</strong></td>
<td>Greater certainty concerning the amount of activity to be performed in a year.</td>
</tr>
</tbody>
</table>
| **Desired outcome** | • To improve operating efficiency by enhancing the capacity to manage costs and monitor performance by creating an explicit relationship between funds allocated and services provided  
  • To achieve greater accountability for management of resources and performance |
| **Primary point of collection** | Patient Medical Record                                                            |
| **Data Collection Source/System** | Hospital PAS, Admitted Patient Data Collection, LHD Activity Targets               |
| **Primary data source for analysis** | HIE                                                                              |
| **Indicator definition** | Variation of year to date sub and non acute weighted activity (NWAU) from the year to date sub and non acute activity target. |
| **Numerator** | **Numerator definition** | Sub and non acute episode funding activity for the year to date NWAU completed episodes. Covers all sub and non acute patients/episodes who occupied a bed in the period, excluding those still in hospital after the period. Less Sub and non acute Episode Funding activity target for the year to date in NWAU episodes. |
| **Numerator source** | HIE and Synaptix                                                                 |
| **Numerator availability** | Available 10-15 days after the end of the period of measurement.                   |
| **Denominator** | **Denominator definition** | Sub and non-acute Episode Funding activity target for the year to date in NWAU episodes. |
| **Note:** | All paediatric episodes with a valid AN SNAP class will generate the relevant SNAP based NWAU. Paediatric cases without a valid AN-SNAP class will generate a per diem NWAU. |
| **Numerator version for 2018-19** | AN-SNAP Version 4.0 (NWAU 18)                                                     |
### Denominator source
LHD Activity Targets

### Denominator availability
Available when targets finalised

### Inclusions
- Sub and non acute episodes (care type 2, 3, 4, 7, 8)
- Episode end date within the period
- Facilities in scope of ABF in 2018-19

### Exclusions
- Ongoing sub-acute episodes within the reporting period
- Episodes with any days in a designated psychiatric unit, i.e. \( \text{days}_{\text{in psych unit}} > 0 \) (for historical time series purposes only)
- ED only episodes, i.e. \( \text{ed status} = '1' \) or '4' (for historical time series purposes only)

### Targets
**Target**
Target: Individual targets 1.0% above or below negotiated activity target.

Not performing: >2.0% above or below negotiated activity target.

Under performing: Between 1.0% and 2.0% above or below negotiated activity target.

### Context
**Related Policies/ Programs**
Activity Based Funding

**Useable data available from**
2009/10

**Frequency of Reporting**
Quarterly

**Time lag to available data**
6 – 7 weeks

**Business owners**
- **Contact - Policy**: Executive Director, System Purchasing Branch
- **Contact - Data**: Executive Director, System Information and Analytics Branch

**Representation**
- **Data type**: Numeric
- **Form**: Number, presented as a percentage (%)
- **Representational layout**: NNN.N
- **Minimum size**: 3
- **Maximum size**: 4
- **Data domain**: 
- **Date effective**: July 2009

**Related National Indicator**
National Efficient Price Determination 2018-19
Purchased Activity Volumes – Variance: Mental Health Admitted - NWAU (%)

**INDICATOR:** KS8101

**Previous IDs:** MHDA-001, MHDA-002

**Shortened Title:** Purchased Activity Variance: MH Admitted

**Service Agreement Type:** Key Performance Indicator

**Framework Strategy:** Strategy 8: Build Financial Sustainability and Robust Governance

**Framework Objective:** 8.1 (Secure a long term sustainable financial position)

**Status:** Final

**Version number:** 1.1

**Scope:** Mental health admitted episodes in 2018-19 ABF in-scope hospitals, excluding Emergency Department only episodes.

**Goal:** Greater certainty concerning the amount of activity to be performed in a year.

**Desired outcome:**
- To improve operating efficiency by enhancing the capacity to manage costs and monitor performance by creating an explicit relationship between funds allocated and services provided.
- To achieve greater accountability for management of resources and performance.

**Primary point of collection:** Patient Medical Record

**Data Collection Source/System:** Hospital PAS, Admitted Patient Data Collection, LHD Activity Targets

**Primary data source for analysis:** HIE

**Indicator definition:** Variation of year to date mental health admitted weighted activity (NWAU) from the year to date acute activity target.

**Numerator**

**Numerator definition:** Mental Health Admitted Episode Funding activity for the year to date NWAU separation (where episode of care type is “Mental Health”). Includes an estimate for the NWAU of uncoded activity, based on the average NWAU for that type of case at that hospital.

**Numerator source:** HIE

**Numerator availability:** Available 2 months after the end of the period of measurement.

**Denominator**

**Denominator definition:** Mental Health Admitted Episode Funding activity target for the year to date in NWAU separations.

**Denominator source:** LHD Activity Targets

**Denominator availability:** Available when targets finalised.
## Inclusions
- Mental Health episodes (care type M)
- Episode end date within the period
- Facilities in scope of ABF in 2018-19

## Exclusions
ED only episodes (for historical time series purposes only)

## Targets
**Target**
Individual targets 1.0% above or below negotiated activity target.

**Not performing**
>2.0% above or below negotiated activity target.

**Under performing**
Between 1.0% and 2.0% above or below negotiated activity target.

## Context
This is an interim measure until the implementation of the National AMHCC and provision of weights by IHPA.

## Related Policies/ Programs
Activity Based Funding

## Useable data available from
2009/10

## Frequency of Reporting
Monthly

## Time lag to available data
6 – 7 weeks

## Business owners
**Contact - Policy**
Executive Director, Mental Health Branch

**Contact - Data**
Executive Director, System Information and Analytics Branch

## Representation
**Data type**
Numeric

**Form**
Number, presented as a percentage (%)

**Representational layout**
NNN.N

**Minimum size**
3

**Maximum size**
4

**Data domain**
Date effective
July 2009

## Related National Indicator
National Efficient Price Determination 2018-19
### Indicators: MHDA-005

#### Purchased Activity Volumes – Variance: Mental Health Non-Admitted - NWAU (%)

<table>
<thead>
<tr>
<th>Previous IDs:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Shortened Title</strong></td>
</tr>
<tr>
<td><strong>Service Agreement Type</strong></td>
</tr>
<tr>
<td><strong>Framework Strategy</strong></td>
</tr>
<tr>
<td><strong>Framework Objective</strong></td>
</tr>
<tr>
<td><strong>Status</strong></td>
</tr>
<tr>
<td><strong>Version number</strong></td>
</tr>
<tr>
<td><strong>Scope</strong></td>
</tr>
<tr>
<td><strong>Goal</strong></td>
</tr>
</tbody>
</table>
| **Desired outcome** | • To improve operating efficiency by enhancing the capacity to manage costs and monitor performance by creating an explicit relationship between funds allocated and services provided  
• To achieve greater accountability for management of resources and performance |
| **Primary point of collection** | Community Health Ambulatory (CHAMB). Activity level collection of service provided to ambulatory clients by specialist mental health teams. |
| **Data Collection Source/System** | Non Admitted Patient Data Collection, LHD Activity Targets |
| **Primary data source for analysis** | Non Admitted Mental Health Service Event (NAMHSE) derived from CHAMB. |
| **Indicator definition** | Variation of year to date non-admitted mental health NWAU from the year to date activity target. |
| **Numerator** | 
| Numerator definition | Non Admitted Mental Health Patient NWAU for the year to date. less Non Admitted Mental Health Patient NWAU notional target for the year to date. |
| Numerator source | CHAMB |
| Numerator availability | Available 2 months after the end of the period of measurement. |
| **Denominator** | 
| Denominator definition | Non Admitted Mental Health Patient NWAU notional target for the year to date. |
| Denominator source | LHD Activity Targets |
| Denominator availability | Available when targets finalised |
| **Inclusions** | Specialist non-admitted mental health activity reported under Tier 2 clinic type of 40.34. |
| **Targets** | 

---

*Page 189*
Target: Individual targets 1.0% above or below negotiated activity target (as per Schedule D).

Not performing: >2.0% above or below negotiated activity target.

Under performing: Between 1.0% and 2.0% above or below negotiated activity target.

Context

Related Policies/ Programs: Activity Based Funding
Useable data available from: 2009/10
Frequency of Reporting: Quarterly
Time lag to available data: 2 months

Business owners
Contact - Policy: Executive Director, Mental Health Branch.
Contact - Data: Executive Director, System Information and Analytics Branch

Representation
Data type: Numeric
Form: Number, presented as a percentage (%)
Representational layout: NNN.N
Minimum size: 3
Maximum size: 4
Data domain
Date effective: July 2009
Related National Indicator: Nil
**INDICATOR: PD-001**

**Purchased Activity Volumes – Variance:** Public Dental Clinical Service - DWAU (%)

**Previous IDs:**

- Purchased Activity Volumes
- Variance

**Shortened Title**

Purchased Activity Variance: Dental

**Service Agreement Type**

Key Performance Indicator

**Framework Strategy**

Strategy 8: Build Financial Sustainability and Robust Governance

**Framework Objective**

8.1 (Secure a long term sustainable financial position)

**Status**

Final

**Version number**

2.4

**Scope**

All dental care items that are provided through public oral health services on a non-admitted basis for eligible children and adults.

**Goal**

To monitor the pressure on public dental waiting lists and non-admitted dental service activity with a particular focus on Indigenous patients, patients at high risk of, or from, major oral health problems and those from rural areas.

**Desired outcome**

That the indicator identifies total non-admitted dental activity, taking into account the relative complexity of dental care provided in a dental appointment.

**Primary point of collection**

Providing dental clinician (dentist or dental therapist or dental oral health therapist or dental Prosthetist/technicians)

**Data Collection Source/System**

Information System for Oral Health (ISOH) or Titanium

**Primary data source for analysis**

ISOH; Titanium

**Indicator definition**

Variation of year to date dental weighted activity (DWAU) from the year to date acute activity target.

A Dental Weighted Activity Unit (DWAU) is a Commonwealth measure based on the relative value of treatment provided in dental appointments. 1 DWAU is the equivalent of 11 dental examination items (ADA item number 011). The Commonwealth have a code set of allowable ADA treatment items with relative weighting against the index value of the 011, which is supplemented by NSW-based weighting for certain service items.

**Numerator**

**Numerator definition**

Dental weighted activity for the year to date.

**Numerator source**

ISOH; Titanium

**Numerator availability**

**Denominator**

**Denominator definition**

Dental weighted activity target for the year to date.

**Denominator source**

LHD Activity Targets

**Denominator availability**

Available when targets finalised
2018-19 Service Performance Agreements
Strategy 8 KPIs: Build Financial Sustainability and Robust Governance

Inclusions
All public oral health eligible patients who have received dental care in NSW public dental clinic or under the NSW OHFFSS in the time period.

Exclusions
NSW residents who are not eligible for public dental care, and NSW residents who received dental care associated with provision of a general anesthetic as an admitted patient in a public hospital.

Note that although Child Dental Benefit Schedule (CDBS) data is included in the data collection process, it is excluded during report generation. This is due to some LHDs changing the items from non-CDBS to CDBS and vice versa. This also allows the calculation of an estimate of the amounts claimed under the CDBS by LHD.

Targets
Target: See Purchased Volumes
Performing: On or above target or <=1.0% below negotiated activity target.
Not performing: >2.0% below negotiated activity target.
Under performing: > 1.0% and <= 2.0% below negotiated activity target.

Context
Delivering a minimum level of public dental activity is currently required as part of Commonwealth funding arrangements for dental services.

Related Policies/Programs
Priority Oral Health Program and List Management Protocols PD 2017_023
Oral Health Fee for Service Scheme PD 2016_018
Early Childhood Oral Health Program PD2013_037

Useable data available from
Electronic reports circulated by the Centre for Oral Health Strategy to Dental Directors and Service Managers

Frequency of Reporting
Monthly

Time lag to available data
Two weeks from when the data is collected to being made available in a report for submission.

Business owners
Office of the Chief Health Officer
Contact - Policy Centre for Oral Health Strategy NSW
Contact - Data Centre for Oral Health Strategy NSW

Representation
Data type Numeric
Form Number, presented as a percentage (%)
Representational layout NNN.N
Minimum size 3
Maximum size 4
Date effective  July 2014
Related National Indicator  Indicator sets and related indicators Part 4 – Performance, Monitoring and Reporting.
<table>
<thead>
<tr>
<th>Shortened Title</th>
<th>Expenditure Matched to Budget YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Agreement Type</td>
<td>Key Performance Indicator</td>
</tr>
<tr>
<td>Framework Strategy</td>
<td>Strategy 8: Build Financial Sustainability and Robust Governance</td>
</tr>
<tr>
<td>Framework Objective</td>
<td>8.1 (Secure a long term sustainable financial position)</td>
</tr>
<tr>
<td>Status</td>
<td>Final</td>
</tr>
<tr>
<td>Version number</td>
<td>1.21</td>
</tr>
<tr>
<td>Scope</td>
<td>Financial Management</td>
</tr>
<tr>
<td>Goal</td>
<td>Health Entities to operate within approved allocation</td>
</tr>
<tr>
<td>Desired outcome</td>
<td>Health Entities achieve an on budget or favorable result</td>
</tr>
<tr>
<td>Primary point of collection</td>
<td>Health Entities</td>
</tr>
<tr>
<td>Data Collection Source/System</td>
<td>Oracle Accounting System</td>
</tr>
<tr>
<td>Primary data source for analysis</td>
<td>Health Entity monthly financial narrative/SMRS</td>
</tr>
<tr>
<td>Indicator definition</td>
<td>General Fund expenditure matched to budget is the YTD expenditure compared to YTD budget.</td>
</tr>
</tbody>
</table>

**Numerator**
- Numerator definition: July to end current month General Fund expenditure.
- Numerator source: SMRS
- Numerator availability: Available

**Denominator**
- Denominator definition: July to end current month Budget General Fund expenditure.
- Denominator source: SMRS
- Denominator availability: Available

**Inclusions**

**Exclusions**
The General Fund Measure excludes Special Purpose & Trust Funds

**Targets**
- Target: < 0.5% variation

**Context**
Health Entities are expected to operate within approved budget

**Related Policies/ Programs**

**Useable data available from**
Annual - Financial year (available from Finance on a monthly basis)

**Frequency of Reporting**
Monthly
<table>
<thead>
<tr>
<th><strong>Time lag to available data</strong></th>
<th>Available at month end</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Business owners</strong></td>
<td>Finance</td>
</tr>
<tr>
<td>Contact - Policy</td>
<td>Chief Financial Officer</td>
</tr>
<tr>
<td>Contact - Data</td>
<td>Director, Financial Performance &amp; Reporting (Jen Smithwick)</td>
</tr>
<tr>
<td><strong>Representation</strong></td>
<td></td>
</tr>
<tr>
<td>Data type</td>
<td>Numeric</td>
</tr>
<tr>
<td>Form</td>
<td>Number, presented as a percentage (%)</td>
</tr>
<tr>
<td>Representational layout</td>
<td>NNN.NN</td>
</tr>
<tr>
<td>Minimum size</td>
<td>1</td>
</tr>
<tr>
<td>Maximum size</td>
<td>6</td>
</tr>
<tr>
<td>Data domain</td>
<td></td>
</tr>
</tbody>
</table>

**Related National Indicator**
2018-19 Service Performance Agreements
Strategy 8 KPIs: Build Financial Sustainability and Robust Governance

<table>
<thead>
<tr>
<th>INDICATOR: KFA103</th>
<th><strong>Own Source Revenue Matched to Budget: Year to date variance – General Fund (%)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous IDs:</td>
<td></td>
</tr>
<tr>
<td>Shortened Title</td>
<td>Revenue Matched to Budget YTD</td>
</tr>
<tr>
<td>Service Agreement Type</td>
<td>Key Performance Indicator</td>
</tr>
<tr>
<td>Framework Strategy</td>
<td>Strategy 8: Build Financial Sustainability and Robust Governance</td>
</tr>
<tr>
<td>Framework Objective</td>
<td>8.1 (Secure a long term sustainable financial position)</td>
</tr>
<tr>
<td>Status</td>
<td>Final</td>
</tr>
<tr>
<td>Version number</td>
<td>1.11</td>
</tr>
<tr>
<td>Scope</td>
<td>Financial Management</td>
</tr>
<tr>
<td>Goal</td>
<td>Health Entities achieve approved own source revenue budget</td>
</tr>
<tr>
<td>Desired outcome</td>
<td>Health Entities achieve an on budget or favourable result</td>
</tr>
<tr>
<td>Primary point of collection</td>
<td>Health Entities</td>
</tr>
<tr>
<td>Data Collection Source/System</td>
<td>Oracle</td>
</tr>
<tr>
<td>Primary data source for analysis</td>
<td>Health Entity Monthly Financial Narrative/SMRS</td>
</tr>
<tr>
<td>Indicator definition</td>
<td>General Fund own source revenue matched to budget is the comparison of YTD actual own source revenue compared to YTD budget.</td>
</tr>
</tbody>
</table>

**Numerator**
- Numerator definition: July to end of current month General Fund own source revenue.
- Numerator source: SMRS
- Numerator availability: Available

**Denominator**
- Denominator definition: July to end current month Budget General Fund own source revenue.
- Denominator source: SMRS
- Denominator availability: Available

**Inclusions**

**Exclusions**
- The General Fund Measure excludes Special Purpose & Trust Funds. The Own Source revenue excludes Government grant contributions (subsidy)

**Targets**
- Target: < 0.5% variation

**Context**
- Health Entities are expected to achieve approved budget

**Related Policies/ Programs**
- Useable data available from: Annual - Financial year (available from Finance on a monthly basis)
- Time lag to available data: Available at month end
### Business owners
- **Contact - Policy**: Chief Financial Officer
- **Contact - Data**: Director, Financial Performance & Reporting (Jen Smithwick)

### Representation

<table>
<thead>
<tr>
<th>Data type</th>
<th>Numeric</th>
</tr>
</thead>
<tbody>
<tr>
<td>Form</td>
<td>Number, presented as a percentage (%)</td>
</tr>
<tr>
<td>Representational layout</td>
<td>XXX.XX</td>
</tr>
<tr>
<td>Minimum size</td>
<td>1</td>
</tr>
<tr>
<td>Maximum size</td>
<td>6</td>
</tr>
</tbody>
</table>

### Related National Indicator
<table>
<thead>
<tr>
<th>INDICATOR:</th>
<th>KS8102</th>
</tr>
</thead>
</table>

### Cost Ratio Performance (%):  
- Cost per NWAU compared to state average - Current year against previous year (%)  

#### Shortened Title  
Cost Ratio Performance  

#### Service Agreement Type  
Key Performance Indicator  

#### Framework Strategy  
Strategy 8: Build Financial Sustainability and Robust Governance  

#### Framework Objective  
8.1 (Secure a long term sustainable financial position)  

#### Status  
Final draft  

#### Version number  
1.1  

#### Scope  
All ABF Hospitals  

#### Goal  
To drive efficiency in ABF hospitals  

#### Desired outcome  
Reduction on previous years when compared using the same currency.  

#### Primary point of collection  
District and Network Return (DNR)  

#### Data Collection Source/System  
District and Network Return (DNR), ABM Portal  

#### Primary data source for analysis  
ABM Portal  

#### Indicator definition  
The difference, from current year to previous year, in the cost per NWAU compared to the state price, expressed in current NWAU.  

#### Numerator  
- Numerator definition: Average district cost (expressed in NWAU)  
- Numerator source: ABM Portal  
- Numerator availability: Annually  

#### Denominator  
- Denominator definition: State Price (in NWAU)  
- Denominator source: ABM Portal  
- Denominator availability: Annually  

#### Inclusions  
ABF hospitals only  

#### Exclusions  
As per state price exclusions  

#### Targets  
- Target: >0% decrease from previous year  
  - Performing: Reduction from previous year  
  - Under-performing: No change from previous year  
  - Not performing: Increase on previous year  

#### Comments
2018-19 Service Performance Agreements
Strategy 8 KPIs: Build Financial Sustainability and Robust Governance

Context
Measuring efficiencies using Average cost per NWAU inherently risk adjust for patient complexity. Therefore the measure can be used across all ABF hospitals and aggregated up to LHD/SHN

Related Policies/ Programs
Useable data available from 1 July 2017
Frequency of Reporting Annually
Time lag to available data Annually

Business owners
Contact - Policy Director, Activity Based Management
Contact - Data Manager, Clinical Cost Data Collection and Standards, Activity Based Management

Representation
Data type Numeric
Form Number
Representational layout N.N
Minimum size 3
Maximum size 3

Related National Indicator
IMPROVEMENT MEASURES FOR 2018-19
## STRATEGY 1 IMs: Keep People Healthy

### Indicator: PH-008C, PH-008D

**Healthy Children Initiative** - Targeted Family Healthy Eating and Physical Activity Program (Go4Fun):

- Completed program (%) *(PH-008C)*
- Enrollments achieved (number) *(PH-008D)*

### Previous ID:

Healthy Children Initiative - Targeted Family Healthy Eating and Physical Activity Program (Go4Fun):

- Completed program (%)
- Enrollments achieved (number)

### Shortened Title(s)

- Go4Fun - Completed program
- Go4Fun – Enrollments achieved

### Service Agreement Type

- Improvement Measure

### Framework Strategy

- Strategy 1: Keep People Healthy

### Framework Objective

- 1.1 (Reduce Childhood Obesity)

### Status

- Final

### Version number

- 1.2

### Scope

Overweight/obese children 7-13 years old across NSW

### Goal

Reduced prevalence of overweight/obesity in children 7-13 years old across NSW.

### Desired outcome

Reduce the risk of lifestyle related chronic disease by promoting healthy weight, increase consumption of fruits and vegetables and increase participation in recommended levels of physical activities.

### Primary point of collection

Program Manager and Program Facilitators

### Data Collection Source/System

- Better Health Data

### Primary data source for analysis

Better Health Data

### Indicator definition

**PH-008C**: Percentage of overweight/obese children 7-13 years old enrolled in the Targeted Family Healthy Eating and Physical Activity Program who complete three or more program sessions, per the once per week delivery model.

**PH-008D**: The number of overweight/obese children 7-13 years old enrolled in the Targeted Family Healthy Eating and Physical Activity Program who complete one or more program sessions.

### Numerator

- **Numerator definition**
  - **PH-008C**: Number of overweight/obese children 7-13 years old who complete three or more sessions, per the once per week delivery model of the Targeted Family Healthy Eating and Physical Activity Program.
  - **PH-008D**: Number of overweight/obese children 7-13 years old who enrol in the Targeted Family Healthy Eating and Physical Activity Program and attend one or more program sessions.

- **Numerator source**: Better Health Data

- **Numerator availability**: Quarterly

### Denominator

- **Denominator definition**
  - **PH-008C**: Number of overweight/obese children 7-13 years old enrolled in the
Targeted Family Healthy Eating and Physical Activity Program who complete three or more program sessions, per the once per week delivery model.

**PH-008D: N/A**

**Denominator source**
Better Health Data

**Denominator availability**
Quarterly

**Inclusions**
Overweight/obese children 7-13 years old across NSW.

**Exclusions**
Any children who do not fall into the inclusions category.

### Targets

<table>
<thead>
<tr>
<th>LHD ID</th>
<th>LHD Name</th>
<th>2018-19 Target enrolment number</th>
<th>Number of programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>X700</td>
<td>Sydney LHD</td>
<td>96</td>
<td>8</td>
</tr>
<tr>
<td>X710</td>
<td>South Western Sydney LHD</td>
<td>264</td>
<td>22</td>
</tr>
<tr>
<td>X720</td>
<td>South Eastern Sydney LHD</td>
<td>192</td>
<td>16</td>
</tr>
<tr>
<td>X730</td>
<td>Illawarra Shoalhaven LHD</td>
<td>80</td>
<td>8</td>
</tr>
<tr>
<td>X740</td>
<td>Western Sydney LHD</td>
<td>288</td>
<td>24</td>
</tr>
<tr>
<td>X750</td>
<td>Nepean Blue Mountains LHD</td>
<td>80</td>
<td>8</td>
</tr>
<tr>
<td>X760</td>
<td>Northern Sydney LH</td>
<td>48</td>
<td>4</td>
</tr>
<tr>
<td>X770</td>
<td>Central Coast LHD</td>
<td>100</td>
<td>10</td>
</tr>
<tr>
<td>X800</td>
<td>Hunter New England LHD</td>
<td>100</td>
<td>10</td>
</tr>
<tr>
<td>X810</td>
<td>Northern NSW LHD</td>
<td>56</td>
<td>7</td>
</tr>
<tr>
<td>X820</td>
<td>Mid North Coast LHD</td>
<td>64</td>
<td>8</td>
</tr>
<tr>
<td>X830</td>
<td>Southern NSW LHD</td>
<td>16</td>
<td>2</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td>1,384</td>
<td>127</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Enrolment target (PH-008D)</th>
<th>Completion (PH-008C)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performing</td>
<td>95-100% target</td>
<td>≥ 85%</td>
</tr>
<tr>
<td>Under performing</td>
<td>90-94%</td>
<td>≥ 75% &amp; &lt; 85%</td>
</tr>
<tr>
<td>Not performing</td>
<td>&lt; 90% target</td>
<td>&lt; 75%</td>
</tr>
</tbody>
</table>

**Comments:**

**PH-008C:** 85% of children enrolled completing three or more sessions per the once per week delivery model of the Program by 30 June 2019. It will be equivalent to 1,204 children completing the Program across NSW if target of 1,416 enrolments is met. Individual annual LHD targets have been established.

**PH-008D:** Target 1,416 children across NSW enrolled in the Program and attend one or more program sessions from 1 June 2018 to 30 June 2019.

Individual LHD commitments are based on the delivery of an agreed number of programs to be delivered from 1 June 2018 to 30 June 2019. Lower/upper age limit: 6 years and 6 months to 13 years and 11 months years of age.

**Context**

The approved NSW Healthy Children Initiative (HCI) commits NSW to achieving targets related to the delivery of the Targeted Family Healthy Eating and Physical Activity Program. Since July 2015 LHDs that elect to participate have committed to
deliver an agreed number of programs which corresponds to a minimum number of enrolled participants per financial year. LHDs that choose to deliver this program are fully funded.

Related Policies/ Programs

- Healthy Children Initiative
- NSW Premiers Priorities to reduce childhood overweight and obesity rates by 5% over 10 years (by 2025)
- NSW Healthy Eating and Active Living Strategy: Preventing overweight and obesity in New South Wales 2013-2018

Useable data available from

July 2012

Frequency of Reporting

Quarterly

Time lag to available data

30 days

Business owners

Centre for Population Health

Contact - Policy

Executive Director, Centre for Population Health (Dr Jo Mitchell)

Contact - Data

Director, Population Health Strategy & Performance (Jo Holden)

Representation

Data type

Numeric

Form

Number

Representational layout

PH-008C: NNN.NN; PH-008D: NNN{NNN}

Minimum size

PH-008C: 4; PH-008D: 3

Maximum size

PH-008C: 6; PH-008D: 6

Data domain

N/A

Date effective

Related National Indicators

Indicator

Source
**INDICATOR**: MS1102

**Previous ID:**

**Childhood Obesity**: Children with height/length and weight recorded (%)

- Proportion of children up to but not including the 17th birthday with their height/length and weight recorded within 24 hours of each other, and at least once on or within the previous 90 days with at least one encounter during the relevant quarterly reporting period (%).

**Shortened Title**: Childhood Obesity

**Service Agreement Type**: Improvement Measure

**Framework Strategy**: Strategy 1: Keep People Healthy

**Framework Objective**: 1.1 (Reduce Childhood Obesity)

**Status**: Final

**Version number**: 1.1

**Scope**: All children up to but not including the 17th birthday who are in contact with any NSW Health facility, within the inpatient, outpatient or community setting (excluding Emergency Departments).

**Goal**: Improve the routine recording of children's height/length (children under the age of 2 are typically measured in length) and weight. Improve the routine identification and management of children who are above or below a healthy weight.

**Desired outcome**: Improve the routine recording of children's height/length and weight in all settings across NSW Health facilities, except Emergency Departments.

**Primary point of collection**: All LHDs via Electronic Management Record (eMR) and Community Health Outpatient Clinic (CHOC) systems.

**Data Collection Source/System**: Local eMRs and CHOC/CHIME.

**Primary data source for analysis**: Report generated using above electronic information systems. Routine compliance reports will be generated by e-Health NSW in collaboration with each Local Health District and submitted to the Health System Information and Performance Reporting Branch, NSW Ministry of Health no later than two weeks following the end of each quarter and in compliance with the **NSW Health - Nutrition Care Policy**. LHDs without electronic information systems will be exempted from reporting, until such time as the necessary systems to support electronic reporting are in place.

**Indicator definition**: Percentage of unique children up to but not including the 17th birthday who have their height/length and weight measured within 24 hours of each other, and entered into the inpatient, outpatient and community electronic records management system appropriate to that LHD, on or within the previous 90 days of any relevant encounter for the quarterly reporting period.

**Numerator**: Number of unique children up to but not including the 17th birthday who have had contact with NSW Health (excluding Emergency Department presentations that were not admitted) and had height/length and weight measured within 24 hours of each other, and entered at least once into the electronic medical record system, on or within 90 days of at least one relevant encounter within the current reporting period.
### Numerator

<table>
<thead>
<tr>
<th>Source</th>
<th>Local eMRs and CHOC/CHIME systems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Availability</td>
<td>Quarterly</td>
</tr>
</tbody>
</table>

### Denominator

<table>
<thead>
<tr>
<th>Definition</th>
<th>Number of unique children up to but not including the 17th birthday who have had at least one relevant encounter with NSW Health services within the current reporting period (with the exception of Emergency Department presentations that were not admitted).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Source</td>
<td>Local eMRs and CHOC/CHIME systems</td>
</tr>
<tr>
<td>Availability</td>
<td>Quarterly</td>
</tr>
</tbody>
</table>

### Inclusions

All children up to but not including the 17th birthday who have contact with NSW Health.

### Exclusions

- Anyone above 17 years of age.
- Any child up to but not including the 17th birthday who presented to an Emergency Department and was not admitted.
- Community encounters where no service contact was made for the reporting period.
- Where measuring weight and height may not be appropriate, or else does not enhance patient care, such as life-threatening illness and end of life care.

### Targets

60% of unique children who had a relevant encounter with the NSW Health service, with at least one complying height/length and weight measurement conducted in the 90 days prior to or on the day of at least one encounter within the current reporting period.

### Context

Local Health Districts are responsible for ensuring all children up to but not including the 17th birthday have height/length and weight measured and entered into the records management system in compliance with the NSW Health Nutrition Care Policy. Compliance with the Policy means that important information about the growth and health of children is captured. This policy contributes to the NSW Premier's Priority to reduce childhood overweight and obesity. To support NSW Health staff within each Local Health District to monitor and achieve compliance with the Policy.

### Related Policies/Programs

Updated NSW Health Nutrition Care Policy (and the relevant supporting procedure - both currently in draft)

### Useable data available from

July 2018 in Districts and Networks where the required electronic medical record systems have been implemented

### Frequency of Reporting

Quarterly

### Time lag to available data

Data should be made available two weeks after the close of the relevant quarterly report.

### Business owners

**Centre for Population Health / Health and Social Policy Branch**

- **Contact - Policy**
  - Executive Director, Centre for Population Health / Health and Social Policy

- **Contact - Data**
  - Executive Director, System Information and Analytics Branch / eHealth NSW
Representation

<table>
<thead>
<tr>
<th>Representation</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data type</td>
<td>Numeric</td>
</tr>
<tr>
<td>Form</td>
<td>Percentage, including numerator and denominator</td>
</tr>
<tr>
<td>Representational layout</td>
<td>NNN.N% (percentage), including nn/NN (corresponding numerator and denominator)</td>
</tr>
<tr>
<td>Minimum size</td>
<td>3</td>
</tr>
<tr>
<td>Maximum size</td>
<td>5</td>
</tr>
<tr>
<td>Data domain</td>
<td>N/A</td>
</tr>
<tr>
<td>Date effective</td>
<td>July 2018</td>
</tr>
</tbody>
</table>

Related National Indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator</td>
<td>N/A</td>
</tr>
</tbody>
</table>
INDICATOR: MS1103
Previous ID: Healthy Children Initiative – Children's Healthy Eating and Physical Activity Program (*Munch & Move*) - Family Day Care Service Providers (sites) achieving agreed proportion of Family Day Care practices (%)

Shortened Title Healthy Children Initiative – Munch and Move FDC

Service Agreement Type Key Performance Indicator
Framework Strategy Strategy 1: Keep People Healthy
Framework Objective 1.1 (Reduce Childhood Obesity)

Status Final
Version number 1.0
Scope All family day care service providers (FDC) in NSW.
Goal To increase the proportion of FDC sites in NSW that implement and adopt the *Munch & Move* program.
Desired outcome Reduce the risk of lifestyle related chronic diseases by promoting healthy eating and physical activity to support healthy weight.
Primary point of collection LHD Program Manager and Health Promotion Officers
Data Collection Source/System Population Health Information Management System (PHIMS)
Primary data source for analysis Data entered into the PHIMS

Indicator definition The proportion of FDC sites that have adopted the *Munch & Move* program practices to attain targets by June 2019.

**Numerator**
Numerator definition Total number of FDC sites that:
- are on the reference list of FDC’s in PHIMS, and
- are active or were active within the defined reporting period, and
- have attended training or are “deemed trained”, and
- are enabled for scheduled follow up, and
- have achieved 50% of the relevant* FDC program practices within the defined reporting period

*N* Some practices may not be relevant to an FDC. For example, an FDC that only caters for children 3-5 years of age would not be monitored on the practice of their educators providing supervised floor-based play for babies 0-12 months of age every day.

Numerator source PHIMS
Numerator availability Quarterly

**Denominator**
Denominator definition Total number of FDC sites that:
- are on the reference list of FDC’s in PHIMS, and
- are active or were active within the defined reporting period, and
- have attended training or are “deemed trained”, and
- are enabled for scheduled follow up.
2018-19 Service Performance Agreements
Strategy 1 IMs: Keep People Healthy

Denominator source  PHIMS
Denominator availability  Quarterly

Inclusions  N/A
Exclusions  N/A

Targets

>= 50% of family day care service providers (sites) to achieve 50% of the FDC program practices

- Performing: >=50% of sites adopting KPI target, with ≥ 50% of Practices achieved
- Under Performing: 40-49% of sites adopting KPI target, with ≥ 50% of Practices achieved
- Not Performing: <40% of sites adopting KPI target, with ≥ 50% of Practices achieved

Comments:
Geographical area of interest: whole state / LHD

Context
The NSW Healthy Children Initiative commits NSW to attain targets related to participation in training and adoption of the Children's Healthy Eating and Physical Activity Program by family day care service providers. LHDs are fully funded for this initiative.

Related Policies/ Programs
- Premier’s Priority to reduce childhood overweight and obesity by 5% by 2025
- NSW Healthy Eating and Active Living Strategy: Preventing overweight and obesity in New South Wales 2013-2018
- Healthy Children Initiative

Useable data available from  July 2017

Frequency of Reporting  Quarterly

Time lag to available data  Real-time (though dependent on timely data entry)

Business owners  Centre for Population Health
  Contact - Policy  Executive Director, Centre for Population Health
  Contact - Data  Manager, Information and Reporting Unit

Representation
  Data type  Numeric
  Form  Number
  Representational layout  NNN.NN
  Minimum size  3
  Maximum size  5
  Data domain  N/A
  Date effective
### Related National Indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>INDICATOR:</td>
<td>PH-017A</td>
</tr>
<tr>
<td>------------</td>
<td>---------</td>
</tr>
<tr>
<td>Previous ID:</td>
<td>Tobacco Compliance Monitoring: compliance with the NSW Health Smoke-free Health Care Policy (%)</td>
</tr>
<tr>
<td>Shortened Title</td>
<td>Tobacco Compliance Monitoring</td>
</tr>
<tr>
<td>Service Agreement Type</td>
<td>Improvement Measure</td>
</tr>
<tr>
<td>Framework Strategy</td>
<td>Strategy 1: Keep People Healthy</td>
</tr>
<tr>
<td>Framework Objective</td>
<td>1.2 (Reduce Tobacco Use)</td>
</tr>
<tr>
<td>Status</td>
<td>Final</td>
</tr>
<tr>
<td>Version number</td>
<td>1.11</td>
</tr>
<tr>
<td>Scope</td>
<td>All NSW Health facilities, grounds and vehicles are smoke-free.</td>
</tr>
<tr>
<td>Goal</td>
<td>Reduce the risks to health associated with tobacco use by clients, staff and visitors to NSW Health facilities and the community’s exposure to second-hand smoke.</td>
</tr>
<tr>
<td>Desired outcome</td>
<td>Eliminate the risks of exposure to particulate matter emitted by second-hand smoke.</td>
</tr>
<tr>
<td>Primary point of collection</td>
<td>High profile areas of major public hospitals or health services in Local Health Districts. Site selection needs to include at least three major hospitals or health services within the Local Health District, with a focus on those where complaints have been received regarding breaches of smoking bans. The same site and area selected must be used for all quarterly observations within the financial year.</td>
</tr>
<tr>
<td>Data Collection Source/System</td>
<td>Tally sheet or template (individually developed by each Local Health District)</td>
</tr>
<tr>
<td>Primary data source for analysis</td>
<td>Local Health Districts develop and complete a reporting template based on the information required in the ‘Protocol for Monitoring compliance with the NSW Health Smoke-free Health Care Policy’. Compliance activity reports are submitted to the Centre for Population Health no later than two weeks following the end of each quarter.</td>
</tr>
<tr>
<td>Indicator definition</td>
<td>Percentage of people (including staff, patients, visitors, contractors) who are observed smoking in a high profile area on hospital and health service grounds during a two hour observation period. Note it is the occasions of smoking, not the number of individual smokers, which are counted.</td>
</tr>
<tr>
<td>Numerator</td>
<td></td>
</tr>
<tr>
<td>Numerator definition</td>
<td>Occasions of smoking observed in high profile area on hospital and health service grounds.</td>
</tr>
<tr>
<td>Numerator source</td>
<td>Tally sheet or template</td>
</tr>
<tr>
<td>Numerator availability</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Denominator</td>
<td></td>
</tr>
<tr>
<td>Denominator definition</td>
<td>Total number of people (excluding those who appear to be less than 18 years of age) observed in the same area.</td>
</tr>
</tbody>
</table>
Denominator source: Tally sheet or template
Denominator availability: Quarterly

**Inclusions**
All people who enter the designated site (hospital or health service ground) during the two hour observation period.

**Exclusions**
Anyone who appears to be less than 18 years of age.

**Targets**
98% compliance with Smoke-free Health Care Policy

**Context**
Local Health Districts are responsible for ensuring compliance by patients, staff and visitors with the NSW Health Smoke-free Health Care Policy. Compliance with the Policy means that all NSW Health buildings, grounds and vehicles are smoke-free with the exception of designated outdoor smoking areas determined by Local Health Districts and specialty network governed statutory health corporations that choose to provide such areas using a smoke-free by-law. NSW Health Authorised Inspectors within each Local Health District monitor compliance with the Policy.

**Related Policies/ Programs**
NSW Health Smoke-free Health Care Policy (PD2015_003)

**Useable data available from**
July 2015

**Frequency of Reporting**
Quarterly

**Time lag to available data**
One month.

**Business owners**
**Centre for Population Health**
- Contact - Policy: Executive Director, Centre for Population Health (Dr Jo Mitchell)
- Contact - Data: Manager, Strategic and Regulatory Policy Branch (Audrey Maag)

**Representation**
- Data type: Numeric
- Form: Number
- Representational layout: NNN.NN
- Minimum size: 1
- Maximum size: 4
- Data domain: N/A
- Date effective: July 2015

**Related National Indicators**
**Indicator:** MS1304  
**Previous IDs:** MS1303

<table>
<thead>
<tr>
<th><strong>Shortened Title</strong></th>
<th>Pregnant women who use substances</th>
</tr>
</thead>
</table>

**Service Agreement Type:** Improvement Measure  
**Framework Strategy:** Strategy 1: Keep People Healthy  
**Framework Objective:** 1.3 (Health system response to alcohol and drug use)

**Status:** Final  
**Version number:** 1.0

**Scope:** All women engaged in NSW Substance Use in Pregnancy and Parenting Services

**Goal:** To improve retention in care for pregnant women with substance use issues and their children.

**Desired outcome:** Improved health and social outcomes for pregnant women who use substances, and their children, by providing sustained care and support for up to two years post-delivery

**Primary point of collection:** Drug & Alcohol Services in the following LHDS that receive specific SUPPS funding: HNELHD, ISLHD, SWSLHD, WSLHD, NBMLHD, SLHD, SESLHD, WNSWLHD

**Data Collection Source/System:** Manual collection via provided Template

**Primary data source for analysis:** Manual collection via provided Template

**Indicator definition:** The number of pregnant women who use substances engaged in treatment and home visiting support for up to two years post-delivery.

**Numerator**
- **Numerator definition:** Total Number of pregnant women who use substances engaged in treatment and long term home visiting support for up to two years post-delivery.
- **Numerator source:** Manual collection via provided Template
- **Numerator availability:** 1 July 2018

**Denominator**
- **Denominator definition:** N/A
- **Denominator source:** N/A
- **Denominator availability:** N/A

**Inclusions**
- All pregnant women who use substances who voluntarily engage in treatment and home visiting support provided by the NSW Substance Use in Pregnancy and Parenting Services

**Exclusions**
- Nil
2018-19 Service Performance Agreements
Strategy 1 IMs: Keep People Healthy

Targets
Target
N/A

Context
The 2016 NSW Drug Package provided an enhancement of $15 million over four years to expand Substance Use in Pregnancy Services across NSW to enhance specialist medical and nursing services throughout pregnancy and post-delivery including ongoing support.

Related Policies/ Programs
NSW Opioid Treatment Program

- NSW Clinical Guidelines – Treatment of Opioid Dependence
- SAFE START Guidelines: Improving Mental Health Outcomes for Parents and Infants 2010.
- Information Sharing – NSW Health and DOCS – Opioid treatment Responsibility – Children under 16.

Useable data available from
1 July 2018

Frequency of Reporting
six monthly, starting 1 July 2018

Time lag to available data
six weeks after reporting period ends

Business owners
Contact - Policy
Executive Director, Centre for Population Health (Dr Jo Mitchell)

Contact - Data
TBA

Representation
Data type
Numeric
Form
Number
Representational layout
NNN{NNN}
Minimum size
3
Maximum size
6

Data domain

Date effective
<table>
<thead>
<tr>
<th>Related National Indicator</th>
<th>N/A</th>
</tr>
</thead>
</table>

2018-19 Service Performance Agreements
Strategy 1 IMs: Keep People Healthy
**INDICATOR:** DPH_1301b

**Drug and Alcohol Opioid Treatment Program** – Unique public patients prescribed buprenorphine or buprenorphine-naloxone (%)

**Previous IDs:** Drug and Alcohol Opioid Treatment Program – Unique public patients prescribed buprenorphine or buprenorphine-naloxone (%)

**Shortened Title**
OTP – Patients Prescribed Buprenorphine or Buprenorphine-Naloxone

**Service Agreement Type**
Improvement Measure

**Framework Strategy**
1.3 (Health system response to alcohol and drug use)

**Framework Objective**
Final

**Status**
Final

**Version number**
1.01

**Scope**
All public patients in NSW for whom an Authority to prescribe buprenorphine or methadone under the NSW Opioid Treatment Program (OTP) has been submitted to the Pharmaceutical Regulatory Unit

**Goal**
To monitor rates of prescribing of buprenorphine or buprenorphine-naloxone by public prescribers in NSW Opioid Treatment Program

**Desired outcome**
An increase in rate of prescribing of buprenorphine or buprenorphine-naloxone for the treatment of opioid dependence, acknowledging its safety profile.

A proportional increase in the rate of prescribing of buprenorphine or buprenorphine-naloxone for the treatment of opioid dependence as compared to prescribing of methadone.

**Primary point of collection**
Number of Authorities to Prescribe Methadone or Buprenorphine or Buprenorphine-naloxone under the NSW Opioid Treatment Program (OTP) submitted to the Pharmaceutical Regulatory Unit

**Data Collection Source/System**
NSW Controlled Drugs Data Collection (CoDDaC), Electronic Recording and Reporting of Controlled Drugs system (ERRCD)

**Primary data source for analysis**
NSW Controlled Drugs Data Collection (CoDDaC)

**Indicator definition**
Proportion of unique public patients for whom an authority is valid to prescribe buprenorphine or buprenorphine-naloxone under the NSW Opioid Treatment Program

**Numerator**
Numerator definition
Total number of unique patients who were prescribed buprenorphine or buprenorphine-naloxone in the public NSW Opioid Treatment Program (OTP) for the last day of the quarter.

Numerator source
NSW Controlled Drugs Data Collection (CoDDaC)

Numerator availability
Quarterly

**Denominator**
Denominator definition
Total number of unique patients who were prescribed opioid pharmacotherapies in the public NSW Opioid Treatment Program for the
2018-19 Service Performance Agreements
Strategy 1 IMs: Keep People Healthy

Denominator source: NSW Controlled Drugs Data Collection (CoDDaC)
Denominator availability: Quarterly

Inclusions
All public patients in NSW for whom an Authority to prescribe buprenorphine or methadone under the NSW Opioid Treatment Program (OTP) has been submitted to the Pharmaceutical Regulatory Unit

All unique patients in NSW who were prescribed opioid pharmacotherapies under the NSW Opioid Treatment Program

Exclusions
All private patients in NSW for whom an Authority to prescribe buprenorphine or methadone under the NSW Opioid Treatment Program (OTP) has been submitted to the Pharmaceutical Regulatory Unit

Targets
Target: Increase on previous year
• Performing: Increase from previous year
• Under performing: No change
• Not performing: decrease from previous year

Context
Buprenorphine and buprenorphine-naloxone have a proven profile for safety and efficacy in the treatment for opioid dependence. As such, a reorientation towards prescribing buprenorphine and buprenorphine-naloxone, as opposed to methadone, where clinically indicated is a focus of reform for the NSW OTP.

Related Policies/Programs
• NSW Treatment Program: Clinical Guidelines for methadone and buprenorphine treatment (2006)
• Medication assisted treatment of opioid dependence (MATOD) (2014)

Useable data available from: 1 July 2017

Frequency of Reporting: Quarterly

Time lag to available data: Quarterly data will be available at the commencement of the next quarter.

Business owners
Centre for Population Health, Pharmaceutical Regulatory Unit
Contact - Policy: Executive Director, Centre for Population Health (Dr Jo Mitchell)
Contact - Data: Director, Chief Pharmacist Unit (Judith Mackson)

Representation
Data type: Numeric
Form: Percentage
Representational layout: NN.N
Minimum size: 3
Maximum size: 4
Data domain:
<table>
<thead>
<tr>
<th>Date effective</th>
<th>1 January 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>INDICATOR:</td>
<td>MS1302</td>
</tr>
<tr>
<td>-------------</td>
<td>--------</td>
</tr>
<tr>
<td>Previous IDs:</td>
<td>Drug and Alcohol Opioid Treatment Program – Public patients who were prescribed opioid pharmacotherapies (Number)</td>
</tr>
</tbody>
</table>

**Shortened Title**
OTP – Patients Prescribed Opioid Pharmacotherapies

**Service Agreement Type**
Improvement Measure

**Framework Strategy**
Strategy 1: Keep People Healthy

**Framework Objective**
1.3 (Health system response to alcohol and drug use)

**Status**
Final

**Version number**
1.01

**Scope**
All unique public patients in NSW who were prescribed opioid pharmacotherapies under the NSW Opioid Treatment Program.

**Goal**
To monitor rate of unique public patients prescribed opioid pharmacotherapies in the NSW Opioid Treatment Program.

**Desired outcome**
To monitor rate of unique public patients prescribed opioid pharmacotherapies in the public NSW Opioid Treatment Program.

**Primary point of collection**
Number of Authorities to Prescribe Methadone, Buprenorphine or Buprenorphine-naloxone under the NSW Opioid Treatment Program (OTP) submitted to the Pharmaceutical Regulatory Unit.

**Data Collection Source/System**
NSW Controlled Drugs Data Collection (CoDDaC), Electronic Recording and Reporting of Controlled Drugs system (ERRCD).

**Primary data source for analysis**
NSW Controlled Drugs Data Collection (CoDDaC).

**Indicator definition**
Total number of unique public patients for whom an authority is valid to prescribe methadone or buprenorphine under the NSW Opioid Treatment Program.

**Numerator**
- **Numerator definition**: Total Number of unique public patients who were prescribed opioid pharmacotherapies in the NSW Opioid Treatment Program for the last day of the quarter.
- **Numerator source**: NSW Controlled Drugs Data Collection (CoDDaC)
- **Numerator availability**: Quarterly

**Denominator**
- **Denominator definition**: N/A
- **Denominator source**
- **Denominator availability**

**Inclusions**
All unique public patients in NSW who were prescribed opioid pharmacotherapies under the NSW Opioid Treatment Program.
Strategy 1 IMs: Keep People Healthy

Exclusions

N/A

Targets

Target  Maintain or Increase from previous year

- Performing: Increase from previous year
- Under performing: No change
- Not performing: Decrease from previous year

Context

Methadone and buprenorphine are listed in the World Health Organisation Model List of Essential Medications

Related Policies/ Programs

- NSW Treatment Program: Clinical Guidelines for methadone and buprenorphine treatment (2006)
- Medication assisted treatment of opioid dependence (MATOD) (2014)

Useable data available from 1 July 2017

Frequency of Reporting Quarterly

Time lag to available data Quarterly data will be available at the commencement of the next quarter.

Business owners Centre for Population Health, Pharmaceutical Regulatory Unit

- Contact - Policy Executive Director, Centre for Population Health (Dr Jo Mitchell)
- Contact - Data Director, Chief Pharmacist Unit (Judith Mackson)

Representation

- Data type Numeric
- Form Number
- Representational layout N(6)
- Minimum size 1
- Maximum size 6
- Data domain
- Date effective 1 January 2017

Related National Indicator

<table>
<thead>
<tr>
<th>INDICATOR:</th>
<th>MS1403</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous IDs:</td>
<td>MS1401, MS1402, PH-014C</td>
</tr>
</tbody>
</table>

**Hepatitis C Treatment Initiated by a GP (%)**

- Proportion of LHD residents initiating hepatitis C treatment whose prescriber was a General Practitioner

**Shortened Title**
Hepatitis C Treatment Initiated by a GP

**Service Agreement Type**
Improvement Measure

**Framework Strategy**
Strategy 1: Keep People Healthy

**Performance Area**
1.4 (reduce impact of infectious diseases)

**Status**
Final

**Version number**
1.0

**Scope**
All NSW residents with chronic hepatitis C prescribed direct acting antiviral treatments listed under the Pharmaceutical Benefits Scheme (PBS) from 1 March 2016.

**Goal**
To improve the health outcomes of people living with hepatitis C in NSW by providing treatment in a range of settings which can prevent the development of the major life-threatening complications of chronic liver disease including cirrhosis and liver cancer.

**Desired outcome**
Increase the number of people with chronic hepatitis C accessing hepatitis C treatment in NSW; and increase the proportion of people treated through primary care models.

**Primary point of collection**
Pharmaceutical Benefits Scheme (PBS).

**Data Collection Source/System**
PBS Highly Specialised Drugs Program data and Repatriation PBS data prepared by the Commonwealth Department of Health for the NSW Ministry of Health.

**Primary data source for analysis**
PBS data extract provided quarterly by the Commonwealth Department of Health (with a three to six month time lag as the PBS closes off the data three months post the relevant quarter)

**Indicator definition**
The percentage of LHD residents initiating hepatitis C direct acting antiviral treatment whose prescriber was a General Practitioner.

**Numerator**

<table>
<thead>
<tr>
<th>Numerator definition</th>
<th>Total number of LHD residents with chronic hepatitis C initiating hepatitis C direct acting antiviral treatment listed under the PBS whose prescriber was a General Practitioner.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Numerator source</strong></td>
<td>PBS Highly Specialised Drugs Programme data and Repatriation PBS data prepared by the Commonwealth Department of Health</td>
</tr>
<tr>
<td><strong>Numerator availability</strong></td>
<td>Quarterly</td>
</tr>
</tbody>
</table>

**Denominator**

<table>
<thead>
<tr>
<th>Denominator definition</th>
<th>Total number of LHD residents with chronic hepatitis C dispensed hepatitis C direct acting antiviral treatment listed under the PBS.</th>
</tr>
</thead>
</table>

Denominator source: PBS Highly Specialised Drugs Programme data and Repatriation PBS data prepared by the Commonwealth Department of Health

Denominator availability: Quarterly

**Inclusions**
- NSW residents
- PBS dispensing from public hospital, private hospital and community pharmacies
- Hepatitis C direct acting antiviral treatments available through the PBS from 1 March 2016.

**Exclusions**
- Non-PBS dispensing
- People accessing treatment through other sources, including overseas purchase and clinical trials
- Patients who were treated with ‘old’ interferon treatments prior to 1 March 2016.

**Targets**
- Increase from previous year
  - Performing: Increase from previous year
  - Under performing: No change
  - Not performing: Increase from previous year

**Context**
The NSW Government is committed to increasing the number of people accessing hepatitis C treatment by 100% over the lifetime of the NSW Hepatitis C Strategy 2014-2020 (The target was set with a note of it being subject to change once new treatments became available). The strategy includes a priority to increase the proportion of people treated through primary care models.

**Related Policies/ Programs**
- NSW Hepatitis C Strategy 2014 – 2020
- Fourth National Hepatitis C Strategy 2014-2017

**Useable data available from**
- 1 March 2016

**Frequency of Reporting**
- Quarterly

**Time lag to available data**
- Three to six months. The time lag is because the PBS closes off the data three months post the relevant quarter prior to providing to the Centre for Population Health for Analysis.

**Business owners**
- Office of the Chief Health Officer
  - Contact - Policy
  - Contact - Data

**Representation**
- Data type: Numeric
- Form: Number
- Representational layout: NN(NNNN)
- Minimum size: 2
### 2018-19 Service Performance Agreements
#### Strategy 1 IMs: Keep People Healthy

<table>
<thead>
<tr>
<th>Maximum size</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data domain</td>
<td>N/A</td>
</tr>
<tr>
<td>Date effective</td>
<td>July 2017</td>
</tr>
</tbody>
</table>

**Related National Indicators**

Indicator: N/A
### 2018-19 Service Performance Agreements
#### Strategy 1 IMs: Keep People Healthy

<table>
<thead>
<tr>
<th>INDICATOR:</th>
<th>SPH001, SPH003</th>
</tr>
</thead>
</table>

**Previous IDs:**
- Children fully immunised at one year of age

**Shortened Title**
- Children fully immunised at one year of age

**Service Agreement Type**
- Improvement Measure

**Framework Strategy**
- Strategy 1: Keep People Healthy

**Framework Objective**
- 1.4 (Reduce impact of infectious diseases)

**Status**
- Final

**Version number**
- 1.2

**Scope**
- All children 12-15 months.

**Goal**
To reduce the incidence of vaccine preventable diseases in children and increase immunisation coverage rates through the implementation of a National Immunisation Program.

**Desired outcome**
- Reduce illness and death from vaccine preventable diseases in children.

**Primary point of collection**
- Data collected by General Practitioners, Community Health Centres, Aboriginal Medical Centres and local government councils.

**Data Collection Source/System**
- Forms and electronic submissions to Australian Immunisation Register (AIR)

**Primary data source for analysis**
- Australian Immunisation Register

**Indicator definition**
The percentage of children aged 12 to 15 months who are registered with Medicare and have received all age appropriate vaccinations as prescribed by the Australian Immunisation Register, disaggregated by Aboriginality.

#### Numerator

<table>
<thead>
<tr>
<th>Numerator definition</th>
<th>(i) Number of Aboriginal children aged 12 to 15 months who have received all age appropriate vaccinations as prescribed by the Australian Immunisation Register.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(ii) Number of Non-Aboriginal children aged 12 to 15 months who have received all age appropriate vaccinations as prescribed by the Australian Immunisation Register.</td>
</tr>
</tbody>
</table>

**Numerator source**
- Australian Immunisation Register

**Numerator availability**
- Available

#### Denominator

<table>
<thead>
<tr>
<th>Denominator definition</th>
<th>(i) Aboriginal children registered with Medicare Australia in 12 to 15 months age group.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(ii) Non-Aboriginal children registered with Medicare Australia in 12 to 15 months age group.</td>
</tr>
</tbody>
</table>

**Denominator source**
- Medicare Australia
### 2018-19 Service Performance Agreements

**Strategy 1 IMs: Keep People Healthy**

#### Denominator availability
Available

#### Inclusions
All children 12 to 15 months of age

#### Exclusions
- Children aged <12 months or > 15 months
- Vaccinations which are not prescribed by Australian Immunisation Register

### Targets

<table>
<thead>
<tr>
<th>Target</th>
<th>94%*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comments</td>
<td>Note that new national targets have been set (95%) and that LHDs that have achieved 94% should be striving for 95% coverage.</td>
</tr>
</tbody>
</table>

*Note that for Northern NSW the target is to maintain or improve 2017-18 coverage for non-Aboriginal children.*

#### Context
Although there has been substantial progress in reducing the incidence of vaccine preventable disease in NSW it is an ongoing challenge to ensure optimal coverage of childhood immunisation.

#### Related Policies/ Programs
National Immunisation Program

#### Useable data available from
2005

#### Frequency of Reporting
Quarterly

#### Time lag to available data
90 days, available August for previous financial year

#### Business owners
**Health Protection NSW**
- Contact - Policy: Manager, Immunisation Unit (Sue Campbell-Lloyd)
- Contact - Data: Manager, Immunisation Unit (Sue Campbell-Lloyd)

#### Representation
<table>
<thead>
<tr>
<th>Data type</th>
<th>Numeric</th>
</tr>
</thead>
<tbody>
<tr>
<td>Form</td>
<td>Number, presented as a percentage (%)</td>
</tr>
<tr>
<td>Representational layout</td>
<td>NNN.NN</td>
</tr>
<tr>
<td>Minimum size</td>
<td>4</td>
</tr>
<tr>
<td>Maximum size</td>
<td>6</td>
</tr>
<tr>
<td>Data domain</td>
<td>N/A</td>
</tr>
<tr>
<td>Date effective</td>
<td>1 July 2014</td>
</tr>
</tbody>
</table>

#### Related National Indicator
**Indicator**
Performance Benchmark 1. Maintaining or increasing vaccination coverage for Indigenous Australians

**Source**
National Partnership Agreement on Essential Vaccines
| INDICATOR: SPH002, SPH004 | **Children fully immunised at four years of age:** Percentage (%) of children fully immunised at 60 to 63 months of age*, disaggregated by:
- Aboriginal children
- Non-Aboriginal children |

**Previous IDs:** Children fully immunised at four years of age

**Shortened Title** | Children fully immunised at four years of age

**Service Agreement Type** | Improvement Measure

**Framework Strategy** | Strategy 1: Keep People Healthy

**Framework Objective** | 1.4 (Reduce impact of infectious diseases)

| **Status** | Final
| **Version number** | 1.3
| **Scope** | All children 60-63 months.
| **Goal** | To reduce the incidence of vaccine preventable diseases in children and increase immunisation coverage rates through the implementation of a National Immunisation Program.
| **Desired outcome** | Reduce illness and death from vaccine preventable diseases in children.

**Primary point of collection** | Data collected by General Practitioners, Community Health Centres, Aboriginal Medical Centres and local government councils.

**Data Collection Source/System** | Forms and electronic submissions to Australian Immunisation Register (AIR)

**Primary data source for analysis** | Australian Immunisation Register

**Indicator definition** | The percentage of children aged 60 to 63 months who are registered with Medicare and have received all age appropriate vaccinations as prescribed by the Australian Immunisation Register, disaggregated by Aboriginality.

*Note that this item measures uptake of the vaccines due at 4 years of age by the time the child turns 5 years and 3 months.*

**Numerator**

| Numerator definition | (i) Number of Aboriginal children aged 60 to 63 months who have received all age appropriate vaccinations as prescribed by the Australian Immunisation Register.

| Numerator definition | (ii) Number of Non-Aboriginal children aged 60 to 63 months who have received all age appropriate vaccinations as prescribed by the Australian Immunisation Register (corrected for known under-reporting by HPNSW).

**Numerator source** | Australian Immunisation Register

**Numerator availability** | Available

**Denominator**
Denominator definition

(i) Aboriginal children registered with Medicare Australia in 60 to 63 months age group.

(ii) Non-Aboriginal children registered with Medicare Australia in 60 to 63 months age group.

Denominator source
Medicare Australia

Denominator availability
Available

Inclusions
All children 60 to 63 months of age

Exclusions
- Children aged < 60 months or > 63 months
- Vaccinations which are not prescribed by Australian Immunisation Register

Targets

<table>
<thead>
<tr>
<th>Target</th>
<th>94%*</th>
</tr>
</thead>
</table>

Comments
Note that new national targets have been set (95%) and that LHDs that have achieved 94% should be striving for 95% coverage.

*Note that for Northern NSW the target is to maintain or improve 2017-18 coverage for non-Aboriginal children.

Context
Although there has been substantial progress in reducing the incidence of vaccine preventable disease in NSW it is an ongoing challenge to ensure optimal coverage of childhood immunisation.

Related Policies/Programs
National Immunisation Program

Useable data available from
2005

Frequency of Reporting
Quarterly

Time lag to available data
90 days, available August for previous financial year

Business owners
Health Protection NSW
Manager, Immunisation Unit (Sue Campbell-Lloyd)

Contact - Policy
Manager, Immunisation Unit (Sue Campbell-Lloyd)

Contact - Data

Representation

Data type
Numeric

Form
Number, presented as a percentage (%)

Representational layout
NNN.NN

Minimum size
4

Maximum size
6

Data domain
N/A

Date effective
1 July 2014

Related National Indicator
Indicator
Performance Benchmark 1. Maintaining or increasing vaccination coverage for Indigenous Australians
| Source | National Partnership Agreement on Essential Vaccines |
**INDICATOR:** PH-006

**Human Papillomavirus Vaccination:**
- Percentage of year 7 students receiving the second dose through the Adolescent Vaccination Program (%)

**Shortened Title**
Human Papillomavirus Vaccination

**Service Agreement Type**
Improvement Measure

**Framework Strategy**
Strategy 1: Keep People Healthy

**Framework Objective**
1.4 (Reduce impact of infectious diseases)

**Status**
Final

**Version number**
1.4

**Scope**
All students enrolled in Year 7 at a NSW school.

**Goal**
To reduce the incidence of vaccine preventable diseases in children and increase immunisation coverage rates through the implementation of a National Immunisation Program.

**Desired outcome**
Reduce illness and death associated with human papillomavirus (HPV).

**Primary point of collection**
Data collected by NSW Public Health Units

**Data Collection Source/System**
Submissions to NSW Ministry of Health

**Primary data source for analysis**
NSW Ministry of Health

**Indicator definition**
The percentage of students enrolled in Year 7 at a NSW school who have received a second dose of human papillomavirus vaccine.

**Numerator**
- **Numerator definition**
  Number of students enrolled in Year 7 at a NSW school who have received a second dose of human papillomavirus vaccine.
- **Numerator source**
  NSW Public Health Units
- **Numerator availability**

**Denominator**
- **Denominator definition**
  Number of students enrolled in Year 7 at a NSW school at the end of Term 1.
- **Denominator source**
  NSW Public Health Units
- **Denominator availability**
  Available

**Inclusions**
All students enrolled in Year 7 in schools participating in the Adolescent Vaccination Program

**Exclusions**
Students vaccinated by other immunisation service providers

**Targets**
- **Target**
  80%

**Context**
Although there has been substantial progress in reducing the incidence of vaccine preventable disease in NSW it is an ongoing challenge to ensure optimal coverage.
<table>
<thead>
<tr>
<th><strong>Related Policies/ Programs</strong></th>
<th>National Immunisation Program</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Useable data available from</strong></td>
<td>2013</td>
</tr>
<tr>
<td><strong>Frequency of Reporting</strong></td>
<td>Annually</td>
</tr>
<tr>
<td><strong>Time lag to available data</strong></td>
<td>Available August for previous eighteen months.</td>
</tr>
<tr>
<td><strong>Business owners</strong></td>
<td>Health Protection NSW</td>
</tr>
<tr>
<td>Contact - Policy</td>
<td>Manager, Immunisation Unit (Sue Campbell-Lloyd)</td>
</tr>
<tr>
<td>Contact - Data</td>
<td>Manager, Immunisation Unit (Sue Campbell-Lloyd)</td>
</tr>
</tbody>
</table>

**Representation**
- **Data type**: Numeric
- **Form**: Number, presented as a percentage (%)
- **Representational layout**: NNN.NN
- **Minimum size**: 4
- **Maximum size**: 6
- **Data domain**: N/A
- **Date effective**: N/A

**Related National Indicator**
INDICATOR: DPH_1402
Previous IDs: Meningococcal Vaccination - Coverage in Years 10 and 11 for serogroups A, C, W, Y (%)

Shortened Title
Meningococcal Vaccination

Service Agreement Type
Improvement Measure

Framework Strategy
Strategy 1: Keep People Healthy

Framework Objective
1.4 (Reduce impact of infectious diseases)

Status
Final

Version number
1.2

Scope
All students enrolled at a NSW high school in the reporting period in:
- Year 10 and
- Year 11.

Goal
To reduce the incidence of vaccine preventable diseases in children and increase immunisation coverage rates through the implementation of a school based vaccination program.

Desired outcome
Reduce illness and death associated with meningococcal W disease in the target population.

Primary point of collection
Data collected by NSW Public Health Units

Data Collection Source/System
Submissions by Public Health Units to Health Protection NSW

Primary data source for analysis
Health Protection NSW

Indicator definition
The percentage of students enrolled at a NSW school in Year 10 and Year 11 who have received a dose of meningococcal ACWY vaccine.

Numerator
Numerator definition
The percentage of students enrolled at a NSW school in Year 10 and Year 11 who have received a dose of meningococcal ACWY vaccine.

Numerator source
NSW Public Health Units

Numerator availability
Available annually

Denominator
Denominator definition
Number of students enrolled in Year 10 and Year 11 at a NSW school at the beginning of Term 1.

Denominator source
NSW Public Health Units

Denominator availability
Available

Inclusions
All students enrolled in Year 10 and Year 11 in schools participating in the NSW School Vaccination Program.

Exclusions
Students vaccinated by other service providers outside of school program.

Targets
### Target
75% for each LHD and NSW as a whole

### Context
Although there has been substantial progress in reducing the incidence of vaccine preventable disease in NSW it is an ongoing challenge to ensure optimal coverage.

### Related Policies/Programs
Useable data available from
May 2017

### Frequency of Reporting
Yearly

### Time lag to available data
Available February for previous 12 months

### Business owners
**Health Protection NSW**
- Contact - Policy: Manager, Immunisation Unit (Sue Campbell-Lloyd)
- Contact - Data: Manager, Immunisation Unit (Sue Campbell-Lloyd)

### Representation
- **Data type**: Numeric
- **Form**: Number, presented as a percentage (%)
- **Representational layout**: NNN.NN
- **Minimum size**: 4
- **Maximum size**: 6
- **Data domain**: 
- **Date effective**:  

### Related National Indicator
N/A
**INDICATOR:** KF-001

**Previous ID:**

**Aboriginal Maternal Infant Health Services** - Women with Aboriginal babies accessing the service (Number)

**Shortened Title**
Women with Aboriginal Babies Accessing AMIHS

**Service Agreement Type**
Improvement Measure

**Framework Strategy**
Strategy 1: Keep People Healthy

**Framework Objective**
1.5 (Embed Aboriginal cultural concepts of health in programs)

**Status**
Final

**Version number**
1.01

**Scope**
Eligible pregnant women offered an Aboriginal Maternal Infant Health Service

**Goal**
Maintain current level of service delivery.

**Desired outcome**
Eligible pregnant women receive an Aboriginal Maternal Infant Health Service

**Primary point of collection**
Aboriginal Maternal and Infant Health Services

**Data Collection Source/System**
Aboriginal Maternal and Infant Health Service Data Collection

**Primary data source for analysis**
eMaternity

**Indicator definition**
The number of new clients registered in an Aboriginal Maternal Infant Health Service.

**Numerator**

**Numerator definition**
Total number of new clients (pregnant women who identify their baby as Aboriginal) admitted to the Aboriginal Maternal Infant Health Service.

**Numerator source**

**Numerator availability**

**Denominator**

**Denominator definition**
N/A

**Denominator source**

**Denominator availability**

**Inclusions**
Non Aboriginal mothers who identify their baby/ies as Aboriginal

**Exclusions**
Pregnant women who do not identify their baby/ies as Aboriginal

**Targets**
N/A

**Context**
The Aboriginal Maternal and Infant Health Service is a community-based maternity service, with a midwife and Aboriginal Health Worker working in partnership with Aboriginal families to provide culturally appropriate and respectful care for Aboriginal women and babies.

**Related Policies/ Programs**
PD2010_017 Maternal & Child Health Primary Health Care Policy

**Useable data available from**
2014
### Frequency of Reporting
Quarterly

### Time lag to available data
3 months

### Business owners
**Health and Social Policy Branch**
- **Contact - Policy**: Director, Maternity, Child Youth & Paediatrics
- **Contact - Data**: Director, Maternity, Child Youth & Paediatrics

### Representation
- **Data type**: Numeric
- **Form**: Number
- **Representational layout**: N[7]
- **Minimum size**: 2
- **Maximum size**: 7
- **Data domain**: N/A
- **Date effective**: N/A

### Related National Indicators
- **Indicator**: N/A

### Source
**INDICATOR:** KF-002

<table>
<thead>
<tr>
<th>Previous ID:</th>
</tr>
</thead>
</table>

| **Building Strong Foundations for Aboriginal Children, Families and Communities – Children enrolled (Number)** |

**Shortened Title**
Building Strong Foundations – Children enrolled

**Service Agreement Type**
Improvement Measure

**Framework Strategy**
Strategy 1: Keep People Healthy

**Framework Objective**
1.5 (Embed Aboriginal cultural concepts of health in programs)

**Status**
Final

**Version number**
1.0

**Scope**

**Goal**
Maintain current level of service delivery.

**Desired outcome**
Aims to ensure that local Aboriginal children and families have improved access to culturally appropriate child and family health care so that Aboriginal children are healthy and ready to learn when they start school.

**Primary point of collection**
Building Strong Foundations for Aboriginal Communities, Families and Communities Services (child and family health nurses)

**Data Collection Source/System**
Excel spreadsheet OR CHOC system where LHD has installed the update that includes the extract

**Primary data source for analysis**
Excel spreadsheet

**Indicator definition**
The number of new clients (incident cases) enrolled in the Building Strong Foundations service.

**Numerator**

**Numerator definition**
Total number of new clients (incident cases) enrolled in the Building Strong Foundations service during the reporting period.

**Numerator source**
Excel spreadsheet

**Numerator availability**
Quarterly

**Denominator**

**Denominator definition**
N/A

**Denominator source**

**Denominator availability**

**Inclusions**
As per the data dictionary provided with the spreadsheet.

**Exclusions**
As per the data dictionary provided with the spreadsheet

**Targets**
As agreed with the Health and Social Policy Branch.

The set target is estimated using the data supplied by Services as part of their Annual Report requirements.

**Context**
Building Strong Foundations provides culturally appropriate early childhood health services for Aboriginal children, birth to school entry age and their families.
<table>
<thead>
<tr>
<th><strong>Related Policies/ Programs</strong></th>
<th>PD2016_013 Building Strong Foundations (BSF) Program Service Standards</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Useable data available from</strong></td>
<td>2015</td>
</tr>
<tr>
<td><strong>Time lag to available data</strong></td>
<td>12 months</td>
</tr>
<tr>
<td>Contact - Policy</td>
<td>Deborah Matha, Director, Maternity, Child Youth &amp; Paediatrics</td>
</tr>
<tr>
<td>Contact - Data</td>
<td>Deborah Matha, Director, Maternity, Child Youth &amp; Paediatrics</td>
</tr>
<tr>
<td><strong>Representation</strong></td>
<td></td>
</tr>
<tr>
<td>Data type</td>
<td>Numeric</td>
</tr>
<tr>
<td>Form</td>
<td>Number</td>
</tr>
<tr>
<td>Representational layout</td>
<td>N[7]</td>
</tr>
<tr>
<td>Minimum size</td>
<td>2</td>
</tr>
<tr>
<td>Maximum size</td>
<td>7</td>
</tr>
<tr>
<td>Data domain</td>
<td>N/A</td>
</tr>
<tr>
<td>Date effective</td>
<td></td>
</tr>
</tbody>
</table>

Source
**INDICATOR:** SPH008, SPH009, SPH010, SPH011

### Comprehensive Antenatal Visits - for all pregnant women before 14 weeks gestation:

First comprehensive antenatal visit provided before 14 weeks gestation (%) for all women who:
- are Aboriginal (**SPH008**)
- are non-Aboriginal with an Aboriginal baby (**SPH009**)
- are Non-Aboriginal with a non-Aboriginal baby (**SPH010**)
- All women (**SPH011**)

### Shortened Title
Comprehensive Antenatal Visits

### Service Agreement Type
Improvement Measure

### Framework Strategy
Strategy 1: Keep People Healthy

### Framework Objective
1.5 (Embed Aboriginal cultural concepts of health in programs)

### Status
Final

### Version number
2.1

### Scope
All mothers giving birth to babies in NSW

### Goal
- To increase the proportion of women giving birth receiving care early in pregnancy.
- To increase the proportion of Aboriginal and non-Aboriginal women giving birth to Aboriginal babies receiving care early in pregnancy.
- Reduced rates of perinatal mortality, preterm birth and low birth weight in Aboriginal babies.

### Version number
1.0

### Primary point of collection
NSW Aboriginal Maternal and Infant Health Service midwives, hospitals’ midwives and independent midwives.

### Data Collection Source/System
- Department of Health: MDCOS (Perinatal Data Collection Online System)

### Primary data source for analysis
NSW Perinatal Data Collection (SaPHaRI)

### Indicator definition
Percentage of women who gave birth where an antenatal visit was reported in the first trimester (up to and including 13 completed weeks), for at least one live or stillborn baby.

Aboriginal means reported as Aboriginal or Torres Strait Islander.

Birth means live birth or stillbirth.

First trimester means up to and including 13 completed weeks.

This indicator is reported for:
- Aboriginal women
- Non-Aboriginal women giving birth to Aboriginal babies
- Non-Aboriginal women giving birth to non-Aboriginal babies
- All women giving birth

**Numerator**
| Numerator definition | (a) Number of Aboriginal women who gave birth where an antenatal visit was reported in the first trimester  
(b) Number of non-Aboriginal women who gave birth to an Aboriginal baby where an antenatal visit was reported in the first trimester  
(c) Number of non-Aboriginal women who gave birth to a non-Aboriginal baby where an antenatal visit was reported in the first trimester  
(d) Number of women who gave birth where an antenatal visit was reported in the first trimester |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator source</td>
<td>NSW Perinatal Data Collection</td>
</tr>
<tr>
<td>Numerator availability</td>
<td>Annually</td>
</tr>
<tr>
<td><strong>Denominator</strong></td>
<td></td>
</tr>
</tbody>
</table>
| Denominator definition| (a) Number of Aboriginal women who gave birth  
(b) Number of non-Aboriginal women who gave birth to an Aboriginal baby  
(c) Number of non-Aboriginal women who gave birth to a non-Aboriginal baby  
(d) Number of women who gave birth |
| Denominator source   | NSW Perinatal Data Collection                                                                    |
| Denominator availability| Annually                                                                                         |
| **Inclusions**       | Women giving birth to babies in NSW, regardless of their place of residence                     |
| **Exclusions**       | Women giving birth outside NSW, who normally reside in NSW                                       |
| **Reporting**        |                                                                                                  |
| Reporting required by LHDs | Yes                                                                                         |
| Indicators reported to | Health Statistics NSW                                                                           |
| Next report due      | Ongoing                                                                                         |
| **Targets**          |                                                                                                  |
| Target               | LHDs to bring performance to 90% - 100% over 3-5 years                                           |
| Time frame for target| Yearly                                                                                           |
| Lower /upper age limit| N/A                                                                                             |
| Sex                  | Female                                                                                           |
| Geographical area of interest | Whole State/LHD/Medicare Locals                                                                     |
| Comments             | Antenatal visits are well established as a means of improving perinatal outcomes. Social disadvantage and family disruption are continuing effects of government policies that have contributed to Aboriginal peoples having the worst health status of any identifiable group in Australia and the poorest access to services. There is evidence that Aboriginal women attend fewer antenatal visits compared with non-Aboriginal women. National guidelines recommend that the first antenatal visit occur before 10 weeks pregnancy to meet high information needs in early pregnancy and allow arrangements to be made for tests that are most effective early in the pregnancy. The criteria for the first comprehensive antenatal visit can be found on pages 37-38 of the |
Australian Government’s 2012 National Clinical Practice Guidelines Antenatal Care – Module 1

**Related Policies/ Programs**
COAG Closing the Gap, AWMAC Clinical Practice Guidelines – Antenatal Care (Module 1)

**Major existing uses**
- Quit for New Life Program Evaluation
- Health Statistics NSW

**Useable data available from**
2012

**Frequency of Reporting**
Annual

**Time lag to available data**
Usual: 7 months following the close of the 6-month period ie January for January-June of the previous year, and July for July to December of the previous year.

**Business owners**
Office of the Chief Health Officer
Manager Priority Populations NSW Kids and Families (Elizabeth Best)
Associate Director, Epidemiology and Biostatistics

**Representation**
- **Data type**: Numeric
- **Form**: Number, presented as a percentage (%)
- **Representational layout**: NNN.NN
- **Minimum size**: 4
- **Maximum size**: 6

**Documentation of indicator**
- **Source**: NSW Perinatal Data Collection (SAPHaRI)
- **Source identification**: Centre for Epidemiology and Evidence
- **Planned review date**: 2015

**Related National Indicators**
National Indigenous Reform Agreement: PI 09-Antenatal care, 2018
http://meteor.aihw.gov.au/content/index.phtml/itemId/668683
Quality of Aboriginal Identification in Reported Data (%):

- Aboriginal people correctly reported in admitted patient data (%)

Shortened Title: Quality of Aboriginal Identification in Data

Service Agreement Type: Improvement Measure
Framework Strategy: Strategy 1: Keep People Healthy
Framework Objective: 1.5 (Embed Aboriginal cultural concepts of health in programs)

Status: Final
Version number: 1.01

Scope: All admitted patients

Goal: To improve the reliability of Aboriginal people’s data

Desired outcome: Improved reporting of Aboriginal people in admitted patient data

Primary point of collection: Patient Medical Record

Data Collection Source/System: Hospital PAS system, Admitted Patient Data Collection, administrative health datasets linked by the Centre for Health Record Linkage (CHeReL)

Primary data source for analysis: The Hospital Performance and Evaluation Dataset (HOPED).

Indicator definition: The number of admitted patient dataset records reported for Aboriginal people compared to the number of episodes expected for Aboriginal people, expressed as a percentage.

**Numerator**
- Numerator definition: Number of admitted patient dataset records reported for Aboriginal people in the reporting period.
- Numerator source: Admitted Patient Data in the Hospital Performance and Evaluation Dataset (HOPED)
- Numerator availability: HOPED is updated 3 months after the close of the quarter.

**Denominator**
- Denominator definition: The number of admitted patient dataset records where the Enhanced Reporting of Aboriginality Variable reports patients as Aboriginal.
- Denominator source: Admitted Patient Data in the Hospital Performance and Evaluation Dataset (HOPED).
- Denominator availability: HOPED is updated 3 months after the close of the quarter.

**Inclusions**: All admitted patient episodes.

**Exclusions**: N/A

**Targets**: 1% improvement per year

**Context**: Provides evidence of the health status of Aboriginal people, and respectful,
responsive and culturally sensitive services.

**Related Policies/Programs**  
NSW Aboriginal Health Plan 2013-2013

**Useable data available from**  
Currently

**Frequency of Reporting**  
Quarterly

**Time lag to available data**  
Data available 3 months after the close of the quarter. Reporting available 4 months after the close of the quarter

**Business owners**
- **Contact - Policy**  
  Director, Centre for Aboriginal Health
- **Contact - Data**  
  Principal Analyst, Strategic Information, Centre for Epidemiology and Evidence

**Representation**
- **Data type**  
  Numeric
- **Form**  
  Number, expressed as a percentage
- **Representational layout**  
  NN.N
- **Minimum size**  
  3
- **Maximum size**  
  4
- **Data domain**
- **Date effective**  
  1 July 2017

**Related National Indicators**

Components
### STRATEGY 2 IMs: Provide World-Class Clinical Care Where Patient Safety is First

**INDICATOR:** SSQ114, SSQ118

**Previous IDs:**

- Inpatients Discharged Against Medical Advice (%)
  
  The proportion of patients who discharge from hospital against medical advice, reported by:
  - Aboriginal People (SSQ114)
  - Non-Aboriginal People (SSQ118)

**Shortened Title**

Patients Discharged Against Medical Advice

**Service Agreement Type**

Improvement Measure

**Framework Strategy**

Strategy 2: Provide World-Class Clinical Care Where Patient Safety is First

**Framework Objective**

2.1 (Embed quality improvement to ensure safer patient care)

**Status**

Final

**Version number**

1.21

**Scope**

Admitted patients, all public hospitals

**Goal**

Decrease the proportion of hospitalisations for Aboriginal people that result in discharge against medical advice. Provide effective and appropriate inpatient health services to Aboriginal people.

**Desired outcome**

Reduce the risk for Aboriginal people of adverse health outcomes associated with discharge against medical advice

**Primary point of collection**

The primary business collection point of the data

Initial source/point / person of collecting data (eg: Medical record, clerk, operator).

**Data Collection Source/System**

Local Health Districts: Patient Medical record, Hospital PAS System

NSW Ministry of Health: NSW Admitted Patient Data Collection

**Primary data source for analysis**

HIE / EDWARD

NSW Admitted Patient Data Collection (SAPHaRI)

**Indicator definition**

Proportion of hospitalisations of Aboriginal patients ending in discharge against medical advice during the reporting period as compared to the proportion of hospitalisations of non-Aboriginal patients ending in discharge against medical advice during the same reporting period.

Indicator is reported separately for:

(i) % of all Aboriginal people who were discharged against medical advice

(ii) % of all non-Aboriginal people who were discharged against medical advice

Note that Aboriginal people include people who identify as Aboriginal and/or Torres Strait Islander.
### Numerator definition

(i) Number of episodes of admitted patient care for Aboriginal people where the mode of separation is recorded as “left against medical advice / discharge at own risk” during the reporting period.

(ii) Number of episodes of admitted patient care for non-Aboriginal people where the mode of separation is recorded as “left against medical advice / discharge at own risk” during the reporting period.


### Numerator source

Hospital PAS Systems. HIE / EDWARD. NSW Admitted Patient Data Collection (SAPHaRI)

### Numerator availability

Data routinely collected and available

### Denominator

(i) The total number of episodes of admitted patient care for Aboriginal people during the reporting period.

(ii) The total number of episodes of admitted patient care for non-Aboriginal people during the reporting period.

### Denominator source

Hospital PAS Systems. HIE / EDWARD. NSW Admitted Patient Data Collection (SAPHaRI)

### Denominator availability

Data routinely collected and available

### Inclusions

All patients admitted to public hospital facilities in NSW

### Exclusions

None

### Targets

Target

To close the gap in rates of discharge against medical advice between Aboriginal and non-Aboriginal people at the LHD and state level.

### Geographical area of interest

Whole state / LHDs

### Comments

Data are not age standardised

### Context

Discharge against medical advice involves patients who have been admitted to hospital who leave against the expressed advice of their treating physician. Patients who discharge against medical advice have higher readmission rates, higher levels of multiple admissions, and a higher rate of in-hospital mortality. This measure provides indirect evidence of the cultural competence of hospital services, and the extent of patient satisfaction with the quality of care provided.

### Related Policies/ Programs

Council of Australian Government National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes.

### Useable data available from

2000

### Frequency of Reporting

Three-monthly
### Time lag to available data
Data fed to HIE weekly, but data entry may be several months late.

### Business owners

<table>
<thead>
<tr>
<th>Contact - Policy</th>
<th>Director, Centre for Aboriginal Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact - Data</td>
<td>• Executive Director, System Information and Analytics</td>
</tr>
<tr>
<td></td>
<td>• Director, Evidence and Evaluation Branch, Centre for Epidemiology and Evidence</td>
</tr>
</tbody>
</table>

### Representation

<table>
<thead>
<tr>
<th>Data type</th>
<th>Numeric</th>
</tr>
</thead>
<tbody>
<tr>
<td>Form</td>
<td>Number, presented as a percentage</td>
</tr>
<tr>
<td>Representational layout</td>
<td>NNN.NN</td>
</tr>
<tr>
<td>Minimum size</td>
<td>3</td>
</tr>
<tr>
<td>Maximum size</td>
<td>6</td>
</tr>
<tr>
<td>Date effective</td>
<td>2013</td>
</tr>
</tbody>
</table>

### Documentation of indicator:

<table>
<thead>
<tr>
<th>Source</th>
<th>NSW Chief Health Officers Report 2012 and Health Statistics NSW</th>
</tr>
</thead>
<tbody>
<tr>
<td>Publisher</td>
<td>Centre for Epidemiology and Evidence</td>
</tr>
<tr>
<td>Planned review date:</td>
<td>2014</td>
</tr>
</tbody>
</table>
**Staphylococcus Aureus Bloodstream Infections (SA-BSI):**

- A1 – C2 facilities (per 10,000 occupied bed days)
- D1a – F8 facilities (per 10,000 occupied bed days)

**Indicators:** KQS101

**Previous IDs:** 9A15, 9A16, 0005

<table>
<thead>
<tr>
<th>Shortened Title</th>
<th>Staphylococcus Aureus Bloodstream Infections</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Service Agreement Type</strong></td>
<td>Improvement Measure</td>
</tr>
<tr>
<td><strong>Framework Strategy</strong></td>
<td>Strategy 2: Provide World-Class Clinical Care Where Patient Safety is First</td>
</tr>
<tr>
<td><strong>Framework Objective</strong></td>
<td>2.1 (Embed quality improvement to ensure safer patient care)</td>
</tr>
<tr>
<td><strong>Status</strong></td>
<td>Final</td>
</tr>
<tr>
<td><strong>Version number</strong></td>
<td>1.22</td>
</tr>
<tr>
<td><strong>Scope</strong></td>
<td>All patients in hospitals</td>
</tr>
<tr>
<td><strong>Goal</strong></td>
<td>To minimize the risks and unnecessary morbidity and mortality from healthcare associated infections (HAI) in NSW public healthcare facilities through implementation of infection control practices.</td>
</tr>
<tr>
<td><strong>Desired outcome</strong></td>
<td>Reduction in the number of <em>Staphylococcus aureus</em> bloodstream infections</td>
</tr>
<tr>
<td><strong>Primary point of collection</strong></td>
<td>Health staff in all NSW public healthcare facilities</td>
</tr>
<tr>
<td><strong>Data Collection Source/System</strong></td>
<td>HAI Monthly Data Collection, NSW Health</td>
</tr>
<tr>
<td><strong>Primary data source for analysis</strong></td>
<td>HAI Monthly Data Collection, NSW Health</td>
</tr>
<tr>
<td><strong>Indicator definition</strong></td>
<td>The number of SA-BSI as a rate of the number of occupied bed days</td>
</tr>
<tr>
<td><strong>Numerator</strong></td>
<td>Number of <em>Staphylococcus aureus</em> bloodstream infections (SA-BSI)</td>
</tr>
<tr>
<td><strong>Numerator source</strong></td>
<td>NSW public healthcare facilities</td>
</tr>
<tr>
<td><strong>Numerator availability</strong></td>
<td>Monthly, available from 1 January 2009</td>
</tr>
<tr>
<td><strong>Denominator</strong></td>
<td>Number of occupied bed days</td>
</tr>
<tr>
<td><strong>Denominator source</strong></td>
<td>Health System Information and Performance Reporting Branch, NSW Health</td>
</tr>
<tr>
<td><strong>Denominator availability</strong></td>
<td>Monthly</td>
</tr>
</tbody>
</table>

**Inclusions**
- Healthcare associated inpatient bloodstream infections caused by *Staphylococcus aureus*:
  - Methicillin sensitive *Staphylococcus aureus* (MSSA)
  - Methicillin resistant *Staphylococcus aureus* (MRSA)
- Healthcare associated non-inpatient MSSA and MRSA bloodstream infections

**Exclusions**
- Community associated MSSA and MRSA bloodstream infections

**Targets**

*Next report due: Monthly from data availability*
Target

Less than 2 SA-BSI per 10,000 occupied bed days

Performing: < 2 SA-BSI
Not performing: >= 2 SA-BSI

Comments
The incidence of SA-BSI provides an indication of compliance with hand hygiene and aseptic technique requirements.

Context
- *Staphylococcus aureus*, a bacterium that commonly colonises human skin and mucosa, is amongst the commonest and more serious causes of community and healthcare associated sepsis.
- Incidence of healthcare associated SA-BSI is used as an outcome marker for hand hygiene compliance of healthcare workers.

Related Policies/ Programs
- *NSW Health Hand Hygiene Policy*
- *Healthcare Associated Infection: Clinical Indicator Manual, version 2.0 November 2008*

Useable data available from
2009

Frequency of Reporting
Monthly

Time lag to available data
Reporting data available one month post last reporting period

Business owners
Clinical Excellence Commission

Contact - Policy
Director, Clinical Governance, Clinical Excellence Commission (Dr Paul Curtis)

Contact - Data
Director, Clinical Governance, Clinical Excellence Commission (Dr Paul Curtis), and Executive Director, Health System Information and Performance Reporting (Mr Ray Messom)

Representation
Data type
Numeric
Form
Number, presented as a rate per 10,000 occupied bed days
Representational layout
X.X
Minimum size
1
Maximum size
2
Date effective
January 2009
### Related National Indicator

<table>
<thead>
<tr>
<th>Indicators</th>
<th>National Healthcare Agreement: PI 22–Healthcare associated infections: Staphylococcus aureus bacteraemia, 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><a href="http://meteor.aihw.gov.au/content/index.phtml/itemId/658487">http://meteor.aihw.gov.au/content/index.phtml/itemId/658487</a></td>
</tr>
<tr>
<td></td>
<td>Meteor ID: 658487</td>
</tr>
<tr>
<td>Shortened Title</td>
<td>ICU CLAB Infections</td>
</tr>
<tr>
<td>-----------------------</td>
<td>----------------------------------------------------------</td>
</tr>
<tr>
<td>Service Agreement Type</td>
<td>Improvement Measure</td>
</tr>
<tr>
<td>Framework Strategy</td>
<td>Strategy 2: Provide World-Class Clinical Care Where Patient Safety is First</td>
</tr>
<tr>
<td>Framework Objective</td>
<td>2.1 (Embed quality improvement to ensure safer patient care)</td>
</tr>
<tr>
<td>Status</td>
<td>Final</td>
</tr>
<tr>
<td>Version number</td>
<td>2.11</td>
</tr>
<tr>
<td>Scope</td>
<td>All intensive care unit (ICU) patients in hospitals.</td>
</tr>
<tr>
<td>Goal</td>
<td>To minimise the risks and unnecessary morbidity and mortality from healthcare associated infections (HAI) in NSW public healthcare facilities through implementation of standardised procedures for insertion and post insertion care of centrally inserted central lines.</td>
</tr>
<tr>
<td>Desired outcome</td>
<td>Reduction in ICU centrally inserted Central Line Associated Bloodstream (CLAB) infections</td>
</tr>
<tr>
<td>Primary point of collection</td>
<td>Health staff in level 5 &amp; level 6 ICUs including the Specialist Children's Hospitals (Children Hospital at Westmead, Sydney Children's Hospital and John Hunter Hospital)</td>
</tr>
<tr>
<td>Data Collection Source/System</td>
<td>HAI Monthly Data Collection, NSW Health</td>
</tr>
<tr>
<td>Primary data source for analysis</td>
<td>HAI Monthly Data Collection, NSW Health</td>
</tr>
<tr>
<td>Indicator definition</td>
<td>The number of adult and paediatric ICU CLAB infections.</td>
</tr>
<tr>
<td><strong>Numerator</strong></td>
<td></td>
</tr>
<tr>
<td>Numerator definition</td>
<td>Total number of adult and paediatric ICU CLAB infections reported.</td>
</tr>
<tr>
<td>Numerator source</td>
<td>NSW ICU</td>
</tr>
<tr>
<td>Numerator availability</td>
<td>Monthly, Available from January 2009 (6 weeks in arrears)</td>
</tr>
<tr>
<td><strong>Denominator</strong></td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Inclusions</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Adult and paediatric ICU</td>
</tr>
<tr>
<td></td>
<td>CLAB infections detected &gt; 48 hours after admission to ICU and within 48 hours of ICU discharge;</td>
</tr>
<tr>
<td></td>
<td>Central line in place or central line removed within 48 hours of bloodstream diagnosis;</td>
</tr>
<tr>
<td></td>
<td>Centrally inserted central lines</td>
</tr>
<tr>
<td><strong>Exclusions</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Peripherally inserted central lines</td>
</tr>
<tr>
<td></td>
<td>Bloodstream infections within 14 days of commencement of previous bloodstream infection by the same organism/s</td>
</tr>
<tr>
<td>Next report due</td>
<td>Monthly from data availability</td>
</tr>
</tbody>
</table>

**Targets**
| **Target** | N/A |
| **Comments** | NSW Health Central line Insertion and Post Insertion Care policy sets out the mandatory requirements for the insertion and post insertion care of central lines. In addition, the Policy sets out skills and knowledge required by clinicians inserting central lines. |
| **Context** | • CLABs are responsible for 20-40% of healthcare associated bloodstream infections. Risks of occurrence differ among clinical units dependent on the type of line used and patient factors. A significant proportion of CLAB events are preventable through adoption of best practice during insertion and ongoing management of the central line.  
• Healthcare Associated Infection: Clinical Indicator Manual, version 2.0 November 2008 – Currently under review  
• Note that for national reporting, a denominator (line days) is required. |
| **Related Policies/ Programs** | • See Comments above.  
• NSW has provided additional resources to LHDs for improved infection control activity and will review;  
• LHD performance as a result of recommendations from the NSW HAI Steering Committee. |
<p>| <strong>Useable data available from</strong> | 2009 |
| <strong>Frequency of Reporting</strong> | Monthly |
| <strong>Time lag to available data</strong> | Reporting data available one month post last reporting period |
| <strong>Business owners</strong> | Clinical Excellence Commission |
| <strong>Contact - Policy</strong> | Director, Clinical Governance, Clinical Excellence Commission (Dr Paul Curtis) |
| <strong>Contact - Data</strong> | Director, Clinical Governance, Clinical Excellence Commission (Dr Paul Curtis), and Executive Director, System Information and Analytics |
| <strong>Representation</strong> |  |
| <strong>Data type</strong> | Numeric |
| <strong>Form</strong> | Number, expressed as a rate per 1,000 central line days |
| <strong>Representational layout</strong> | N |
| <strong>Minimum size</strong> | 0 |
| <strong>Maximum size</strong> | N/A |
| <strong>Related National Indicator</strong> |  |</p>
<table>
<thead>
<tr>
<th>INDICATOR:</th>
<th>MS2104</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous IDs:</td>
<td>Surgical Site Infections - Rate (per 1,000 surgical procedural DRG separations)</td>
</tr>
<tr>
<td>Shortened Title</td>
<td>Surgical Site Infections</td>
</tr>
<tr>
<td>Service Agreement Type</td>
<td>Improvement Measure</td>
</tr>
<tr>
<td>Framework Strategy</td>
<td>Strategy 2: Provide World-Class Clinical Care Where Patient Safety is First</td>
</tr>
<tr>
<td>Framework Objective</td>
<td>2.1 (Embed quality improvement to ensure safer patient care)</td>
</tr>
<tr>
<td>Status</td>
<td>Final</td>
</tr>
<tr>
<td>Version number</td>
<td>2.0</td>
</tr>
<tr>
<td>Scope</td>
<td>All public hospital separations</td>
</tr>
<tr>
<td>Goal</td>
<td>Improve post-surgical care and Increase quality outcomes.</td>
</tr>
<tr>
<td>Desired outcome</td>
<td>Reduction in the number of patients developing infections following a surgical procedure.</td>
</tr>
<tr>
<td>Primary point of collection</td>
<td>Administrative and clinical patient data collected at admission and discharge</td>
</tr>
<tr>
<td>Data Collection Source/System</td>
<td>Diagnosis codes / Hospital Patient Admission Systems (PAS), Admitted Patient Data Collection</td>
</tr>
<tr>
<td>Primary data source for analysis</td>
<td>Health Information Exchange (HIE)</td>
</tr>
<tr>
<td>Indicator definition</td>
<td>The rate of surgical site infections occurring after surgery, per 1,000 surgical procedures.</td>
</tr>
<tr>
<td>Numerator</td>
<td></td>
</tr>
<tr>
<td>Numerator definition</td>
<td>Number of surgical procedures with surgical site infections occurring after surgery within the reporting period.</td>
</tr>
<tr>
<td>Numerator source</td>
<td>HIE</td>
</tr>
<tr>
<td>Numerator availability</td>
<td>HIE available monthly</td>
</tr>
<tr>
<td>Denominator</td>
<td></td>
</tr>
<tr>
<td>Denominator definition</td>
<td>The total number surgical procedures within the reporting period.</td>
</tr>
<tr>
<td>Denominator source</td>
<td>HIE</td>
</tr>
<tr>
<td>Denominator availability</td>
<td>Monthly</td>
</tr>
</tbody>
</table>
Inclusions

Exclusions
Exclusion from numerator and denominator: separations with ANY of the following:

• Same-day chemotherapy - DRG V8: R63Z and admission date = separation date
• Same-day haemodialysis - DRG V8: L61Z and admission date = separation date
• Primary diagnosis mental health care - Major Diagnostic Category = 19 or 20
• Care type is 'Newborn' - Care type = 5
• Care type is 'Hospital boarder' - Care type = 0
• Care type is 'Organ procurement-posthumous' - Care type = 9

Targets

Target TBA
Performing: Reduction from the previous financial year's rate of in scope surgical site infections.
Under performing: No change from the previous financial year's rate of in scope surgical site infections.
Not performing: Increase on the previous financial year's rate of in scope surgical site infections.

Context

Related Policies/ Programs

Useable data available from 2000
Frequency of Reporting 3 monthly
Time lag to available data Varies between 1 month and 3 months
Business owners Clinical Excellence Commission
Contact - Policy Director, Clinical Excellence Commission
Contact - Data Executive Director, System Information and Analytics Branch (hsipr@doh.health.nsw.gov.au)

Representation

Data type Numeric
Form Number
Representational layout NN.N
Minimum size 3
Maximum size 4
Data domain
Date effective 1st July 2017
Related National Indicator ACSQHC Hospital Acquired Complication list:
INDICATOR: MS2106

**Harm-free Admitted Care:** Inpatient Stays without Harm (%)

- Episodes where no harm (hospital acquired complication or injury) resulted from the care provided (avoidable or unavoidable) (%)

**Service Agreement Type:** Improvement Measure

**Framework Strategy:** Strategy 2: Provide World-Class Clinical Care Where Patient Safety is First

**Framework Objective:** 2.1 (Embed quality improvement to ensure safer patient care)

**Status**

- Final

**Version number**

- 1.01

**Scope**

All public hospital separations

**Goal**

Improve medical and surgical care and increase quality outcomes.

**Desired outcome**

Fewer patients experiencing harmful events or conditions during their hospital stay

**Primary point of collection**

Administrative and clinical patient data collected at admission and discharge

**Data Collection Source/System**

Diagnosis codes / Hospital Patient Admission Systems (PAS), Admitted Patient Data Collection

**Primary data source for analysis**

HIE

**Indicator definition**

The percentage of hospital separations **without** a recorded harmful event or condition during their hospital stay.

**Numerator**

**Numerator definition**

Number of hospital separations **without** a harmful event or condition occurring during the hospital stay in the reporting period.

Harm is identified via the following ICD-10AM 9th and 10th edition codes:

(i) A separation with external cause codes of V00 – Y84 in any diagnosis field with condition onset flag of 1, **OR**

(ii) A separation with external cause codes of V00 – Y84 in any diagnosis field with condition onset flag of 9. The ICD10-AM codes for place of Occurrence which is immediately following the external cause code must be in the range Y92.22 – Y92.24

Excludes the following ICD10-AM codes

- V10-V39
- V60-V88
- V90-V97
- W28-W30

**OR**

(iii) A separation with diagnosis codes of O85 – O91.x or with
additional codes (see embedded .xlsx file) in any diagnosis field without an immediately following external cause code AND with a condition onset flag of 1.

Numerator source: HIE  
Numerator availability: HIE available monthly

**Denominator**

Denominator definition: The total number of hospital separations within the reporting period.  
Denominator source: HIE  
Denominator availability: Monthly

**Inclusions**

**Exclusions**

Exclusion from numerator and denominator: separations with ANY of the following
- Care type is 'Hospital boarder' - Care type = 0
- Care type is 'Organ procurement-posthumous' - Care type = 9
- Preterm infants with birth weight less than 2,000 grams

Targets

Target: N/A

Context

Related Policies/ Programs

Useable data available from: 2010

Frequency of Reporting: 3 monthly

Time lag to available data: Varies between 1 month and 3 months

Business owners

Contact - Policy: Director, Clinical Excellence Commission
Contact - Data: Executive Director, System Information and Analytics

Representation

Data type: Numeric  
Form: Number  
Representational layout: NN.N  
Minimum size: 3  
Maximum size: 4
Date effective 1st July 2017

Related National Indicator
2018-19 Service Performance Agreements
Strategy 2 IMs: Integrate Systems to Deliver Truly Connected Care

INDICATOR: KQS202
Previous IDs: 9A11, 0003

Incorrect Procedures: Operating Theatre - Resulting in Death or Major Permanent Loss of Function (Number)

Shortened Title
Incorrect Procedures Resulting in Death or Loss of Function

Service Agreement Type
Improvement Measure

Framework Strategy
Strategy 2: Provide World-Class Clinical Care Where Patient Safety is First

Framework Objective
2.1 (Embed quality improvement to ensure safer patient care)

Status
Final

Version number
1.21

Scope
All patients in hospitals

Goal
To eliminate incidents involving incorrect patient, incorrect site and incorrect procedure in operating theatre

Desired outcome
Improved quality and safety of treatment

Primary point of collection
All health service staff that report or notify an incident.

Data Collection Source/System
Incident Information Management System (IIMS)

Primary data source for analysis
RIB Database, Clinical Excellence Commission

Indicator definition
The number of incidents reported for procedures performed on the incorrect patient, incorrect site or incorrect procedure is performed in operating theatres resulting in death or major permanent loss of function

Numerator
Numerator definition
Number of incidents reported for procedures performed on incorrect patient/incorrect site procedure in operating theatres resulting in death or major permanent loss of function

Numerator source
RIB Database, Clinical Excellence Commission

Numerator availability
Available, monthly

Denominator
N/A

Inclusions
1. Pre-op anaesthetic, delivery suite procedures, dental procedures in operating theatres, scopes; incorrect prosthetic insertion
2. Misadministration (wrong dose)
3. Incidents resulting in death or major permanent loss of function

Exclusions
- Retained instruments
- Excludes incorrect procedures in Radiology, Radiation Oncology, Nuclear Medicine

Targets
0 incorrect Procedures

Comments
Incorrect procedure counts are from SAC1 RIBs (Severity Assessment Code 1 Reportable incident Briefs).

Context
Such events though rare, provide insight into system failures that allow them
to happen. Health studies have indicated that with the implementation of incorrect patient/site/procedure policies, these incidents can be eliminated.

**Related Policies/ Programs**

- Clinical Procedure Safety PD2014_036
- Patient Safety and Clinical Quality Program
- Incident Management Policy PD2014_004

**Useable data available from**

January 2010

**Frequency of Reporting**

Monthly and Financial Year

**Time lag to available data**

Reporting data available at least 70 days following SAC 1 clinical incident notification in the Incident Information Management System (IIMS)

**Business owners**

- Contact - Policy: Director, Clinical Governance, Clinical Excellence Commission
- Contact - Data: Director, Clinical Governance, Clinical Excellence Commission

**Representation**

- Data type: Numeric
- Form: Number
- Representational layout: NNN
- Minimum size: 1
- Maximum size: 3

**Related National Indicator**
### Root Cause Analysis (%)

**Previous IDs:** 1.6, 0006

<table>
<thead>
<tr>
<th>Root Cause Analysis completed in 70 days (%)</th>
</tr>
</thead>
</table>

**Shortened Title**

Root Cause Analysis

**Service Agreement Type**

Improvement Measure

**Framework Strategy**

Strategy 2: Provide World-Class Clinical Care Where Patient Safety is First

**Framework Objective**

2.1 (Embed quality improvement to ensure safer patient care)

**Status**

Final

**Version number**

1.11

**Scope**

All clinical SAC 1 incidents reported to NSW Health

**Goal**

Timely management of serious clinical incidents

**Desired outcome**

All clinical SAC 1 RCA reports are received by the Ministry of Health within 70 days of incident notification in IIMS.

**Primary point of collection**

LHD Clinical Governance Unit Staff

**Data Collection Source/System**

RIB Database, Clinical Excellence Commission

**Primary data source for analysis**

RIB Database, Clinical Excellence Commission

**Indicator definition**

The percentage of Clinical SAC 1 RCA reports submitted to the Ministry of Health within 70 days of notification within IIMS

<table>
<thead>
<tr>
<th>Numerator</th>
<th>Denominator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Clinical SAC 1 RCA reports submitted to the Ministry of Health within 70 days of notification within IIMS</td>
<td>Number of clinical SAC 1 clinical incidents requiring an RCA</td>
</tr>
<tr>
<td>RIB Database, Clinical Excellence Commission</td>
<td>RIB Database, Clinical Excellence Commission</td>
</tr>
<tr>
<td>Available</td>
<td>Available</td>
</tr>
</tbody>
</table>

**Inclusions**

All clinical SAC 1 Reportable Incidents

**Exclusions**

Clinical SAC 2, 3, 4 Reportable Incidents

Corporate SAC 1, 2, 3, 4 Reportable Incidents

**Targets**

N/A

**Context**

Root Cause Analysis reports can be used to identify the factors that cause adverse events. The RCA process is a vital component of the NSW Patient Safety and Clinical Quality program. The process assists with answering questions about what happened, why it occurred and what can be done to prevent high risk incidents from re-occurring. The information obtained from RCA reports is used in the development of policies and patient safety initiatives.
### 2018-19 Service Performance Agreements

**Strategy 2 IMs: Integrate Systems to Deliver Truly Connected Care**

<table>
<thead>
<tr>
<th><strong>Related Policies/ Programs</strong></th>
<th>NSW Health Incident Management Policy Directive PD2014_004</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Useable data available from</strong></td>
<td>January 2010</td>
</tr>
<tr>
<td><strong>Frequency of Reporting</strong></td>
<td>Monthly and Financial Year</td>
</tr>
<tr>
<td><strong>Time lag to available data</strong></td>
<td>Reporting data available at least 70 days following SAC 1 clinical incident notification in the Incident Information Management System (IIMS)</td>
</tr>
</tbody>
</table>

**Business owners**

- **Contact - Policy**: Director, Patient Safety, Clinical Excellence Commission
- **Contact - Data**: Principal Program Analyst, Patient Safety, Clinical Excellence Commission

**Representation**

- **Data type**: Numeric
- **Form**: Number, presented as a percentage (%)
- **Representational layout**: XXX.XX
- **Minimum size**: 1
- **Maximum size**: 5
## 2018-19 Service Performance Agreements

### Strategy 2 IMs: Integrate Systems to Deliver Truly Connected Care

<table>
<thead>
<tr>
<th>INDICATOR: MS2107</th>
<th>Clinical Incident Monitoring: Severity Assessment Code (SAC) 1 and 2 incidents (Number)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous IDs:</td>
<td>Clinical Incident Monitoring</td>
</tr>
</tbody>
</table>

**Shortened Title**
Clinical Incident Monitoring

**Service Agreement Type**
Improvement Measure

**Framework Strategy**
Strategy 2: Provide World-Class Clinical Care Where Patient Safety is First

**Framework Objective**
2.1 (Embed quality improvement to ensure safer patient care)

**Status**
Draft

**Version number**
1.01

**Scope**
All clinical SAC 1 and 2 incidents reported to NSW Health

**Goal**
Timely management of serious clinical incidents

**Desired outcome**
Reduction in the number of clinical SAC 1 and 2 incidents.

**Primary point of collection**
LHD Clinical Governance Unit Staff

**Data Collection Source/System**
RIB Database, Clinical Excellence Commission

**Primary data source for analysis**
RIB Database, Clinical Excellence Commission

**Indicator definition**
The number of Clinical SAC 1 and 2 RCA incidents.

#### Numerator
- **Numerator definition**
  Number of Clinical SAC 1 and 2 RCA reports submitted to the Ministry of Health.
- **Numerator source**
  RIB Database, Clinical Excellence Commission
- **Numerator availability**
  Available

#### Denominator
- **Denominator definition**
  Number of Clinical SAC 1 and 2 RCA incidents
- **Denominator source**
  RIB Database, Clinical Excellence Commission
- **Denominator availability**
  Available

**Inclusions**
All clinical SAC 1 and 2 Reportable Incidents

**Exclusions**
Clinical SAC 3, 4 Reportable Incidents
Corporate SAC 1, 2, 3, 4 Reportable Incidents

**Targets**
Target
N/A

**Context**
Root Cause Analysis reports can be used to identify the factors that cause adverse events. The RCA process is a vital component of the NSW Patient Safety and Clinical Quality program. The process assists with answering questions about what happened, why it occurred and what can be done to prevent high risk incidents from re-occurring. The information obtained from RCA reports is used in the development of policies and patient safety...
initiatives.

**Related Policies/ Programs**

NSW Health Incident Management Policy Directive PD2014_004

**Useable data available from**

August 2005

**Frequency of Reporting**

Monthly and Financial Year

**Time lag to available data**

Reporting data available at least 70 days following SAC 1 clinical incident notification in the Incident Information Management System (IIMS)

**Business owners**

Clinical Excellence Commission

**Contact - Policy**

Director, Patient Safety, Clinical Excellence Commission (Dr Bernadette Eather)

**Contact - Data**

Vanessa Brooks, Principal Program Analyst, Patient Safety Clinical Excellence Commission

**Representation**

<table>
<thead>
<tr>
<th>Data type</th>
<th>Numeric</th>
</tr>
</thead>
<tbody>
<tr>
<td>Form</td>
<td>Number</td>
</tr>
<tr>
<td>Representational layout</td>
<td>N(6)</td>
</tr>
<tr>
<td>Minimum size</td>
<td>1</td>
</tr>
<tr>
<td>Maximum size</td>
<td>6</td>
</tr>
</tbody>
</table>
INDICATOR: MS2105

Shortened Title: National Sentinel Events

Previous IDs: National Sentinel Events

Service Agreement Type: Improvement Measure

Framework Strategy: Strategy 2: Provide World-Class Clinical Care Where Patient Safety is First

Framework Objective: 2.1 (Embed quality improvement to ensure safer patient care)

Status: Final

Version number: 1.1

Scope: All public hospital admissions

Goal:

Desired outcome: Reduction in the number of adverse events that result in death or serious harm to a patient.

Primary point of collection

Data Collection Source/System: CEC Reportable Incident Brief Database

Primary data source for analysis: CEC Reportable Incident Brief Database

Indicator definition: The number of adverse events that result in death or serious harm to a patient within the reporting period.

Numerator

Numerator definition: Number of adverse events that result in death or serious harm to a patient within the reporting period.

The National Sentinel Events list is as follows:

- Surgery or other invasive procedure performed on the wrong site resulting in serious harm or death
- Surgery or other invasive procedure performed on the wrong patient resulting in serious harm or death
- Wrong surgical or other invasive procedure performed on a patient resulting in serious harm or death
- Unintended retention of a foreign object in a patient after surgery or other invasive procedure resulting in serious harm or death
- Haemolytic blood transfusion reaction resulting from ABO incompatibility resulting in serious harm or death
- Suspected suicide of a patient in an acute psychiatric unit or acute psychiatric ward
- Medication error resulting in serious harm or death
- Discharge or release of an infant or child to an unauthorised person
- Use of an incorrectly positioned oro- or naso- gastric tube resulting in serious harm or death
<table>
<thead>
<tr>
<th>Numerator source</th>
<th>RIB Database</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator availability</td>
<td>TBA</td>
</tr>
</tbody>
</table>

**Denominator**

<table>
<thead>
<tr>
<th>Denominator definition</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator source</td>
<td></td>
</tr>
<tr>
<td>Denominator availability</td>
<td></td>
</tr>
</tbody>
</table>

**Inclusions**

**Exclusions**

**Targets**

<table>
<thead>
<tr>
<th>Target</th>
<th>N/A</th>
</tr>
</thead>
</table>

**Context**

**Related Policies/Programs**

**Useable data available from**

<table>
<thead>
<tr>
<th>TBA</th>
</tr>
</thead>
</table>

**Frequency of Reporting**

<table>
<thead>
<tr>
<th>TBA</th>
</tr>
</thead>
</table>

**Time lag to available data**

**Business owners**

<table>
<thead>
<tr>
<th>Contact - Policy</th>
<th>Director, Clinical Excellence Commission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact - Data</td>
<td>Director, Patient Safety, Clinical Excellence Commission</td>
</tr>
</tbody>
</table>

**Representation**

<table>
<thead>
<tr>
<th>Data type</th>
<th>Numeric</th>
</tr>
</thead>
<tbody>
<tr>
<td>Form</td>
<td>Number</td>
</tr>
<tr>
<td>Representational layout</td>
<td>NNN(N)</td>
</tr>
<tr>
<td>Minimum size</td>
<td>3</td>
</tr>
<tr>
<td>Maximum size</td>
<td>4</td>
</tr>
<tr>
<td>Data domain</td>
<td></td>
</tr>
<tr>
<td>Date effective</td>
<td>1st July 2017</td>
</tr>
</tbody>
</table>

**Related National Indicator**

ACSQHC Australian Sentinel Events List:
**INDICATOR:** SSQ101

**Previous IDs:** 9A13

**Deteriorating Patients – Rapid Response Calls (Rate)**

- Rate per 1,000 separations

**Shortened Title**
Rapid Response Calls Rate

**Service Agreement Type**
Improvement Measure

**Framework Strategy**
Strategy 2: Provide World-Class Clinical Care Where Patient Safety is First

**Framework Objective**
2.1 (Embed quality improvement to ensure safer patient care)

**Status**
Final

**Version number**
2.31

**Scope**
All admitted patients in acute facilities
- Adults
- Paediatrics (inclusive of newborns)
- Maternity

**Goal**
To provide a process measure for utilisation of the Clinical Emergency Response Systems (CERS) as part of the Between the Flags program in NSW hospitals.

**Desired outcome**
Rapid Response call rate that is above 20 calls per 1000 separations.

**Primary point of collection**
NSW public healthcare facilities

**Data Collection Source/System**
LHD Data Collection examples:
- PowerChart - Rapid Response Data Collection form
- Paper based Rapid Response Record Form
- Switchboard Rapid Response activation record.

**Primary data source for analysis**
LHD Data Collection

**Indicator definition**
The number of Rapid Response (Red Zone) calls per 1000 separations. NB: This number includes cardiopulmonary arrest calls.

\[
\text{Numerator} \times 1,000 \\
\text{Denominator}
\]

The number of Rapid Response calls should be reported: (i) as a total for all patients, and (ii) separately for each different patient population cared for in a facility, i.e.

**Adults (excluding Maternity Patients)** whose observations are documented on a Standard Adult General Observation (SAOGO) Chart.

**Paediatrics,** includes
- All children treated in a Specialist Children's hospital,
- Children aged less than 16 years in a non-Specialist Children's hospital, whose observations are documented on a Standard Paediatric Observation Chart (SPOC). NB: babies whose observations are documented on a Standard Newborn Observation Chart (SNOC) should be included with the paediatric count.

**Maternity patients** whose observations are documented on a Standard
Numerator

Numerator definition: The number of Rapid Response calls for patients with Red Zone criteria as defined on the appropriate NSW Health Standard Observation Chart. NB: This number includes cardiopulmonary arrest calls.

Numerator source: NSW public healthcare facilities,
- PowerChart- Rapid Response Data Collection form
- Paper based Rapid Response Record Form
- Switchboard Rapid Response activation record.

Numerator availability: Monthly, available from 1 July 2010

Denominator

Denominator definition: All Separations in acute facilities (counted as stays not episodes) with the following subgroups defined:
- Adults: Patients 16 years and over
- Paediatrics: Patients less than 16 years (includes newborns)
- Maternity: Patients allocated to any DRG in MDC 14 Pregnancy, Childbirth and the Puerperium

Denominator source: HIE / APDC

Denominator availability: Monthly

Inclusions: All admitted patients

Exclusions:
- Non-admitted patients
- Patients in subacute, non-acute and residential aged care facilities
- Patients in an emergency department, operating theatre, adult/paediatric/neonatal intensive care units (ICU) or a high dependency unit collocated within an ICU should not be counted in the numerator.

Targets: Negotiated in individual LHD performance agreement.

Related Policies/ Programs:
- Recognition and Management of Patients who are Clinically Deteriorating (PD2013_049).
- NSQHS - Standard 9 “Recognising and responding to clinical deterioration in acute health care”

Comments: The optimum Rapid Response calling rate is currently unknown. There is evidence to suggest that there is a dose-response relationship between the number of Rapid Response calls and a reduction in mortality and other serious events such as cardiac arrests and unplanned admissions to ICU, with no apparent upper threshold. This is because a higher call rate may indicate that patients who are clinically deteriorating are being identified and reviewed promptly. Initially, as the Between the Flags program matures it is expected that the Rapid Response rate would increase.

Reference: Australian Commission on Safety and Quality in Health Care (2011), A guide to support implementation of the National Consensus
Statement: Essential Elements for Recognising and Responding to Clinical Deterioration, Sydney, ACSQHC.


<table>
<thead>
<tr>
<th>Useable data available from</th>
<th>July 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency of Reporting</td>
<td>Monthly</td>
</tr>
<tr>
<td>Time lag to available data</td>
<td>Reporting data available one month post last reporting period</td>
</tr>
</tbody>
</table>

**Business owners**

Director, Medication Safety, BTF and Sepsis Programs, Clinical Excellence Commission (Dr Harvey Lander)

Executive Director, Health System Information and Performance Reporting Branch, Ministry of Health

**Representation**

- **Data type**: Numeric
- **Form**: Number
- **Representational layout**: X.X
- **Minimum size**: 3
- **Maximum size**: 3

**Related National Indicator**

Page 265
## Deteriorating Patients – Unexpected cardiopulmonary arrest (Rate)

- Rate per 1,000 separations

### Shortened Title

Unexpected Cardiopulmonary Arrest Rate

### Service Agreement Type

Improvement Measure

### Framework Strategy

Strategy 2: Provide World-Class Clinical Care Where Patient Safety is First

### Framework Objective

2.1 (Embed quality improvement to ensure safer patient care)

### Status

Final

### Version number

2.21

### Scope

All patients in acute facilities
- Adults
- Paediatrics (inclusive of newborns)
- Maternity

### Goal

To provide an outcome measure of the effectiveness of the Between the Flags program.

### Desired outcome

Fewer instances of cardiopulmonary arrest through earlier recognition and response to clinical deterioration.

### Primary point of collection

NSW public healthcare facilities

### Data Collection Source/System

LHD Data Collection examples:
- PowerChart - Rapid Response Data Collection form
- Paper based Rapid Response Record Form
- Switchboard Rapid Response activation record.

### Primary data source for analysis

LHD Data Collection

### Indicator definition

The rate of occurrence of cardiopulmonary arrest where there was no ‘not for resuscitation’ order per 1,000 separations.

Cardiopulmonary arrest refers to either cardiac or respiratory arrest.

Cardiac arrest is defined as the absence of pulse and respiratory effort, and unconsciousness, necessitating the commencement of resuscitation in the absence of ‘not for resuscitation’ orders.

Respiratory arrest is defined as the absence of respiratory effort and the presence of palpable pulse and measurable blood pressure, necessitating the commencement of resuscitation in the absence of ‘not for resuscitation’ orders.

<table>
<thead>
<tr>
<th>Numerator x 1,000</th>
<th>Denominator</th>
</tr>
</thead>
<tbody>
<tr>
<td>The number of cardiopulmonary arrest calls should be reported: (i) as a total for all patients, and (ii) separately for each different patient population cared for in a facility, i.e.</td>
<td></td>
</tr>
</tbody>
</table>

**Adults (excluding Maternity Patients)** whose observations are documented
on a Standard Adult General Observation (SAGO) Chart. **Paediatrics**, includes
- All children treated in a Specialist Children’s hospital,
- Children aged less than 16 years in a non-Specialist Children’s hospital, whose observations are documented on a Standard Paediatric Observation Chart (SPOC). NB: babies whose observations are documented on a Standard Newborn Observation Chart (SNOC) should be included with the paediatric count.

**Maternity patients** whose observations are documented on a Standard Maternity Observation Chart (SMOC).

**Numerator**

**Numerator definition**
Number of patients who have experienced an unexpected cardiopulmonary arrest (without a documented Not For Resuscitation (NFR)/ Allow a Natural Death (AND) order).

Note: This is a subset within the group of patients who require Rapid Response calls.

**Numerator source**
NSW public healthcare facilities,
- PowerChart- Rapid Response Data Collection form
- Paper based Rapid Response Record Form
- Switchboard Rapid Response activation record.

**Numerator availability**
Monthly, available from 1st July 2010

**Denominator**

**Denominator definition**
All Separations in acute facilities (counted as stays not episodes) with the following subgroups defined:
- **Adults**: Patients 16 years and over
- **Paediatrics**: Patients less than 16 years (includes newborns)
- **Maternity**: Patients allocated to any DRG in MDC 14 Pregnancy, Childbirth and the Puerperium

**Denominator source**
HIE / APDC

**Denominator availability**
Monthly

**Inclusions**
- All admitted patients

**Exclusions**
- Non-admitted patients
- Patients in subacute, non-acute and residential aged care facilities
- Patients in an emergency department, operating theatre, adult/ paediatric/ neonatal intensive care units (ICU) or a high dependency unit collocated within an ICU should not be counted in the numerator.

**Targets**
< 3 cardiopulmonary arrest calls/1000 acute separations

**Related Policies/ Programs**
- Recognition and Management of Patients who are Clinically Deteriorating (PD2013_049).
- NSQHS - Standard 9 “Recognising and responding to clinical deterioration in acute health care”
### Comments


### Frequency of Reporting

Monthly

### Time lag to available data

Reporting data available one month post last reporting period

### Business owners

Clinical Excellence Commission

#### Contact - Policy

Director, Medication Safety, BTF and Sepsis Programs, Clinical Excellence Commission (Dr Harvey Lander)

#### Contact - Data

Executive Director, Health System Information and Performance Reporting Branch, Ministry of Health

### Representation

| Data type | Numeric |
| Form      | Number |
| Representational layout | NN.N |
| Minimum size | 4 |
| Maximum size | 4 |

### Related National Indicator

Page 268
### 2018-19 Service Performance Agreements
#### Strategy 2 IMs: Integrate Systems to Deliver Truly Connected Care

**INDICATOR:** MS2108

**Previous IDs:**

- Risk Standardised Mortality Ratio (RSMR): 30-day mortality following hospitalization: (%)
  - Acute myocardial infarction
  - Ischaemic stroke
  - Haemorrhagic stroke
  - Congestive heart failure
  - Pneumonia
  - Chronic obstructive pulmonary disease
  - Hip fracture surgery

| Shortened Title(s) | Risk Standardised Mortality Ratio: AMI
|                    | Risk Standardised Mortality Ratio: Ischaemic Stroke
|                    | Risk Standardised Mortality Ratio: Haemorrhagic Stroke
|                    | Risk Standardised Mortality Ratio: CHF
|                    | Risk Standardised Mortality Ratio: Pneumonia
|                    | Risk Standardised Mortality Ratio: COPD
|                    | Risk Standardised Mortality Ratio: Hip Fracture Surgery

| Service Agreement Type | Improvement Measure
|------------------------|------------------------
| Framework Strategy     | Strategy 2: Provide World-Class Clinical Care Where Patient Safety is First
| Framework Objective    | 2.1 (Embed quality improvement to ensure safer patient care)

| Status | Draft
| Version number | 1.01

| Scope | All inpatient episodes
| Goal | TBA
| Desired outcome | TBA

| Primary point of collection | Medical Records
| Data Collection Source/System | Admitted Patient Data Collection
| Primary data source for analysis | HIE, CheReL

**Indicator definition**

The ratio of ‘observed’ deaths to ‘expected’ deaths each of the following clinical conditions:

- Acute myocardial infarction
- Ischaemic stroke
- Haemorrhagic stroke
- Congestive heart failure
- Pneumonia
- Chronic obstructive pulmonary disease
- Hip fracture surgery

**Numerator**

| Numerator definition | Refer to Bureau of Health Information publication
| Numerator source | 
| Numerator availability | 
### Denominator

<table>
<thead>
<tr>
<th>Description</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator definition</td>
<td>Refer to Bureau of Health Information publication</td>
</tr>
<tr>
<td>Denominator source</td>
<td></td>
</tr>
<tr>
<td>Denominator availability</td>
<td></td>
</tr>
</tbody>
</table>

### Inclusions

Refer to Bureau of Health Information publication

### Exclusions

Refer to Bureau of Health Information publication

### Targets

<table>
<thead>
<tr>
<th>Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td>N/A</td>
</tr>
</tbody>
</table>

### Context

Refer to Bureau of Health Information publication

### Related Policies/ Programs

Useable data available from

### Frequency of Reporting

Monthly

### Time lag to available data

Bureau of Health Information

**Contact - Policy**

Director, Bureau of Health Information

**Contact - Data**

Director, Bureau of Health Information

### Representation

<table>
<thead>
<tr>
<th>Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data type</td>
<td>Numeric</td>
</tr>
<tr>
<td>Form</td>
<td>Number</td>
</tr>
<tr>
<td>Representational layout</td>
<td>N[6]</td>
</tr>
<tr>
<td>Minimum size</td>
<td>1</td>
</tr>
<tr>
<td>Maximum size</td>
<td>6</td>
</tr>
</tbody>
</table>
INDICATOR: SSQ108, SSQ109, SSQ110, SSQ111, MS2109, MS2110, MS2111, MS2112

### Unplanned hospital readmission rates for patients discharged following management of targeted conditions (%)

Percentage of unplanned and unexpected hospital readmissions to the same public hospital within 28 days for:

- Acute Myocardial Infarction (SSQ108)
- Heart Failure (SSQ109)
- Knee and hip replacements (SSQ110)
- Paediatric tonsillectomy and adenoidectomy (SSQ111)
- Ischaemic stroke (MS2109)
- Pneumonia (MS2110)
- Hip fracture surgery (MS2111)
- COPD (MS2112)

### Previous IDs:

- Unplanned hospital readmission rates for patients discharged following management of targeted conditions (%)
- Percentage of unplanned and unexpected hospital readmissions to the same public hospital within 28 days for:
  - Acute Myocardial Infarction (SSQ108)
  - Heart Failure (SSQ109)
  - Knee and hip replacements (SSQ110)
  - Paediatric tonsillectomy and adenoidectomy (SSQ111)
  - Ischaemic stroke (MS2109)
  - Pneumonia (MS2110)
  - Hip fracture surgery (MS2111)
  - COPD (MS2112)

### Shortened Title(s)

- Unplanned Hospital Readmission – AMI
- Unplanned Hospital Readmission – Heart Failure
- Unplanned Hospital Readmission – Hip/Knee Replacement
- Unplanned Hospital Readmission – Paed Tonsilladenoidectomy
- Unplanned Hospital Readmission – Ischaemic Stroke
- Unplanned Hospital Readmission – Pneumonia
- Unplanned Hospital Readmission – Hip Fracture Surgery
- Unplanned Hospital Readmission – COPD

### Service Agreement Type

Improvement Measure

### Framework Strategy

Strategy 2: Provide World-Class Clinical Care Where Patient Safety is First

### Framework Objective

2.1 (Embed quality improvement to ensure safer patient care)

### Status

Draft

### Version number

2.01

### Scope

All admitted patient admissions to public facilities in peer groups A1 – C2.

### Goal

To decrease the number of unplanned readmissions. Increase the focus on the safe transfer of care, coordinated care in the community and early intervention.

### Desired outcome

Improved quality and safety of treatment, with reduced unplanned events.

### Primary point of collection

Administrative and clinical patient data collected at admission and discharge.

### Data Collection Source/System

Admitted Patient Data Collection, Hospital Patient Admission Systems (PAS).

### Primary data source for analysis

HIE / IQ & HOIST

### Indicator definition

Unplanned readmission of a patient within 28 days following discharge to the same facility following an initial admission for:

- Acute Myocardial Infarction
- Heart Failure
- Knee and hip replacements
- Paediatric tonsillectomy and adenoidectomy
• Ischaemic stroke
• Pneumonia
• Hip fracture surgery
• Chronic Obstructive Pulmonary Disease (COPD)

Numerator

Numerator definition

The total number of unplanned admissions for each targeted condition, reported separately, with admission date within reference period and patient previously discharged from same facility in previous 28 days.

SSQ108: Acute Myocardial Infarction
The separation is a readmission to the same facility following an initial separation where “Acute myocardial infarction” (ICD-10-AM codes I21.-) or “Unstable angina” (ICD-10-AM code I20.0) is the principal diagnosis for both the original episode and the subsequent readmission. The readmission is the episode included in the numerator.

SSQ109: Heart Failure
The separation is a readmission to the same facility following an initial separation where “Heart failure” (ICD-10-AM codes I50.-) is the principal diagnosis for both the initial episode and the subsequent readmission. The readmission is the episode included in the numerator.

SSQ110: Knee and hip replacements
• The separation is a readmission to the same facility following an initial separation in which one of the following procedures was performed:
  o 49518-00 (Total arthroplasty of knee, unilateral)
  o 49519-00 (Total arthroplasty of knee, bilateral)
  o 49521-00 (Total arthroplasty of knee with bone graft to femur, unilateral)
  o 49521-01 (Total arthroplasty of knee with bone graft to femur, bilateral)
  o 49521-02 (Total arthroplasty of knee with bone graft to tibia, unilateral)
  o 49521-03 (Total arthroplasty of knee with bone graft to tibia, bilateral)
  o 49524-00 (Total arthroplasty of knee with bone graft to femur and tibia, unilateral)
  o 49524-01 (Total arthroplasty of knee with bone graft to femur and tibia, bilateral)
  o 49318-00 (Total arthroplasty of hip, unilateral)
  o 49319-00 (Total arthroplasty of hip, bilateral)
• A principal diagnosis for the readmission has one of the following ICD-10-AM codes: T80–88, T98.3, E89.x, G97.x, H59.x, H95.x, I97.x, J95.x, K91.x, M96.x or N99.x. Where a readmission has multiple episodes of care, the principal diagnosis criteria is limited to the first episode ONLY.
• This indicator is NOT limited to the principal procedure, and includes all episodes where the procedure was present in the initial coded record.

SSQ111: Paediatric tonsillectomy and adenoidectomy
• The separation is a readmission to the same facility following an initial separation in which one of the following procedures was performed:
  o 41789-00 (Tonsillectomy without adenoidectomy)
  o 41789-01 (Tonsillectomy with adenoidectomy)
  o 41801-00 (Adenoidectomy without tonsillectomy)
• A principal diagnosis for the readmission has one of the following ICD-10-AM codes: T80–88, T98.3, E89, G97, H59, H95, I97, J95, K91, M96 or N99. Where a readmission has multiple episodes of care, the principal diagnosis criteria is limited to the first episode ONLY.
• This indicator is NOT limited to the principal procedure, and includes all episodes where the procedure was present in the initial coded record.
• Paediatric is defined as <16 years of age at point of initial admission.

**MS2109: Ischaemic stroke**
The separation is a readmission to the same facility following an initial separation where "Cerebral infarction" (ICD-10-AM codes I63.-) is the principal diagnosis for both the original episode and the subsequent readmission. The readmission is the episode included in the numerator.

**MS2110: Pneumonia**
The separation is a readmission to the same facility following an initial separation where the following ICD-10-AM codes are the principal diagnosis for both the original episode and the subsequent readmission:
  • Pneumonia due to *Streptococcus pneumonia* (J13)
  • Pneumonia due to *Haemophilus influenzae* (J14)
  • Bacterial pneumonia, not elsewhere classified (J15-)
  • Pneumonia due to other infectious organisms, not elsewhere classified (J16-)
  • Pneumonia, organism unspecified (J18-)

The readmission is the episode included in the numerator.

**MS2111: Hip fracture surgery**
• The separation is a readmission to the same facility following an initial separation in which (i) one of the following procedures was performed:
  o 47519-00 (1479) - Internal fixation of fracture of trochanteric or subcapital femur;
  o 47522-00 (1489) - Hemiarthroplasty of femur;
  o 47528-01 (1486) - Open reduction of fracture of femur;
  o 47531-00 (1486) – Closed reduction of fracture of femur with internal fixation;
  o 49315-00 (1489) - Partial arthroplasty of hip;
  o *49318-00 (1489) - Total arthroplasty of hip;
  o *49319-00 (1489) - Total arthroplasty of hip, bilateral
• (ii) contains a principal diagnosis of “Hip fracture” (ICD-10-AM codes S72.0x, S72.1x or S72.2x)
• (iii) where External cause fall (W00-W19) or Tendency to fall (R29.6) are present.
NOTE: procedures flagged with an * above are only included if combined with one of the following Australian Diagnostic Related Groups (AR_DRGs): 'I03B', 'I08B', 'I78B', 'I08A', 'I03A', 'I78A', 'I73A', 'Z63A'.

A principal diagnosis for the readmission has one of the following ICD-10-AM codes: T80–88, T93.1, T98.3, E89.x, G97.x, H59.x, H95.x, I97.x, J95.x, K91.x, M96.x or N99.x. Where a readmission has multiple episodes of care, the principal diagnosis criteria is limited to the first episode ONLY. This indicator is NOT limited to the principal procedure, and includes all episodes where the procedure was present in the initial coded record.

**MS2112: COPD**
The separation is a readmission to the same facility following an initial separation where “Other chronic obstructive pulmonary disease” (ICD-10-AM codes J44.-) is the principal diagnosis for both the original episode and the subsequent readmission. The readmission is the episode included in the numerator.

For all measures:

- Unplanned is defined as emergency_status = 1.
- A readmission is defined as an admission with an admission_date within 28 days of the discharge_date of a previous stay for the same patient at the same facility (identified by MRN and facility_identifier).

**Numerator source**

- HIE / IQ

**Numerator availability**

- HIE/IQ Available monthly
- HOIST depends on refresh frequency

**Denominator definition**
The total number of admissions for each targeted condition, reported separately, with admission dates within reference period.

**SSQ108 - Acute Myocardial Infarction:** The total number of separations where “Acute myocardial infarction” (ICD-10-AM codes I21.-) or “Unstable angina” (ICD-10-AM code I20.0) are the principal diagnosis. Note: the readmission episode that is included in the numerator is also included in the denominator.

**SSQ109 - Heart Failure:** The total number of separations where “Heart failure” (ICD-10-AM codes I50.-) is the principal diagnosis. Note: the readmission episode that is included in the numerator is also included in the denominator.

**SSQ110 - Knee and hip replacements:** The total number of separations where one of the following procedures was performed:

- 49518-00 (Total arthroplasty of knee, unilateral)
- 49519-00 (Total arthroplasty of knee, bilateral)
- 49521-00 (Total arthroplasty of knee with bone graft to femur, unilateral)
- 49521-01 (Total arthroplasty of knee with bone graft to femur,
• 49521-02 (Total arthroplasty of knee with bone graft to tibia, unilateral)
• 49521-03 (Total arthroplasty of knee with bone graft to tibia, bilateral)
• 49524-00 (Total arthroplasty of knee with bone graft to femur and tibia, unilateral)
• 49524-01 (Total arthroplasty of knee with bone graft to femur and tibia, bilateral)
• 49318-00 (Total arthroplasty of hip, unilateral)
• 49319-00 (Total arthroplasty of hip, bilateral)

SSQ111 - Paediatric tonsillectomy and adenoidectomy: The total number of separations where one of the following procedures was performed:

• 41789-00 (Tonsillectomy without adenoidectomy)
• 41789-01 (Tonsillectomy with adenoidectomy)
• 41801-00 (Adenoidectomy without tonsillectomy)

MS2109: Ischaemic stroke
The total number of separations where “Cerebral infarction” (ICD-10-AM codes I63.-) is the principal diagnosis. Note: the readmission episode that is included in the numerator is also included in the denominator.

MS2110: Pneumonia
The total number of separations where the following ICD-10-AM codes are the principal diagnosis:

• Pneumonia due to Streptococcus pneumonia (J13)
• Pneumonia due to Haemophilus influenzae (J14)
• Bacterial pneumonia, not elsewhere classified (J15.-)
• Pneumonia due to other infectious organisms, not elsewhere classified (J16.-)
• Pneumonia, organism unspecified (J18.-)

Note: the readmission episode that is included in the numerator is also included in the denominator.

MS2111: Hip fracture surgery
The total number of separations where (i) one of the following procedures was performed:

o 47519-00 (1479) - Internal fixation of fracture of trochanteric or subcapital femur;
• 47522-00 (1489) - Hemiarthroplasty of femur;
• 47528-01 (1486) - Open reduction of fracture of femur;
• 47531-00 (1486) – Closed reduction of fracture of femur with internal fixation;
• 49315-00 (1489) - Partial arthroplasty of hip;
• *49318-00 (1489) -Total arthroplasty of hip;
• *49319-00 (1489) - Total arthroplasty of hip, bilateral

(ii) contains a principal diagnosis of “Hip fracture” (ICD-10-AM codes S72.0x, S72.1x or S72.2x)
• (iii) where External cause fall (W00-W19) or Tendency to fall (R29.6) are present.
• **NOTE:** procedures flagged with an * above are only included if combined with one of the following Australian Diagnostic Related Groups (AR_DRGs): 'I03B', 'I08B', 'I78B', 'I08A', 'I03A', 'I78A', 'I73A', 'Z63A'.

**MS2112: COPD**
The total number of separations where “Other chronic obstructive pulmonary disease” (ICD-10-AM codes J44.-) is the principal diagnosis. Note: the readmission episode that is included in the numerator is also included in the denominator.

Denominator source
- HIE/IQ

Denominator availability
- HIE/IQ Available monthly
- HOIST depends on refresh frequency

**Inclusions**
N/A

**Exclusions**
Facilities in peer groups below C2.

**Targets**
- Target: Reduction on previous year.

**Context**
Facilities with a low readmission rate may be able to demonstrate good patient management practices and post-discharge care; facilities with a high readmission rate may indicate a problem with a clinical care pathway.

**Related Policies/ Programs**
- Useable data available from: 2001/02
- Frequency of Reporting: Monthly
- Time lag to available data:
  - HIE/IQ data have a 6 month lag, available December for previous financial year
  - Availability depends on HOIST refresh frequency

**Business owners**
- Contact - Policy: Director, Clinical Governance, Clinical Excellence Commission (Dr Paul Curtis)
- Contact - Data: Executive Director, Health System Information and Performance Reporting

**Representation**
- Data type: Numeric
- Form: Number, presented as a percentage (%)
- Representational layout: NNN.N%
- Minimum size: 4
- Maximum size: 6
- Data domain: N/A
- Date effective: 1 July 2014
Related National Indicator

National Healthcare Agreement: PI 23-Unplanned hospital readmission rates, 2018
http://meteor.aihw.gov.au/content/index.phtml/itemId/658485
Meteor ID: 658485

Person—reason for readmission following acute coronary syndrome episode, code N[N]
Meteor ID: 359404
INDICATOR: MS2407

Oesophageal Cancer Resection Caseload Threshold (with Active MDT) (%)

- Resections for Oesophageal Cancer Performed in Centres above Annual Minimum Recommended Caseload and with an Active Multidisciplinary Team (%)

Shortened Title

Oesophageal Cancer Resection Caseload Threshold

Service Agreement Type

Improvement Measure

Framework Strategy

Strategy 2: Provide World-Class Clinical Care Where Patient Safety Is First

Framework Objective

2.1 (Embed quality improvement to ensure safer patient care)

Status

Final

Version number

1.0

Scope

People undergoing surgery for oesophageal cancer in NSW.

Goal

Improved case selection, improved surgical quality, and improved post-surgical patient outcomes.

Desired outcome

Increased or maintained percentage of resections performed in hospitals above the annual minimum recommended caseload.

Primary point of collection

Patient medical record and patient administration systems.

Data Collection Source/System

NSW Admitted Patient Data Collection

Primary data source for analysis

Health Information Exchange (HIE), NSW Admitted Patient Data Collection (SaPHaRI).

Indicator definition

The percentage of oesophagectomies for cancer that were performed in hospitals that conducted six or more oesophagectomies per year and with an active multidisciplinary team listed on Canrefer.

Numerator

Numerator definition

The number of oesophagectomies for cancer performed in hospitals that conducted six or more oesophagectomies per year and with an active multidisciplinary team listed on Canrefer.

Numerator source

HIE, SaPHaRI, Canrefer database

Numerator availability

Data routinely collected and available.

Denominator

Denominator definition

The number of oesophagectomies for cancer performed at all hospitals.

Denominator source

HIE, SaPHaRI

Denominator availability

Data routinely collected and available.

Inclusions

People with a diagnosis of oesophageal cancer (ICD-10-AM C15.x or C16.0) undergoing oesophagectomy, defined using the following procedure codes:

- 30535-00 Oesophagectomy by abdominal and transthoracic mobilisation, with thoracic oesophagogastric anastomosis
- 30536-00 Oesophagectomy by abdominal and transthoracic mobilisation, with cervical oesophagogastric anastomosis
- 30536-01 Oesophagectomy by abdominal and transthoracic mobilisation, with cervical oesophagostomy
- 30541-00 Trans-hiatal oesophagectomy by abdominal and cervical mobilisation, with oesophagogastrointestinal anastomosis
- 30541-01 Trans-hiatal oesophagectomy by abdominal and cervical mobilisation, with oesophagojejunal anastomosis
- 30545-00 Oesophagectomy by abdominal and thoracic mobilisation with thoracic anastomosis, large intestine interposition and anastomosis
- 30545-01 Oesophagectomy by abdominal and thoracic mobilisation with thoracic anastomosis using Roux-en-Y reconstruction
- 30550-00 Oesophagectomy by abdominal and thoracic mobilisation with cervical anastomosis, large intestine interposition and anastomosis
- 30550-01 Oesophagectomy by abdominal and thoracic mobilisation with cervical anastomosis using Roux-en-Y reconstruction

**Exclusions**

**Targets**

Target Increased or maintained percentage compared with previous reporting period.

**Context**

Evidence from Australian and international studies indicate that patients who receive surgery for oesophageal cancer in higher-volume hospitals experience lower post-operative morbidity and mortality, along with improved long-term survival and higher quality of life.

**Related Policies/Programs**

Reporting for Better Cancer Outcomes (RBCO), NSW Cancer Plan.

**Useable data available from**

July 2001

**Frequency of Reporting**

This can be computed quarterly and reported as a two year rolling average.

**Time lag to available data**

Between 1 month and 3 months for inpatient data from the HIE. NSW Admitted Patient Data Collection depends on refresh frequency.

**Business owners**

Cancer Institute NSW

- **Contact - Policy**
  - Chief Executive Officer, Cancer Institute NSW

- **Contact - Data**
  - Director, Cancer Services and Information, Cancer Institute NSW

**Representation**

- **Data type** Numeric
- **Form** Percentage
- **Representational layout** NNN.N%
- **Minimum size** 4
- **Maximum size** 5
- **Data domain**
- **Date effective** 01/07/2018
<table>
<thead>
<tr>
<th>INDICATOR:</th>
<th>MS2408</th>
</tr>
</thead>
</table>

**Previous IDs:**
- Pancreatic Cancer Resection Caseload Threshold (with Active MDT) (%)

**Shortened Title**
- Pancreatic Cancer Resection Caseload Threshold

**Service Agreement Type**
- Improvement Measure

**Framework Strategy**
- Strategy 2: Provide World-Class Clinical Care Where Patient Safety Is First

**Framework Objective**
- 2.1 (Embed quality improvement to ensure safer patient care)

**Status**
- Final

**Version number**
- 1.0

**Scope**
- People undergoing surgery for pancreatic cancer in NSW.

**Goal**
- Improved case selection, improved surgical quality, and improved post-surgical patient outcomes.

**Desired outcome**
- Increased percentage of resections performed in hospitals above the annual minimum recommended caseload.

**Primary point of collection**
- Patient medical record and patient administration systems.

**Data Collection Source/System**
- NSW Admitted Patient Data Collection.

**Primary data source for analysis**
- Health Information Exchange (HIE), NSW Admitted Patient Data Collection (SaPHaRI).

**Indicator definition**
- The percentage of pancreatectomies for cancer that were performed in hospitals that conducted six or more pancreatectomies for cancer per year and with an active multidisciplinary team listed on Canrefer.

**Numerator**
- **Numerator definition**: The number of pancreatectomies for cancer performed in hospitals that conducted six or more pancreatectomies per year and with an active multidisciplinary team listed on Canrefer.
- **Numerator source**: HIE, SaPHaRI, Canrefer Database.
- **Numerator availability**: Data routinely collected and available.

**Denominator**
- **Denominator definition**: The number of pancreatectomies for cancer performed at all hospitals.
- **Denominator source**: HIE, SaPHaRI.
- **Denominator availability**: Data routinely collected and available.

**Inclusions**
- People with a diagnosis of pancreatic cancer (ICD-10-AM C17.0, C25.x, or C24.x) undergoing pancreatectomy, defined using the following procedure codes:
  - 30583-00 Distal pancreatectomy
  - 30584-00 Pancreaticoduodenectomy with formation of stoma
  - 30593-00 Pancreatectomy
  - 30593-01 Pancreatectomy with splenectomy
**2018-19 Service Performance Agreements**

**Strategy 2 IMs: Integrate Systems to Deliver Truly Connected Care**

---

**Exclusions**

**Targets**

Target: Increased or maintained percentage compared with previous reporting period.

**Context**

Evidence from Australian and international studies indicate that patients who receive surgery for pancreatic cancer in higher-volume hospitals experience lower post-operative morbidity and mortality, along with improved long-term survival and higher quality of life.

**Related Policies/Programs**

Reporting for Better Cancer Outcomes (RBCO), NSW Cancer Plan.

**Useable data available from**

July 2001

**Frequency of Reporting**

This can be computed quarterly and reported as a two year rolling average.

**Time lag to available data**

Between 1 month and 3 months for inpatient data from the HIE. NSW Admitted Patient Data Collection depends on refresh frequency.

**Business owners**

Cancer Institute NSW

- Contact - Policy: Chief Executive Officer, Cancer Institute NSW
- Contact - Data: Director, Cancer Services and Information, Cancer Institute NSW

**Representation**

- **Data type**: Numeric
- **Form**: Percentage
- **Representational layout**: NNN.N%
- **Minimum size**: 4
- **Maximum size**: 5
- **Data domain**
- **Date effective**: 01/07/2018

**Related National Indicator**

---
### Telehealth Service Access: Non-admitted services provided through telehealth (%)

**INDICATOR:** MS2213  
**Previous IDs:**

#### Shortened Title
Telehealth Service Access

#### Service Agreement Type
Improvement Measure

#### Framework Strategy
Strategy 2: Provide World-Class Clinical Care Where Patient Safety is First

#### Framework Objective
2.2 (Move from volume to patient-centred value-based care)

#### Status
Final

#### Version number
2.0

#### Scope
All non-admitted patient service events

#### Goal
Improved service access for patients (particularly rural) through expanding telehealth.

#### Desired outcome
Increase the number of telehealth service events delivered.

#### Primary point of collection
Hospital outpatient departments and community health services.  
Non-admitted patient appointment scheduling

#### Data Collection Source/System
Various administrative and clinical information systems are used across settings and clinical streams, including enterprise systems such as iPM and Cerner PASs, eMR (CHOC), CHIME and service specific systems e.g. ISOH (for dental health), MOSAIQ (for oncology services) etc.

#### Primary data source for analysis
EDWARD Non-admitted Patient Data Mart

#### Indicator definition
The percentage of non-admitted patient service events with a modality of care of “Telehealth”.

#### Numerator
- **Numerator definition:** Total number of non-admitted patient service events with a modality of care of “Telehealth”.
- **Numerator source:** EDWARD Non-admitted Patient Data Mart
- **Numerator availability:** The day after the first data mart refresh after the 15th working day of the month of the month following the reporting period.

#### Denominator
- **Denominator definition:** Total number of non-admitted patient service events
- **Denominator source:** EDWARD Non-admitted Patient Data Mart
- **Denominator availability:** The day after the first data mart refresh after the 15th working day of the month of the month following the reporting period.

#### Inclusions
- Numerator: EDW SERVICE_CONTACT_MODE_CODE “3”, “C” or “P”, : OR Version 4.1 Non Admitted Tier 2 Clinics: 20.55, 40.61

Note: While SERVICE_CONTACT_MODE_CODE “3” is included in the calculation, this is not a valid Service Contact Mode code from 1 July
2017. The continued supply of this code by LHDs will trigger its inclusion in the Activity Based Funding Model’s Data Quality Adjustor.

Exclusions

Targets

Target: N/A

Context

Telehealth is the secure transmission of images, voice and data between two or more units via Telecommunication channels, to provide clinical advice, consultation, monitoring, education and training and administrative services.

Related Policies/ Programs

Useable data available from: 2015

Frequency of Reporting: Monthly

Time lag to available data: 4 weeks

Business owners

Contact - Policy: Executive Director, System Information and Analytics

Contact - Data: Executive Director, System Information and Analytics

Representation

Data type: Numeric

Form: Number, expressed as a percentage

Representational layout: NNN.NN

Minimum size: 3

Maximum size: 6

Data domain

Date effective: 1st July 2017

Related National Indicator
INDICATOR: RXT001  

Pain Management (NWAU)

Previous ID: Pain Management

Shortened Title  

Service Agreement Type  

Improvement Measure

Framework Strategy  

Strategy 2: Provide World-Class Clinical Care Where Patient Safety Is First

Framework Objective  

2.2 (Move from volume to patient-centred value-based care)

Status  

Final

Version number  

1.01

Scope  

Districts with Tier 3 and/or Tier 2 Pain Management Services to maintain all services in 2017/18, including those provided through enhancement. Tier 3 services funded to support Tier 2 services are required to continue to support these services.

Goal  

Improve on current level of service delivery.

Desired outcome  

To ensure that dedicated funding provided for specialist pain management services enables a greater volume of pain services to be provided. This target relates only to the investment from 2012/13 and does not include activity related to previous investment in the 11 Tier 3 services.

Primary point of collection  

Local Health District / Specialty Health Network

Data Collection Source/System  

NSW Non-admitted Patient Data Collection

Primary data source for analysis  

EDWARD Non-admitted Patient Data Mart

Indicator definition  

Total NWAU volume provided by the Ministry to support specialist pain management services, as outlined in Priorities for Pain Management in NSW.

Numerator  

Numerator definition: Total NWAU volume provided by the Ministry to support specialist pain management services.

Numerator source: ABM Portal

Numerator availability

Denominator  

Denominator definition: N/A

Denominator source

Denominator availability

Inclusions  

LHDs and networks that received funding under the NSW Pain Management Plan and subsequent election commitments

Exclusions  

Teaching, training and research activity

Targets  

Individual targets as negotiated with the LHD/SHN.

Context  

Based on funding provided by the Ministry to support specialist pain management services, i.e., not including funding provided for Training, Education and Research.
<table>
<thead>
<tr>
<th><strong>Related Policies/ Programs</strong></th>
<th>NSW Pain Management Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Useable data available from</strong></td>
<td>2016</td>
</tr>
<tr>
<td><strong>Frequency of Reporting</strong></td>
<td>Quarterly</td>
</tr>
<tr>
<td><strong>Time lag to available data</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Business owners</strong></td>
<td><strong>Health and Social Policy Branch</strong></td>
</tr>
<tr>
<td>Contact - Policy</td>
<td>Executive Director, Health and Social Policy Branch</td>
</tr>
<tr>
<td>Contact - Data</td>
<td>Director, Activity Based Management</td>
</tr>
<tr>
<td><strong>Representation</strong></td>
<td></td>
</tr>
<tr>
<td>Data type</td>
<td>Numeric</td>
</tr>
<tr>
<td>Form</td>
<td>Number</td>
</tr>
<tr>
<td>Representational layout</td>
<td>N{9}.N{2}</td>
</tr>
<tr>
<td>Minimum size</td>
<td>3</td>
</tr>
<tr>
<td>Maximum size</td>
<td>12</td>
</tr>
<tr>
<td>Data domain</td>
<td>N/A</td>
</tr>
<tr>
<td>Date effective</td>
<td>1 July 2017</td>
</tr>
<tr>
<td><strong>Related National Indicators</strong></td>
<td>None</td>
</tr>
</tbody>
</table>
**INDICATOR:** MS2201, MS2202, MS2203, MS2204  

**Leading Better Value Care:** Non-admitted Service Units established to support services provided to targeted patient cohorts (Number)

- Osteoarthritis Chronic Care Program (OACCP) (MS2201)
- Osteoporotic Re-fracture Prevention (ORP) (MS2202)
- High Risk Foot Service (HRFS) (MS2203)
- Renal Supportive Care (RSC) (MS2204)

**Previous IDs:**

Leading Better Value Care: Non-admitted Service Units established to support services provided to targeted patient cohorts (Number)

<table>
<thead>
<tr>
<th>Shortened Title(s)</th>
<th>LBVC – Service Units Established (OACCP)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>LBVC – Service Units Established (ORP)</td>
</tr>
<tr>
<td></td>
<td>LBVC – Service Units Established (HRFS)</td>
</tr>
<tr>
<td></td>
<td>LBVC – Service Units Established (RSC)</td>
</tr>
</tbody>
</table>

**Service Agreement Type:** Improvement Measure

**Framework Strategy:** Strategy 2: Provide World-Class Clinical Care Where Patient Safety Is First

**Framework Objective:** 2.2 (Move from volume to patient-centred value-based care)

**Status**

Final

**Version number**

1.01

**Scope**

**OACCP:** Patients aged 18 years and over with osteoarthritis affecting their hips or knees as primary condition.

**ORP:** Patients 50 years and over with osteoporosis presenting with a minimal trauma fracture.

**HRFS:** Patients with diabetic foot related conditions including lower limb amputation due to diabetes; Excision of bone due to osteomyelitis with diabetes as co-morbidity; Diabetic foot related infections/ulcers of foot or lower limb; Diabetic foot procedures, and Rehabilitation following lower limb amputation due to diabetes.

**RSC:** Patients with Chronic Kidney Disease (CKD) / End Stage Kidney Disease (ESKD) receiving renal replacement therapies who have persistent symptoms and/or severe comorbidities or those who opt not to pursue renal replacement.

**Goal**

To facilitate access to care in the appropriate setting

**Desired outcome**

Reduced treatment of the patient cohort in the admitted setting by increasing the availability of appropriate outpatient care

**Primary point of collection**

HERO

**Data Collection Source/System**

HERO

**Primary data source for analysis**

HERO, EDWARD

**Indicator definition**

The total number of non-admitted service units registered in HERO under the Leading Better Value Care initiative to support services
Numerator provided to targeted patient cohorts, reported by service program.

**Numerator**

**Numerator definition**
The total number of non-admitted service units registered in HERO under the Leading Better Value Care initiative to support services provided to targeted patient cohorts, broken down by service program:

- OACCP
- OPR
- HRFS
- Renal Supportive Care

**Numerator source**
HERO

**Numerator availability**
2017

**Inclusions**
N/A

**Exclusions**
N/A

**Targets**
N/A

**Context**

**Related Policies/ Programs**
Better Value Care Initiative

**Useable data available from**
2017

**Frequency of Reporting**
3 monthly

**Time lag to available data**
TBA

**Business owners**
Agency for Clinical Innovation

- **Contact - Policy**
  Director, Agency for Clinical Innovation

- **Contact - Data**
  Manager, Health Economics & Evaluation Team, Agency for Clinical Innovation

**Representation**

**Data type**
Numeric

**Form**
Number

**Representational layout**
NNN

**Minimum size**
1

**Maximum size**
3

**Data domain**

**Date effective**
1 July 2017
Related National Indicator
**2018-19 Service Performance Agreements**

**Strategy 2 IMs: Integrate Systems to Deliver Truly Connected Care**

<table>
<thead>
<tr>
<th>INDICATOR:</th>
<th>MS2208, MS2209, MS2210, MS2211</th>
</tr>
</thead>
</table>

**Previous IDs:**

- Osteoarthritis Chronic Care Program (OACCP) (MS2208)
- Osteoporotic Refracture Prevention (ORP) (MS2209)
- High Risk Foot Service (HRFS) (MS2210)
- Renal Supportive Care (RSC) (MS2211)

**Leading Better Value Care:** Non-admitted Patient Service Events provided to Targeted Patient Cohorts (NWAU)

<table>
<thead>
<tr>
<th>Shortened Title</th>
<th>LBVC – NAP Service Events (OACCP)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>LBVC – NAP Service Events (ORP)</td>
</tr>
<tr>
<td></td>
<td>LBVC – NAP Service Events (HRFS)</td>
</tr>
<tr>
<td></td>
<td>LBVC – NAP Service Events (RSC)</td>
</tr>
</tbody>
</table>

**Service Agreement Type:** Improvement Measure

**Framework Strategy:** Strategy 2: Provide World-Class Clinical Care Where Patient Safety Is First

**Framework Objective:** 2.2 (Move from volume to patient-centred value-based care)

**Status:** Final

**Version number:** 1.01

**Scope**

- **OACCP:** Patients aged 18 years and over with **osteoarthritis** affecting their hips or knees as primary condition.
- **ORP:** Patients 50 years and over with **osteoporosis** presenting with a minimal trauma fracture.
- **HRFS:** Patients with **diabetic foot related conditions** including lower limb amputation due to diabetes; Excision of bone due to osteomyelitis with diabetes as co-morbidity; Diabetic foot related infections/ulcers of foot or lower limb; Diabetic foot procedures, and Rehabilitation following lower limb amputation due to diabetes).
- **RSC:** Patients with **Chronic Kidney Disease (CKD) / End Stage Kidney Disease (ESKD)** receiving renal replacement therapies who have persistent symptoms and/or severe comorbidities or those who opt not to pursue renal replacement.

**Goal**

To facilitate access to care in the appropriate setting

**Desired outcome**

Reduced treatment of the patient cohort in the admitted setting by increasing the availability of appropriate outpatient care

**Primary point of collection**

Non-admitted patient services

**Data Collection Source/System**

Cerner CHOC, CHIME, iPM

**Primary data source for analysis**

HERO, EDWARD, ABM Portal

**Indicator definition**

The total number of non-admitted service events, in NWAU, provided by service units under the Leading Better Value Care initiative to support
services provided to targeted patient cohorts, reported by service program.

**Numerator**

**Numerator definition**
The total number of non-admitted service events, in NWAU, provided by service units under the Leading Better Value Care initiative to support services provided to targeted patient cohorts, broken down by service program:

- OACCP
- OPR
- HRFS
- Renal Supportive Care

**Numerator source**
ABM Portal

**Numerator availability**
2017

**Inclusions**
N/A

**Exclusions**
N/A

**Targets**
N/A

**Context**

**Related Policies/ Programs**
Better Value Care Initiative

**Useable data available from**
2017

**Frequency of Reporting**
3 monthly

**Time lag to available data**
TBA

**Business owners**
Agency for Clinical Innovation
- **Contact - Policy**
  Director, Agency for Clinical Innovation
- **Contact - Data**
  Director, Agency for Clinical Innovation

**Representation**

**Data type**
Numeric

**Form**
Number

**Representational layout**
NNN

**Minimum size**
1

**Maximum size**
3

**Data domain**

**Date effective**
1 January 2018
Related National Indicator
**INDICATOR:** MS2205  
**Previous IDs:** N/A

<table>
<thead>
<tr>
<th><strong>Leading Better Value Care:</strong> Completion of education modules for inpatient diabetic care (Number)</th>
</tr>
</thead>
</table>

**Shortened Title**  
LBVC – Diabetic Education Modules

**Service Agreement Type**  
Improvement Measure

**Framework Strategy**  
Strategy 2: Provide World-Class Clinical Care Where Patient Safety Is First

**Framework Objective**  
2.2 (Move from volume to patient-centred value-based care)

**Status**  
Draft

**Version number**  
1.01

**Scope**  
People aged 16 and over with a hospitalisation for any condition (eg heart failure) that is affected by diabetes.

**Goal**  
To identify, implement and assess a statewide approach to improve glycaemia management for patients with diabetes in hospital.

**Desired outcome**  
To improve patient experience; reduce adverse events and hospital length of stay and avoid failed hospital discharge.

**Primary point of collection**  
TBA

**Data Collection Source/System**  
TBA

**Primary data source for analysis**
- Training data (TBD)
- Clinical Audit*
- eMeds sites (eMeds Mpage could be a data source)
- My Health Learning / ACI moodle site

**Indicator definition**  
Total number of staff completing education modules in inpatient diabetic care

**Numerator**

**Numerator definition**  
Number of staff completing education modules in inpatient diabetic care

The total number of sites that participate in clinical audit (LHD Service Agreement) and % of admissions audited.

Baseline analysis to measure “movement” in common complications against. (Baseline to include linked audit and administrative data and other data as appropriate)

**Numerator source**  
Clinical audit
<table>
<thead>
<tr>
<th><strong>Numerator availability</strong></th>
<th>TBA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inclusions</strong></td>
<td>TBA</td>
</tr>
<tr>
<td><strong>Exclusions</strong></td>
<td>TBA</td>
</tr>
<tr>
<td><strong>Targets</strong></td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Context</strong></td>
<td>TBA</td>
</tr>
<tr>
<td><strong>Related Policies/ Programs</strong></td>
<td>Better Value Care Initiative</td>
</tr>
<tr>
<td><strong>Useable data available from</strong></td>
<td>TBA</td>
</tr>
<tr>
<td><strong>Frequency of Reporting</strong></td>
<td>TBA – proposed 6 monthly</td>
</tr>
<tr>
<td><strong>Time lag to available data</strong></td>
<td>TBA</td>
</tr>
<tr>
<td><strong>Business owners</strong></td>
<td>Agency for Clinical Innovation</td>
</tr>
<tr>
<td>Contact - Policy</td>
<td>Director, Acute Care, Agency for Clinical Innovation</td>
</tr>
<tr>
<td>Contact - Data</td>
<td>Manager, Health Economics &amp; Evaluation Team</td>
</tr>
<tr>
<td></td>
<td>Director, Acute Care, Agency for Clinical Innovation</td>
</tr>
<tr>
<td><strong>Representation</strong></td>
<td></td>
</tr>
<tr>
<td>Data type</td>
<td>Numeric</td>
</tr>
<tr>
<td>Form</td>
<td>Number</td>
</tr>
<tr>
<td>Representational layout</td>
<td>NNN</td>
</tr>
<tr>
<td>Minimum size</td>
<td>1</td>
</tr>
<tr>
<td>Maximum size</td>
<td>3</td>
</tr>
<tr>
<td>Data domain</td>
<td></td>
</tr>
<tr>
<td>Date effective</td>
<td>1 July 2017</td>
</tr>
<tr>
<td><strong>Related National Indicator</strong></td>
<td></td>
</tr>
</tbody>
</table>
2018-19 Service Performance Agreements
Strategy 2 IMs: Integrate Systems to Deliver Truly Connected Care

INDICATOR: MS2206, MS2207
Previous IDs:

Leading Better Value Care: Services investigating inpatient clinical variation (Number)
- Chronic Heart Failure (CHF) (MS2206)
- Chronic Obstructive Pulmonary Disease (COPD) (MS2207)

Shortened Title(s)
LBVC – Services Investigating Variation (CHF)
LBVC – Services Investigating Variation (COPD)

Service Agreement Type Improvement Measure
Framework Strategy Strategy 2: Provide World-Class Clinical Care Where Patient Safety Is First
Framework Objective 2.2 (Move from volume to patient-centred value-based care)

Status Draft
Version number 1.01

Scope
MS2206: People aged 18 years and older, admitted to a NSW public hospital with a primary diagnosis of chronic heart failure (CHF).
MS2207: People aged 40 years and older, admitted to a NSW public hospital with a primary diagnosis of chronic obstructive pulmonary disease (COPD).

Goal
The overarching goal of the work to be undertaken in 2017/18 is to ensure that by 2018-19 clear purchasing and funding decisions can be made around care for these cohorts and that care solutions support the triple aim of goals of improving patient/carer/staff experience, outcomes and efficiency and effectiveness.

To assess:
- The provision of best practice clinical care via audit based on the dimensions of the NSW CHF Care Bundle, based on the NSW Clinical Service Framework for Chronic Heart Failure and the Heart Foundation Guidelines for the prevention, detection and management of chronic heart failure in Australia (2011)
- The provision of best practice clinical care via audit based on the dimensions of the COPDX Plan: Australian and New Zealand Guidelines for the management of COPD 2016 and the Thoracic Society of Australia and New Zealand (TSANZ) oxygen guidelines for acute oxygen use in adults 2015
- The impact of variation in current care on selected patient outcome variables and efficiency measures through the triangulation and linkage of data.

Desired outcome
To improve patient experience; address any demonstrated unwarranted clinical variation in mortality and readmissions (as per the BHI report) and, where appropriate, improve efficiency and effectiveness of care in terms of length of stay, rate of hospitalisation and care in the last year of life.
Primary point of collection: TBA

Data Collection Source/System: TBA

Primary data source for analysis: TBA

Indicator definition: The total number of inpatient services that have participated in a clinical audit, reported by targeted condition.

Numerator:
- Numerator definition: The total number of inpatient services that have participated in a clinical audit, reported by targeted condition.
- Numerator source: TBA
- Numerator availability: TBA

Inclusions: TBA

Exclusions: TBA

Targets: N/A

Context:

Related Policies/Programs: Better Value Care Initiative

Useable data available from: TBA

**NOTE:** Work is currently ongoing with stakeholders to progress the linkage and triangulation of data as specified below (ACI, Health Economics and Evaluation Team):

Provision of sufficient data to support the following four stage process:
1. Collection of clinical audit data
2. Linkage of clinical audit data to NSW data sets
3. Triangulation of audit, administrative, fact of death (CHF and COPD) and other relevant data
4. Articulated issue to be addressed and documented solution

ACI to develop articulated and documented solution to issues identified. (ACI, Acute Care).

Frequency of Reporting: TBA – quarterly for audit counts

Time lag to available data: TBA
### Business owners
- Agency for Clinical Innovation
- Director, Acute Care, Agency for Clinical Innovation
- Manager, Health Economics & Evaluation Team

### Representation
<table>
<thead>
<tr>
<th>Data type</th>
<th>Numeric</th>
</tr>
</thead>
<tbody>
<tr>
<td>Form</td>
<td>Number</td>
</tr>
<tr>
<td>Representational layout</td>
<td>NNN</td>
</tr>
<tr>
<td>Minimum size</td>
<td>1</td>
</tr>
<tr>
<td>Maximum size</td>
<td>3</td>
</tr>
<tr>
<td>Date effective</td>
<td>1 July 2017</td>
</tr>
</tbody>
</table>

### Related National Indicator
**Breast Screen Participation Rates:**

- All women aged 50-69 (% (SSA126)
  - Aboriginal women aged 50-69 (% (SSA127)
  - Culturally and linguistically diverse women aged 50-69 (% (SSA128)
- All women aged 70-74 (% (SSA129)
  - Aboriginal women aged 70-74 (% (SSA130)
  - Culturally and linguistically diverse women aged 70-74 (% (SSA131)

**Shortened Title(s)**
- Breast Screen Participation Rates – All 50-69
- Breast Screen Participation Rates – Aboriginal 50-69
- Breast Screen Participation Rates – CALD 50-69
- Breast Screen Participation Rates – All 70-74
- Breast Screen Participation Rates – Aboriginal 70-74
- Breast Screen Participation Rates – CALD 50-69

**Service Agreement Type**
Improvement Measure

**Framework Strategy**
Strategy 2: Provide World-Class Clinical Care Where Patient Safety Is First

**Framework Objective**
2.3 (Improve the patient experience)

**Status**
Final

**Version number**
1.11

**Scope**
To measure the percentage of women aged 50-74 residing in the Service catchment area (Local Health District) who were screened by BreastScreen NSW during the most recent 24-month period. The indicator is disaggregated by age into 50-69, and 70-74 year age groups and by ethnicity (Aboriginality and culturally and linguistically diverse).

**Goal**
\[\geq 70\% \text{ of women aged 50-69 years participate in screening in the most recent 24-month period.}\]

**Desired outcome**
To increase access to screening for eligible women

**Primary point of collection**
BreastScreen NSW

**Data Collection Source/System**
Screening information from the BreastScreen NSW Program
Projected population data for the designated years from the Epidemiology and Surveillance Branch, NSW Ministry of Health Australian Bureau of Statistic (ABS) Census population data

**Primary data source for analysis**
BreastScreen NSW data

**Indicator definition**
Percentage of women in the target age group who were screened by BreastScreen NSW during the most recent 24-month period

**Numerator**

- **Numerator definition**
  Number of individual women residing in the Service catchment areas (LHD) in NSW aged 50-69 and 70-74 who had one or more breast

**INDICATOR:** SSA126, SSA127, SSA128, SSA129, SSA130, SSA131

**Previous IDs:** 8A1, 0037
screening episode with any Service in the Program during the 24-month reporting period

_Aboriginal women_
Number of individual Aboriginal women residing in the Service catchment areas (LHD) in NSW aged 50-69 and 70-74 years who had one or more breast screening episode with any Service in the Program during the 24-month reporting period. Aboriginality is derived from self-identification as being descended from Aboriginal and/or Torres Strait Islander

_Women from Culturally and Linguistically Diverse Backgrounds_
Number of individual culturally and linguistically diverse women residing in the Service catchment areas (LHD) in NSW aged 50-69 and 70-74 years who had one or more breast screening episode with any Service in the Program during the 24-month reporting period. Culturally and Linguistically Diverse status is derived from self-report of the main language spoken at home being a language other than English.

**Numerator source**
BreastScreen NSW data

**Numerator availability**
Available 10 business days after the end of the period of measurement.

**Denominator**

**Denominator definition**
- The population for all women is the weighted average of the projected population for women aged 50-74 years for the two reporting years as at 30 June
- The population for Aboriginal women and Culturally and Linguistically Diverse women is the most recent census population count for women in those specific groups

**Denominator source**
- Projected population data for the designated years from the Epidemiology and Surveillance Branch, NSW Ministry of Health.
- Census population for Aboriginal and Culturally and Linguistically Diverse women from the Australian Bureau of Statistics

**Denominator availability**
Available as requested

**Inclusions**
- No attempt has been made to adjust the population for women who have previously had breast cancer and are therefore not eligible for breast cancer screening through BreastScreen Australia

**Exclusions**
- Interstate women are excluded in the numerator
- Assessment-only women
- Numerator is the number of individual women screened by age group within a 24 month period (i.e. If a woman has been screened more than once in a 24 month period, then only the last screen is to be counted.)
- Women for whom the additional demographic information required to determine status of Aboriginality or Culturally and Linguistically Diverse (e.g. Language spoken at home and Indigenous status) is not stated or missing are excluded from the numerator for those disaggregations
### Targets

| Target | ≥70% of women aged 50-69 years participate in screening in the most recent 24-month period. |

### Context

**Related Policies/Programs**
- BreastScreen Australia National Accreditation Standards

**Useable data available from**
- 2002

**Frequency of Reporting**
- Monthly

**Time lag to available data**
- 1-2 weeks

**Business owners**
- Cancer Institute NSW

- **Contact - Policy**
  - Director, Screening and Prevention

- **Contact - Data**
  - Director, Screening and Prevention

**Representation**

<table>
<thead>
<tr>
<th>Data type</th>
<th>Numeric</th>
</tr>
</thead>
<tbody>
<tr>
<td>Form</td>
<td>Number, presented as a percentage (%)</td>
</tr>
<tr>
<td>Representational layout</td>
<td>NNN.N</td>
</tr>
<tr>
<td>Minimum size</td>
<td>3</td>
</tr>
<tr>
<td>Maximum size</td>
<td>4</td>
</tr>
<tr>
<td>Data domain</td>
<td>Percentage</td>
</tr>
<tr>
<td>Date effective</td>
<td>1 July 2013</td>
</tr>
</tbody>
</table>

**Related National Indicator**
- BreastScreen Australia 2005, Data Dictionary
- BreastScreen Australia 2008, National Accreditation Standards
### INDICATOR: MS2307

**Previous ID:**

### Shortened Title

**Patient Reported Experience Measures: Medications - adults who received information about safe use of medicines (%)**

### Service Agreement Type

**Improvement Measure**

### Framework Strategy

**Strategy 2: Provide World-Class Clinical Care Where Patient Safety is First**

### Framework Objective

2.3 (Improve the patient experience)

### Status

**Draft**

### Version number

**1.01**

### Scope

All patients who complete a Patient Reported Experience Measure

### Goal

To improve levels of patient understanding about the medications they are taking.

### Desired outcome

**Primary point of collection**

TBA

**Data Collection Source/System**

TBA

**Primary data source for analysis**

TBA

**Indicator definition**

Proportion of adults who received information about the safe use of medication in the reporting period.

### Numerator

**Numerator definition**

Number of adults completing a survey that received information about the safe use of medication in the reporting period.

**Numerator source**

Bureau of Health Information

**Numerator availability**

TBA

### Denominator

**Denominator definition**

Number of adults completing a survey in the reporting period.

**Denominator source**

Bureau of Health Information

**Denominator availability**

TBA

### Inclusions

TBA

### Exclusions

TBA

### Targets

**Context**

**Related Policies/ Programs**

**Useable data available from**

TBA

**Frequency of Reporting**

TBA

**Time lag to available data**

TBA
<table>
<thead>
<tr>
<th><strong>Business owners</strong></th>
<th>Bureau of Health Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact - Policy</td>
<td>Executive Director, Bureau of Health Information</td>
</tr>
<tr>
<td>Contact - Data</td>
<td>Executive Director, Bureau of Health Information</td>
</tr>
</tbody>
</table>

**Representation**

- **Data type**: Numeric
- **Form**: Number
- **Representational layout**: NNN.NN
- **Minimum size**: 4
- **Maximum size**: 6
- **Data domain**
- **Date effective**: 1 July 2017

**Related National Indicators**

- **Components**
### INDICATOR: SSQ119

**Previous IDs:**

- Patient Experience Survey – Emergency Department Patients: overall rating of care (%)
  - Percentage of patients rating care as “good” or “very good”

#### Shortened Title

Patient Experience Survey ED Patients

#### Service Agreement Type

Improvement Measure

#### Framework Strategy

Strategy 2: Provide World-Class Clinical Care Where Patient Safety is First

#### Status

Final

#### Version number

1.21

#### Scope

Sample of adult patients who attend hospital emergency departments in peer groups A1, A2, A3, B1, B2, C1 and C2 and where person-level data are supplied to statewide HIE. These hospitals contribute to the LHD total in proportion to the total number of emergency department attendances for all A1-C2 hospitals in that LHD.

#### Goal

Improve patients’ experience of care

#### Desired outcome

Increase proportion of patients rating their overall care as “good” or “very good”

#### Primary point of collection

Postal survey of recent emergency department patients with up to two reminders and alternative completion online

#### Data Collection Source/System

NSW Patient Survey Program data. Responses to Emergency Department Patient Survey

#### Indicator definition

Weighted percentage of survey respondents who rate their overall care in an Emergency Department as “good” or “very good”.

#### Numerator

<table>
<thead>
<tr>
<th>Numerator definition</th>
<th>Number of survey respondents who rate their overall care in an Emergency Department as “good” or “very good”. Data are weighted to represent the age profile of patients at each hospital.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator source</td>
<td>NSW Patient Survey Program data</td>
</tr>
<tr>
<td>Numerator availability</td>
<td>Available</td>
</tr>
</tbody>
</table>

#### Denominator

<table>
<thead>
<tr>
<th>Denominator definition</th>
<th>Total number of survey respondents answering this question. Data are weighted to represent the age profile of patients at each hospital.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator source</td>
<td>NSW Patient Survey Program data</td>
</tr>
<tr>
<td>Denominator availability</td>
<td>Available</td>
</tr>
</tbody>
</table>

#### Inclusions

All patients surveyed during the target period.
Facilities in peer groups A1 – C2
Valid Australian postal address

**Exclusions**
- As per inclusions above
- Subsequently admitted from the emergency department for care or treatment of:
  - termination of pregnancy
  - delivery of stillborn baby
  - maltreatment diagnosis codes (incl. sexual and physical abuse)
  - contraceptive management
- Patients that have died

**Targets**
- **Target:** Increase over previous years.
- **Context:** Health services should not only be of good clinical quality but should also provide a positive experience for the patient.

**Related Policies/ Programs**

**Useable data available from**
Quarterly data is available for April to June 2013 onwards. Previous data from 2007-2011 exists however direct comparisons are not advisable due to changes in the question wording.

**Frequency of Reporting**
Quarterly reporting at LHD level

**Time lag to available data**
Seven months from the end of each quarter

**Business owners**
- **Contact - Policy:** Directorate, Patient Based Care, Clinical Excellence Commission
- **Contact - Data:** Director Surveys and Quarterly Reports, Bureau of Health Information

**Representation**
- **Data type:** Numeric
- **Form:** Number, presented as a percentage
- **Representational layout:** NNN
- **Minimum size:** 1
- **Maximum size:** 3
- **Data domain:** Date effective
- **Date effective:** 2015

**Related National Indicator**
For other patient experience indicators, see the National Healthcare Agreement: PI 32 - Patient satisfaction/experience, 2018 [http://meteor.aihw.gov.au/content/index.phtml/itemId/658467](http://meteor.aihw.gov.au/content/index.phtml/itemId/658467)
# 2018-19 Service Performance Agreements

## Strategy 2 IMs: Integrate Systems to Deliver Truly Connected Care

### INDICATOR: MS2311

<table>
<thead>
<tr>
<th>Previous IDs:</th>
<th><strong>Patient Experience Survey – Respect and Dignity Score</strong> (Number)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>• Patient Experience Survey score of adult admitted patients on questions measuring that patient’s assessment of their being treated with respect and dignity.</strong></td>
<td></td>
</tr>
</tbody>
</table>

### Shortened Title

Respect and Dignity Score

### Service Agreement Type

Improvement Measure

### Framework Strategy

Strategy 2: Provide World-Class Clinical Care Where Patient Safety is First

### Framework Objective

2.3 (Improve the patient experience)

### Status

Final

### Version number

1.0

### Scope

Sample of adult patients who attend hospital emergency departments in peer groups A1, A2, A3, B1, B2, C1 and C2 and where person-level data are supplied to statewide HIE. These hospitals contribute to the LHD total in proportion to the total number of emergency department attendances for all A1-C2 hospitals in that LHD.

### Goal

Improve patients' experience of care

### Desired outcome

Increase LHD results patient-reported experience measure (PREM) on being treated with respect and dignity score (maximum possible score 10)

### Primary point of collection

Postal survey of recent emergency department patients with up to two reminders and alternative completion online

### Data Collection Source/System

NSW Patient Survey Program data.

### Primary data source for analysis

Weighted responses to Adult Admitted Patient Survey

### Indicator definition

The weighted average respect and dignity score across all patients with a valid response within the reporting period.

### Numerator

**Numerator definition**

Sum of scored responses for the following question and response scores:

- Did you feel you were treated with respect and dignity while you were in the hospital?
  - Yes, always (10); Yes, sometimes (5); No (0).

Missing values excluded from calculation.

Data are weighted to represent the age and stay type (overnight or same day) profile of patients at each hospital.

**Numerator source**

NSW Patient Survey Program data

**Numerator availability**

Available

### Denominator

**Denominator definition**

Total number of patients responding to question with a valid response option (as specified in the list of response options under ‘numerator’)
Data are weighted to represent the age and stay type (overnight or same day) profile of patients at each hospital.

Denominator source: NSW Patient Survey Program data
Denominator availability: Available

**Inclusions**
- Facilities in peer groups A1, A3, B1, B2, C1 and C2
- Patients aged 17 years or older until Dec 2013, then 18 years or older from Jan 2014 onwards
- Valid Australian postal address

**Exclusions**
- As per inclusions above
- Same day admissions less than 3 hours
- Same day episodes with a mode of separation of transfer
- Maternity admissions (incl. stillbirths, miscarriages and termination of pregnancy procedures)
- Patients treated for contraceptive management
- Haemodialysis patients
- Admitted patients treated in a mental health setting
- Maltreatment codes (incl. sexual and physical abuse)
- Patients that have died

**Targets**
- Target score of 10.0 out of 10.0
  - Not performing <=9.0
  - Underperforming >9.0 to <9.5 (non-exclusive)
  - Performing – organisational score >=9.5

**Context**
All patients should be treated with respect and dignity by staff of NSW Health. While performance is high, improvement is still possible and desirable.

**Related Policies/ Programs**
Useable data available from Quarterly data is available for January to March 2013 onwards.

**Frequency of Reporting**
Quarterly reporting at LHD level

**Time lag to available data**
Nine months from the end of each quarter

**Business owners**
- Contact - Policy: Executive Director, System Purchasing Branch, Ministry of Health
- Contact - Data: Director, Data Analysis and Management, Bureau of Health Information

**Representation**
- Data type: Numeric
- Form: Number
- Representational layout: NN.N
- Minimum size: 3
- Maximum size: 4
<table>
<thead>
<tr>
<th>Data domain</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Date effective</td>
<td>2018</td>
</tr>
</tbody>
</table>
### Organ and Tissue Donation:

**Organ and Tissue Donation – Discussed**

- Family discussed (%) *(PH-007A)*

**Organ and Tissue Donation – Consented**

- Family consented (%) *(PH-007B)*

<table>
<thead>
<tr>
<th>Service Agreement Type</th>
<th>Improvement Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Framework Strategy</td>
<td>Strategy 2: Provide World-Class Clinical Care Where Patient Safety Is First</td>
</tr>
<tr>
<td>Framework Objective</td>
<td>2.3 (Improve the patient experience)</td>
</tr>
</tbody>
</table>

#### Scope

NSW Hospitals within the DonateLife Network (employ DonateLife donation specialist staff).

#### Goal

Monitor the percentage of families of potential organ donors with whom organ donation for transplantation was discussed and who agreed to organ donation for transplantation.

#### Desired outcome

Increase the percentage of families of potential organ donors with whom organ donation for transplantation was discussed and who agreed to organ donation for transplantation.

#### Primary point of collection

Medical Records / PAS reviewed by DonateLife Auditor

#### Data Collection Source/System

DonateLife Audit Tool

#### Primary data source for analysis

DonateLife Audit

#### Indicator definition

**PH-007A** - The percentage of families of potential organ donors with whom organ donation for transplantation was discussed, whether raised by staff or the family or the patient’s wishes were otherwise determined.

**PH-007B** – The percentage of families of potential organ donors who consented to organ donation for transplantation. This includes where a decision was registered on the AODR or RMS register and a Designated Officer has approved donation where the potential donor had no contactable family.

**Potential Organ Donor** – A potential organ donor is a patient who is medically suitable to donate organs for transplantation and has the potential to do so through Donation after Brain Death (DBD).

**Brain Death** - Death determined to have occurred on the basis of the absence of brain function.

#### Numerator

**Numerator definition**

**PH-007A** – The total number of families of potential organ donors with whom organ donation for transplantation was discussed, whether raised by staff or the family or the patient’s wishes were otherwise determined.
2018-19 Service Performance Agreements
Strategy 2 IMs: Integrate Systems to Deliver Truly Connected Care

**PH-007B** – The total number of families of potential organ donors who consented to organ donation for transplantation. This includes where a Designated Officer has approved donation where a decision was registered on the AODR or RMS register and the potential donor had no contactable family.

Numerator source: DonateLife Audit
Numerator availability: Available from the NSW Organ and Tissue Donation Service

**Denominator**
Denominator definition: **PH-007A** and **PH-007B** – The total number of potential organ donors.

Denominator source: DonateLife Audit
Denominator availability: Available from the NSW Organ and Tissue Donation Service

**Inclusions**
All potential DBD organ donors.

**Exclusions**
Eye and tissue donation.

**Targets**
**PH-007A** – 100%
**PH-007B** – 75%

**Context**
Increasing Organ Donation in NSW Government Plan 2012

**Related Policies/ Programs**
N/A

**Useable data available from**
July 2015

**Frequency of Reporting**
Hospital specific outcomes are reported to the hospital executive/leadership/organ and tissue donation teams on a quarterly basis.

**Time lag to available data**
Two months after the end of each quarter.

**Business owners**
Contact - Policy: Office of the Chief Health Officer
Contact - Data: NSW Organ and Tissue Donation Service

**Representation**
Data type: Numeric
Form: Number, presented as a percentage (%)
Representational layout: N{NN}
Minimum size: 1
Maximum size: 3
Data domain: N/A
Date effective: July 2015

**Related National Indicators**
Strategy 2 IMs: Integrate Systems to Deliver Truly Connected Care

Indicator: N/A
| INDICATOR: MS2302; MS2303; MS2304; MS2308; MS2309; MS2310 | Elective Surgery Access Performance Impact (%):

- Elective Surgery Patients Treated on Time by (i) the Relative Socio-economic Disadvantage Index (IRSD) and (ii) Aboriginality (%):
  - Category 1 by IRSD (MS2302)
  - Category 1 by Aboriginality (MS2308)
  - Category 2 by IRSD (MS2303)
  - Category 2 by Aboriginality (MS2309)
  - Category 3 by IRSD (MS2304)
  - Category 3 by Aboriginality (MS2310)

| Previous ID: |
|---|---|

**Shortened Title**

Elective Surgery Access Performance Impact

**Service Agreement Type**

Improvement Measure

**Framework Strategy**

Strategy 2: Provide World-Class Clinical Care Where Patient Safety is First

**Framework Objective**

2.4 (Ensure timely access to care)

**Status**

Final

**Version number**

1.01

**Scope**

All elective surgery patients who are admitted and included in the NSW Ministry of Health Waiting Times Collection.

**Goal**

To ensure that elective surgical patients receive their surgery within the clinically recommended timeframe in NSW public hospitals.

**Desired outcome**

Better management of waiting lists to minimise waiting time for elective surgery.

**Primary point of collection**

Waiting List/Booking Clerk: Receipt of inbound Recommendation for Admission Form (RFA) to a public hospital for patient registration on waiting list.

**Data Collection Source/System**

Patient Admission System (PAS)/Waiting List Collection On–Line System (WLCOS)

**Primary data source for analysis**

WLCOS/Wait List /Scheduling Data Stream (via EDWARD)

**Indicator definition**

The percentage (%) of elective surgery patients on the NSW Ministry of Health Waiting Times Collection who were admitted within the timeframe recommended for their clinical urgency/priority category, disaggregated by (i) the Relative Socio-economic Disadvantage Index (IRSD) and (ii) Aboriginality, for each clinical urgency/priority category.

- Aboriginal = indigenous_status codes of 1, 2 or 3
- Non-Aboriginal = indigenous_status codes of 4, 8 or 9

The IRSD is based upon the SLA of the patient's home address.

**Numerator**

Numerator definition

Total number of elective surgery patients in the NSW Ministry of Health Waiting Times Collection, disaggregated by clinical urgency/priority category, who:

- have been admitted for treatment within the reporting period,
- (measured by removal from the waiting list removal with a status = 1, 2, 7, 8), AND
were admitted within the timeframe recommended for their clinical urgency/priority category, where waiting time is measured from the last assigned clinical urgency/priority category or any other previous equal to or higher clinical urgency/priority category;

- disaggregated by (i) the Relative Socio-economic Disadvantage Index. The IRSD is based upon the SLA of the patient’s home address; and (ii) Aboriginality

Note: Includes:

- Staged patients Refer to Waiting Time and Elective Surgery Policy for management of staged patients
- Emergency admissions for their recorded waitlist procedure

Note on the transition to EDWARD: Whereas WLCOS receives the last 3 clinical urgency/priority category changes for a given booking, EDWARD receives all clinical urgency/priority category changes for a given booking. There are some instances where the WLCOS and EDWARD result will differ due to this limitation, with EDWARD reporting a more accurate value.

**Numerator source**
WLCOS

**Numerator availability**
Available Monthly

**Denominator**

**Denominator definition**
Total number of surgical patients in the NSW Ministry of Health Waiting Times Collection who have been admitted for treatment within the reporting period for each clinical urgency/priority category, disaggregated by (i) the Relative Socio-economic Disadvantage Index and (ii) Aboriginality

**Denominator source**
WLCOS

**Denominator availability**
Available

**Inclusions**
Surgical patients in the NSW Ministry of Health Waiting Times Collection who have been admitted for treatment, where the reason for removal is:

- 1 Routine admission
- 2 Emergency Admissions, where the patient has surgery for the waitlisted procedure
- 7 Admission contracted to another hospital, OR
- 8 Admission contracted to a private hospital/day procedure centre

**Exclusions**
- Patients whose Waiting List Category is not ‘Elective Surgery’
- Elective surgery patients with an Indicator Procedure Code of 277 (Peritonectomy)

**Targets**
N/A

**Context**
To ensure timely access to Elective Surgery.

**Related Policies and Programs**
- Waiting Time and Elective Surgery Policy 2012
- Agency for Clinical Innovation: Surgery, Anaesthesia and Critical Care Portfolio
• Operating Theatre Efficiency Guidelines: A guide to the efficient management of operating theatres in New South Wales hospitals

Useable data available from
July 2005

Frequency of Reporting
Monthly/Weekly

Time lag to available data
Reporting required by the 10th day of each month, data available for previous month.

Business owners
Contact - Policy
Executive Director, System Purchasing Branch

Contact - Data
Executive Director, System Information and Analytics

Representation
Data type
Numeric

Form
Number, presented as a percentage (%)

Representational layout
NNN.NN

Minimum size
3

Maximum size
6

Date effective
1 July 2017

Related National Indicator
National Healthcare Agreement: PI 20a–Waiting times for elective surgery: waiting times in days, 2018
http://meteor.aihw.gov.au/content/index.phtml/itemId/658495
Meteor ID: 658495

National Healthcare Agreement: PI 20b–Waiting times for elective surgery: proportion seen on time, 2018
http://meteor.aihw.gov.au/content/index.phtml/itemId/658493
Meteor ID: 658493
INDICATOR: SSA101, SSA102

Patients with Total time in ED <= 4hrs:

- Admitted (to a ward/ICU/theatre from ED) (%) (SSA101)
- Not Admitted (to an Inpatient Unit from ED) (%) (SSA102)

Previous IDs:

Patients in ED <=4hrs – Admitted
Patients in ED <=4hrs – Not Admitted

Service Agreement Type: Improvement Measure
Framework Strategy: Strategy 2: Provide World-Class Clinical Care Where Patient Safety is First
Framework Objective: 2.4 (Ensure timely access to care)

Status: Final
Version number: 4.22

Scope: All emergency presentations where treatment has been completed
Goal: To improve access to public hospital services

Desired outcome:
- Improved patient satisfaction
- Improved efficiency of Emergency Department services

Primary point of collection: Emergency Department Clerk
Data Collection Source/System: Emergency Department Data Collection
Primary data source for analysis: HIE (ED_Visit)

Indicator definition:
The percentage of ED patients whose clinical care in the ED has ceased as a result of their physically leaving the ED, or where clinical care has ceased as a result of their being ready for departure following discharge from the ED, and whose ED stay length is <= 4 hours, disaggregated by their mode of separation (admitted and not admitted).

ED stay length is calculated as subtracting presentation date/time from ED physical departure date/time, where:

- **Presentation date/time in the ED** is the time and date of the first recorded contact with an emergency department staff member. The first recorded contact can be the commencement of the clerical registration or triage process, whichever happens first and;

- **Departure date/time** is measured using the following business rules:
  
  - If the patient is subsequently admitted to this hospital (either short stay unit, hospital-in-the-home or non-emergency department hospital ward), then record the time the patient leaves the emergency department to go to the admitted patient facility. For NSW, this corresponds to Mode of Separation codes ‘01’, ‘10’ or ‘11’, and is calculated using the “Actual Departure Date and Time” field in source systems.
  
  - If the service episode is completed without the patient being admitted, and the patient is referred to another hospital for admission, then record the time the patient leaves the emergency department. For NSW, this corresponds to Mode of Separation code ‘05’ and is calculated using the “Actual Departure Date and Time” field in source systems.
If the service episode is completed without the patient being admitted, including where the patient is referred to another clinical location, then record the time the patient's emergency department non-admitted clinical care ended. For NSW, this corresponds to Mode of Separation codes '04' or '09' and is calculated using the earlier of “Departure Ready Date and Time”, or “Actual Departure Date and Time” fields in source systems.

If the patient did not wait, then record the time the patient leaves the emergency department or was first noticed as having left. For NSW, this corresponds to Mode of Separation code ‘06’ and is calculated using the “Actual Departure Date and Time” field in source systems.

If the patient leaves at their own risk, then record the time the patient leaves the emergency department or was first noticed as having left. For NSW, this corresponds to Mode of Separation codes ‘07’ and is calculated using the “Actual Departure Date and Time” field in source systems.

If the patient died in the emergency department, then record the time the body was removed from the emergency department. For NSW, this corresponds to Mode of Separation code ‘03’ and is calculated using the “Actual Departure Date and Time” field in source systems.

If the patient was dead on arrival, then record the time the body was removed from the emergency department. If an emergency department physician certified the death of the patient outside the emergency department, then record the time the patient was certified dead. For NSW, this corresponds to Mode of Separation code ‘08’ and is calculated using the "Actual Departure Date and Time" field in source systems.

**NOTE:** For the purposes of this Measure, an ED presentation is defined as the totality of an ED visit, from the time and date of the first recorded contact with an emergency department staff member to the point where the visit has concluded and the clinical care in the ED has ceased.

**Numerator**

**Numerator definition**

**SSA101:** All patients, whose actual_departure_date falls within the reporting period, and who have a length of stay from presentation time to actual departure time of less than or equal to 4 hours, and who are admitted to a ward, to ICU or to theatre from ED, as represented by one of the following separation modes: ‘1’, ‘10’, ‘11’

**SSA102:** All patients, whose actual_departure_date falls within the reporting period, and who have a length of stay from presentation time to actual departure time of less than or equal to 4 hours, and who are not admitted to a ward, to ICU or to theatre from ED.

**Numerator source**

HIE (Emergency Department Data Collection)

**Numerator availability**

Available

**Denominator**

**Denominator definition**

**SSA101:** The total number of emergency department presentations who were admitted to a ward, to ICU or to theatre from ED, where the actual_departure_date falls within the reporting period.

**SSA102:** The total number of emergency department presentations who were not admitted to a ward, to ICU or to theatre from ED, where the actual_departure_date falls within the reporting period.
### Denominator source
HIE (Emergency Department Data Collection)

### Denominator availability
Available

#### Inclusions
- All patients presenting to the emergency department at facilities that currently provide patient episode data to the non-admitted patients ED minimum data collection
- All patients that departed during the reporting period
- Only records where “Presentation time” (i.e. triage or arrival time) and actual Departure date/time are present
- For SSA101, the following Emergency Department Modes of Separation values are included in calculation:
  - 1- Admitted to a ward/inpatient unit, not critical care
  - 10-Admitted to a critical care unit
  - 11-Admitted via operating suite

#### Exclusions
- Records where total time in ED is missing, less than zero or greater than 99,998 minutes
- Visit type in ('12', '13') i.e. Telehealth presentation, current admitted patient presentation
- Separation mode = ‘99’ i.e. Registered in error
- Duplicate with same facility, MRN, arrival date, arrival time and birth date

#### Targets
N/A

#### Context
Improved public patient access to emergency department (ED) services by improving efficiency and capacity in public hospitals

#### Related Policies/Programs
- Intergovernmental Agreement on Federal Financial Relations
- Whole of Health Program
- Centre for Health Care Redesign

#### Useable data available from
July 1996

#### Frequency of Reporting
Monthly

#### Time lag to available data
Reporting required by the 10th day of each month, data available for previous month

#### Business owners
- **Contact - Policy**: Executive Director, System Purchasing Branch
- **Contact - Data**: Executive Director, System Information and Analytics

#### Representation
<table>
<thead>
<tr>
<th>Data type</th>
<th>Numeric</th>
</tr>
</thead>
<tbody>
<tr>
<td>Form</td>
<td>Number, presented as a percentage (%)</td>
</tr>
<tr>
<td>Representational layout</td>
<td>NNN.NN</td>
</tr>
<tr>
<td>Minimum size</td>
<td>3</td>
</tr>
<tr>
<td>Maximum size</td>
<td>5</td>
</tr>
<tr>
<td>Data domain</td>
<td></td>
</tr>
<tr>
<td>Date effective</td>
<td>1 July 2012</td>
</tr>
</tbody>
</table>
2018-19 Service Performance Agreements
Strategy 2 IMs: Integrate Systems to Deliver Truly Connected Care

Related National Indicators

National Healthcare Agreement: PI 21b-Waiting times for emergency hospital care: proportion of patients whose length of emergency department stay is less than or equal to four hours, 2018
Meteor ID: 658489
http://meteor.aihw.gov.au/content/index.phtml/itemId/658489

National Health Performance Authority, Hospital Performance: Waiting times for emergency hospital care: Percentage completed within four hours, 2014
Meteor ID: 558277
http://meteor.aihw.gov.au/content/index.phtml/itemId/558277

Components

Meteor ID 474181 Non-admitted patient emergency department service episode—service episode length, total minutes NNNNN
The amount of time, measured in minutes, between when a patient presents at an emergency department, and when the non-admitted emergency department service episode has concluded
http://meteor.aihw.gov.au/content/index.phtml/itemId/474181

Meteor ID 471889 Emergency department stay—presentation time, hhmm
The time of patient presentation at the emergency department is the time of first recorded contact with an emergency department staff member. The first recorded contact can be the commencement of the clerical registration or triage process, whichever happens first
http://meteor.aihw.gov.au/content/index.phtml/itemId/471889
**INDICATOR:** SSA104

**Previous ID:** 9B2, 0011, 0012, 0013, 0014 & 0015

---

**Shortened Title**

ED presentations treated within benchmark times

---

### Service Agreement Type

Improvement Measure

---

### Framework Strategy

Strategy 2: Provide World-Class Clinical Care Where Patient Safety is First

---

### Framework Objective

2.4 (Ensure timely access to care)

---

### Status

Final

---

### Version number

3.11

---

### Scope

All presentations to the Emergency Department that have been allocated a valid Triage Category

---

### Goal

- To improve access to clinical services
- To reduce waiting time in the Emergency Department

---

### Desired outcome

- Reduced waiting time by improvement in process
- Better management of resources and workloads

---

### Primary point of collection

Emergency Department Clerk

---

### Data Collection Source/System

Emergency Department Data Collection

---

### Primary data source for analysis

HIE (ED_Visit)

---

### Indicator definition

The triage performance is the percentage of presentations where commencement of clinical care is within national performance indicator thresholds for the first assigned triage category as follows:

- **Triage category 1:** seen within seconds, calculated as less than or equal to 2 minutes
- **Triage category 2:** seen within 10 minutes
- **Triage category 3:** seen within 30 minutes
- **Triage category 4:** seen within 60 minutes
- **Triage category 5:** seen within 120 minutes

where:

- **Presentation time** is the triage date/time. If the triage time is missing it is the arrival date/time and;
- **Commencement of clinical care** is the earliest of first seen clinician date/time or first seen nurse date/time

**Note:** Where a patient changes triage category while waiting for treatment (re-triage), the originally assigned triage category is to be used for the purposes of calculating performance against this service measure.

**NOTE:** For the purposes of this Measure, an **ED presentation** is defined as the totality of an ED visit, from the date and time of Triage (or arrival time if missing) to the point where the visit has concluded and the clinical care in the ED has ceased.
**Numerator**

**Numerator definition**
The number of presentations within the originally assigned triage category where the time between presentation time and commencement of clinical care is within performance indicator thresholds for the relevant Triage category, where the actual_departure_date falls within the reporting period.

**Numerator source**
HIE (Emergency Department Data Collection)

**Numerator availability**
Available

**Denominator**

**Denominator definition**
The total number of presentations in each triage category, where the actual_departure_date falls within the reporting period.

**Denominator source**
HIE (Emergency Department Data Collection)

**Denominator availability**
Available

**Inclusions**
- Only records where Presentation time, and clinical care commenced time are present
- Emergency visit type in (‘1’, ‘3’, ‘11’) i.e. Emergency presentation, unplanned return visit for continuing condition or disaster

**Exclusions**
- Records where waiting time in ED is missing or greater than 99,998 minutes
- Separation mode in (‘99’, ‘6’, ‘8’) i.e. registered in error, did not wait or dead on arrival
- Duplicate with same facility, MRN, arrival date, arrival time and birth date

**Targets**
- Triage Category 1 = 100%
- Triage Category 2 = 80%
- Triage Category 3 = 75%
- Triage Category 4 = 70%
- Triage Category 5 = 70%

**Context**
Triage aims to ensure that patients commence clinical care in a timeframe appropriate to their clinical urgency and allocates patients into one of the 5 triage categories.

The accuracy of triage is the core process of clinical services and determining of clinical urgency for treatment. Triage categorisation is required to identify the commencement of the service and the calculation of waiting times.

**Related Policies/ Programs**
- Whole of Health Program
- Centre for Health Care Redesign
- [PD2013_047 Triage of Patients in NSW Emergency Departments](#)

**Useable data available from**
July 1995

**Frequency of Reporting**
Monthly / Weekly

**Time lag to available data**
Reporting required by the 10th day of each month, data available for previous month

**Business owners**
Contact - Policy
Executive Director, System Relationships Branch
### Representation

<table>
<thead>
<tr>
<th>Data type</th>
<th>Numeric</th>
</tr>
</thead>
<tbody>
<tr>
<td>Form</td>
<td>Number, presented as a percentage (%)</td>
</tr>
<tr>
<td>Representational layout</td>
<td>NNN.N</td>
</tr>
<tr>
<td>Minimum size</td>
<td>1</td>
</tr>
<tr>
<td>Maximum size</td>
<td>3</td>
</tr>
<tr>
<td>Date effective</td>
<td>1 July 2007</td>
</tr>
</tbody>
</table>

### Related National Indicators

- National Healthcare Agreement: PI 21a-Waiting times for emergency hospital care: Proportion seen on time, 2018
  - Meteor ID 658491
  - [http://meteor.aihw.gov.au/content/index.phtml/itemId/658491](http://meteor.aihw.gov.au/content/index.phtml/itemId/658491)

- National Health Performance Authority, Hospital Performance: Percentage of patients who commenced treatment within clinically recommended time 2014
  - Meteor ID: 563081
  - [http://meteor.aihw.gov.au/content/index.phtml/itemId/563081](http://meteor.aihw.gov.au/content/index.phtml/itemId/563081)

### Components

- Meteor ID 471932 Emergency department stay—waiting time (to commencement of clinical care), total minutes NNNNN
  - Calculated by subtracting the date and time the patient presents to the emergency department from the date and time the emergency department non-admitted clinical care commenced. Although triage category 1 is measured in seconds, it is recognised that the data will not be collected with this precision
  - [http://meteor.aihw.gov.au/content/index.phtml/itemId/471932](http://meteor.aihw.gov.au/content/index.phtml/itemId/471932)

- Meteor ID 471889 Emergency department stay—presentation time, hhmm
  - The time of patient presentation at the emergency department is the time of first recorded contact with an emergency department staff member. The first recorded contact can be the commencement of the clerical registration or triage process, whichever happens first
  - [http://meteor.aihw.gov.au/content/index.phtml/itemId/471889](http://meteor.aihw.gov.au/content/index.phtml/itemId/471889)
INDICATOR: KSA201
Previous ID: 9B9, 0028

Emergency Department Extended Stays: Presentations staying in ED > 24 hours (number)

Previously known as:
- ED Presentations staying in ED > 24 hours (number)

Shortened Title
ED Extended Stays > 24 hrs

Service Agreement Type
Improvement Measure

Framework Strategy
Strategy 2: Provide World-Class Clinical Care Where Patient Safety is First

Framework Objective
2.4 (Ensure timely access to care)

Status
Final

Version number
2.43

Scope
All Emergency Department patients

Goal
To improve access to services within the Emergency Departments and other admitted patient areas

Desired outcome
- Improve the patient satisfaction and availability of services with reduced length of stay and waiting time for services within the Emergency Department
- Improve the access to inpatient services for patients admitted via the Emergency Department

Primary point of collection
Emergency Department Clerk

Data Collection Source/System
Emergency Department Data Collection

Primary data source for analysis
HIE (ED_Visit)

Indicator definition
The number of presentations where the total time spent in ED was longer than 24 hours, measured from presentation time to departure time where:
- **Presentation time in the ED** is the triage time. If the triage time is missing it is the arrival time and;
- **Departure time** is the earliest of departure ready date/time or actual departure date/time for non-admitted patients with a mode of separation 2, 4 or 9; otherwise it is the actual departure date/time.

**NOTE:** For the purposes of this Measure, an **ED presentation** is defined as the totality of an ED visit, from the date and time of Triage (or arrival time if missing) to the point where the visit has concluded and the clinical care in the ED has ceased.

**Numerator**

**Numerator definition**
The number of presentations in the Emergency Department where total time spent in the ED > 24 hours, where the **actual_departure_date** falls within the reporting period.

**Numerator source**
HIE (Emergency Department Data Collection)

**Numerator availability**
Available

**Denominator**

**Denominator definition**

**Denominator source**

**Denominator availability**
**Inclusions**

Emergency visit type in ('1', '3', '11')

**Exclusions**

- Records where total time in ED is missing, less than zero or greater than 99,998 minutes
- Separation mode in ('6', '7', '8', '99') i.e. DNW, Left at own risk, DoA and Registered in error
- Duplicate with same facility, MRN, arrival date, arrival time and birth date

**Targets**

Target: 0 (zero / nil) presentations during a month

Not performing: > 5 presentations during a month

Under performing: Between 1 and 5 presentations during a month.

**Context**

Timely admission to a hospital bed, for those emergency department patients who require inpatient treatment, contributes to patient comfort and improves outcomes and the availability of Emergency Department services for other patients.

**Related Policies/ Programs**

- Whole of Health Program
- Centre for Health Care Redesign

**Useable data available from**

July 2001

**Frequency of Reporting**

Monthly/Weekly

**Time lag to available data**

Reporting required by the 10th day of each month, data available for previous month

**Business owners**

- Contact - Policy: Executive Director, System Relationships Branch
- Contact - Data: Executive Director, System Information and Analytics

**Representation**

<table>
<thead>
<tr>
<th>Data type</th>
<th>Numeric</th>
</tr>
</thead>
<tbody>
<tr>
<td>Form</td>
<td>Number</td>
</tr>
<tr>
<td>Representational layout</td>
<td>NNNNNNN</td>
</tr>
<tr>
<td>Minimum size</td>
<td>3</td>
</tr>
<tr>
<td>Maximum size</td>
<td>6</td>
</tr>
<tr>
<td>Data domain</td>
<td></td>
</tr>
<tr>
<td>Date effective</td>
<td></td>
</tr>
</tbody>
</table>

**Related National Indicators**

**Components**

Meteor ID 474181 Non-admitted patient emergency department service episode—service episode length, total minutes NNNNN

The amount of time, measured in minutes, between when a patient presents at an emergency department, and when the non-admitted emergency department service episode has concluded

http://meteor.aihw.gov.au/content/index.phtml/itemid/474181

Meteor ID 471889 Emergency department stay—presentation time, hh:mm

The time of patient presentation at the emergency department is the time of first recorded contact with an emergency department staff member. The first recorded contact can be the commencement of the clerical registration or triage process,
whichever happens first

http://meteor.aihw.gov.au/content/index.phtml/itemId/471889
### Emergency Department Extended Stays: Presentations staying in ED > 12 hours (number)

**INDICATOR:** MS2401

**Previous ID:**

<table>
<thead>
<tr>
<th>Shortened Title</th>
<th>ED Extended Stays &gt; 12 hrs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Service Agreement Type</strong></td>
<td>Improvement Measure</td>
</tr>
<tr>
<td><strong>Framework Strategy</strong></td>
<td>Strategy 2: Provide World-Class Clinical Care Where Patient Safety is First</td>
</tr>
<tr>
<td><strong>Framework Objective</strong></td>
<td>2.4 (Ensure timely access to care)</td>
</tr>
<tr>
<td><strong>Status</strong></td>
<td>Final</td>
</tr>
<tr>
<td><strong>Version number</strong></td>
<td>1.03</td>
</tr>
<tr>
<td><strong>Scope</strong></td>
<td>All Emergency Department patients</td>
</tr>
<tr>
<td><strong>Goal</strong></td>
<td>To improve access to services within the Emergency Departments and other admitted patient areas</td>
</tr>
</tbody>
</table>
| **Desired outcome** | • Improve the patient satisfaction and availability of services with reduced length of stay and waiting time for services within the Emergency Department  
• Improve the access to inpatient services for patients admitted via the emergency department |
| **Primary point of collection** | Emergency Department Clerk |
| **Data Collection Source/System** | Emergency Department Data Collection |
| **Primary data source for analysis** | HIE (ED_Visit) |
| **Indicator definition** | The number of presentations where the total time spent in ED was longer than 12 hours, measured from presentation time to departure time where:  
• **Presentation time in the ED** is the triage time. If the triage time is missing it is the arrival time and;  
• **Departure time** is the earliest of departure ready date/time or actual departure date/time for non-admitted patients with a mode of separation 2, 4 or 9; otherwise it is the actual departure date/time.  

**NOTE:** For the purposes of this Measure, an ED presentation is defined as the totality of an ED visit, from the date and time of Triage (or arrival time if missing) to the point where the visit has concluded and the clinical care in the ED has ceased. |

#### Numerator

**Numerator definition** | The number of presentations in the Emergency Department where total time spent in the ED > 12 hours, where the actual_departure_date falls within the reporting period. |
| **Numerator source** | HIE (Emergency Department Data Collection) |
| **Numerator availability** | Available |

#### Denominator

**Denominator definition** | N/A |
**Inclusions**
Emergency visit type in ('1','3','11')

**Exclusions**
- Records where total time in ED is missing, less than zero or greater than 99,998 minutes
- Separation mode in ('6','7','8','9') i.e. DNW, Left at own risk, DoA and Registered in error
- Duplicate with same facility, MRN, arrival date, arrival time and birth date

**Targets**
N/A

**Context**
Timely admission to a hospital bed, for those emergency department patients who require inpatient treatment, contributes to patient comfort and improves outcomes and the availability of emergency department services for other patients.

**Related Policies/ Programs**
- Whole of Health Program
- Centre for Health Care Redesign

**Useable data available from**
July 2001

**Frequency of Reporting**
Monthly/Weekly

**Time lag to available data**
Reporting required by the 10th day of each month, data available for previous month

**Business owners**
- Contact - Policy: Executive Director, System Relationships Branch
- Contact - Data: Executive Director, System Information and Analytics

**Representation**
- Data type: Numeric
- Form: Number
- Representational layout: NNNNNN
- Minimum size: 3
- Maximum size: 6

**Related National Indicators**
**Components**
Meteor ID 474181 Non-admitted patient emergency department service episode—service episode length, total minutes NNNNNN
The amount of time, measured in minutes, between when a patient presents at an emergency department, and when the non-admitted emergency department service episode has concluded
http://meteor.aihw.gov.au/content/index.phtml/itemid/474181

Meteor ID 471889 Emergency department stay—presentation time, hhmm
The time of patient presentation at the emergency department is the time of first recorded contact with an emergency department staff member. The first recorded contact can be the commencement of the clerical registration or triage process, whichever happens first
INDICATOR: MS2406

**Outpatient On Time Performance:** Patients waiting more than 365 days for an initial outpatient service appointment (Number)

**Previous IDs:**

**Shortened Title**
Outpatient On Time Performance

**Service Agreement Type**
Improvement Measure

**Framework Strategy**
Strategy 2: Provide World-Class Clinical Care Where Patient Safety Is First

**Framework Objective**
2.4 (Ensure timely access to care)

**Status**
Final

**Version number**
1.0

**Scope**
All non-admitted activity provided by Tier 2 clinics all classes (10, 20, 30 and 40).

**Goal**
Improve the delivery of public outpatient services, to ensure patients across NSW have equitable access to optimal quality services in the public outpatient setting

**Desired outcome**
Reduction in the number of patients waiting more than 365 days for a public outpatient service.

**Primary point of collection**
Registration and classification of non-admitted patient service units
Scheduling non-admitted patient appointments
Recording non-admitted patient service attendances
Documenting service provision details in patient medical records

**Data Collection Source/System**
NSW Non-admitted Patient Data Collection
HERO Organisation Provider Data Set

Non-admitted patient activity is recorded in a wide range of source systems, some of which address the needs of specific clinical specialties.

The strategic source systems from which the majority of activity is expected are HNA Millennium / eMR (Cerner), iPM and CHIME.

HERO (Health Establishment Registration On-line system) is the source system used by LHDs / SHNs to register non-admitted patient service units, indicate their parent hospital / community health service and classify them by service unit type.

**Primary data source for analysis**
EDWARD Non-admitted Patient Data Mart

Note: The data mart acquires its data from the following sources:
- EDWARD (activity)
- HERO (service unit details)

**Indicator definition**
The number of initial service events reported for a month by NSW Health outpatient services where the waiting time (measured as the number of calendar days) between the referral listing (referral received) date and the service event start date is greater than 365 days.
Initial is defined as: the first attendance at an outpatient clinic for a new condition following a formal (written) referral.

**Numerator**
- **Numerator definition**: Number of service events where the difference between the Referral Listing (Referral Received) Date and the Service Event Start Date is > 365 days, AND where the Initial / Subsequent Indicator Flag for the service event is recorded as “Initial”.
- **Numerator source**: EDWARD, HERO and EDWARD Non-admitted Patient Data Mart
- **Numerator availability**: Available 2 months after the end of the period of measurement

**Denominator**
- **Denominator definition**: N/A
- **Denominator source**: N/A
- **Denominator availability**: N/A

**Inclusions**
- All Outpatient Services as defined through their mapping to a Version 5.0 Tier 2 clinic from the 10, 20, 30 or 40 series.

**Exclusions**
- Non-admitted patient service events classified as a subsequent consultation that have occurred.

**Targets**
- **Target**: No patient waited more than 365 days for an initial outpatient service.

**Context**
Public clinics are available in the outpatient sector across NSW, however, patient pathways and service delivery processes are inconsistent, leading to decreased service efficiency, and delayed access for patients. This KPIs measures access to public outpatient services, to ensure patients across NSW have equitable and timely access to quality services in the public outpatient setting.

**Related Policies/ Programs**
Outpatient Services Framework 2018

**Useable data available from**
Data is collected from 1 July 2013 (from EDWARD via WebNAP).

**Frequency of Reporting**
Monthly

**Time lag to available data**
6 – 7 weeks

**Business owners**
- **Contact - Policy**: Executive Director, System Purchasing Branch
- **Contact - Data**: Executive Director, System Information and Analytics Branch

**Representation**
- **Data type**: Numeric
- **Form**: Number
Representational layout
Minimum size
Maximum size
Data domain
Date effective

Related National Indicator
2018-19 Service Performance Agreements
Strategy 2 IMs: Integrate Systems to Deliver Truly Connected Care

<table>
<thead>
<tr>
<th>INDICATOR: MS2402 Previous ID:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Median waiting time for elective surgery</strong> (Days)</td>
</tr>
</tbody>
</table>

**Shortened Title**: Median waiting time for elective surgery

**Service Agreement Type**: Improvement Measure

**Framework Strategy**: Strategy 2: Provide World-Class Clinical Care Where Patient Safety Is First

**Framework Objective**: 2.4 (Ensure timely access to care)

**Status**: Final

**Version number**: 1.01

**Scope**: All elective surgery patients who are admitted and included in the NSW Health Waiting Times Collection

**Goal**: The goal is to facilitate monitoring and management of waitlist to ensure that elective surgical patients receive their surgery within the clinically recommended timeframe in NSW public hospitals. The desired outcome is better management of waiting lists to minimise waiting time for elective surgery.

**Desired outcome**: To ensure a minimum level of elective surgery is undertaken
- To achieve greater accountability for management of resources and performance

**Primary point of collection**: Waiting List/Booking Clerk: Receipt of inbound Recommendation for Admission Form (RFA) to a public hospital for patient registration on waiting list.

**Data Collection Source/System**: Patient Admission System (PAS)/Waiting List Collection On–Line System (WLCOS)

**Primary data source for analysis**: WLCOS/Wait List / Scheduling Data Stream (via EDWARD)

**Indicator definition**: The median time elapsed (in days) for a patient on the elective surgery waiting list from the date they were added to the waiting list for the procedure to the date they were removed from the waiting list, reported by clinical urgency category/priority, excluding:
- any days where the patient was not ready for care and
- any days the patients was waiting with a less urgent clinical urgency category than their clinical urgency category at removal.

**Computation**:

\[ n \times p \text{ (percentile value divided by 100)} = i \text{ (integer)} + f \text{ (fractional part of } n \times p) \]

- If \( n \times p \) is an integer, then the percentile value will correspond to the average of the values for the \( i \)th and \((i+1)\)th observations.
- If \( n \times p \) is not an integer, then the percentile value will correspond to
the value for the (i+1)th observation.

- For example, if there were 100 hospital separations, the median will correspond to the average time for the 50th and 51st observations. If there were 101 observations, the median will correspond to the time for the 51st observation.

Where:
Median waiting times are rounded to the nearest whole day.

Waiting times are calculated for patients whose reason for removal was:
- For clinical urgency categories:
  1. Admitted as an elective patient for awaited procedure by or on behalf of this hospital or the state/territory, or
  2. Admitted as emergency patient for awaited procedure by or on behalf of this hospital or the state/territory.

For the purposes of reporting by urgency category, patients are reported as the final urgency category they were when treated.

Data source
WLCOS

Data availability
Available monthly

Inclusions
Total number of elective surgery patients in the NSW Health Waiting Times Collection who:
have been admitted for treatment within the reporting period (measured by removal from the waiting list removal with a status = (WLCOS codes 1, 2, 7 & 8) See inclusions below,

Surgical patients in the NSW Ministry of Health Waiting Times Collection who have been admitted for treatment, that is where the reason for removal is:
1 Routine admission
2 Emergency Admissions, where the patient has surgery for the waitlisted procedure
7 Admission contracted to another hospital or
8 Admission contracted to a private hospital/day procedure centre.

Exclusions
The calculation of waiting time excludes:
- All days the patient was waiting with a less urgent elective surgery urgency category than their urgency category when removed from the list. When a patient’s urgency category changes, existing NMDS business rules will apply.
- All patients who: Were transferred to another hospital’s elective surgery waiting list
- Were treated elsewhere but not on behalf of the hospital
- Were not contactable for booking the surgery or at booked time of surgery
- Died prior to receiving their surgery
- Declined surgery.
- Patients whose Waiting List Category is not ‘Elective Surgery’

Targets
N/A
## Context
Note: Calculation in Edward will vary from those in WLCOS. WLCOS only receives the last three clinical priority/category changes. In the EDWARD environment all category changes for a booking will be available. So, while the same calculation method will apply the results from the two systems may differ.

## Related Policies/Programs
- Waiting Time and Elective Surgery Policy 2012
- Agency for Clinical Innovation: Surgery, Anaesthesia and Critical Care Portfolio

Operating Theatre Efficiency Guidelines: A guide to the efficient management of operating theatres in New South Wales hospitals

## Useable data available from
July 2005

## Frequency of Reporting
Monthly

## Time lag to available data
Reporting required by the 10th working day of each month, data available for previous month.

## Business owners

**Contact - Policy**
Executive Director, System Purchasing Branch

**Contact - Data**
Executive Director, System Information and Analytics

## Representation

<table>
<thead>
<tr>
<th>Data type</th>
<th>Numeric</th>
</tr>
</thead>
<tbody>
<tr>
<td>Form</td>
<td>Number</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Representational layout</th>
<th>NNNN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum size</td>
<td>1</td>
</tr>
<tr>
<td>Maximum size</td>
<td>4</td>
</tr>
</tbody>
</table>

## Related National Indicator
### Elective Surgery: Activity Compared to Previous Year (Number)

<table>
<thead>
<tr>
<th>Shortened Title</th>
<th>Elective Surgery: Activity compared to previous year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Agreement Type</td>
<td>Improvement Measure</td>
</tr>
<tr>
<td>Framework Strategy</td>
<td>Strategy 2: Provide World-Class Clinical Care Where Patient Safety Is First</td>
</tr>
<tr>
<td>Framework Objective</td>
<td>2.4 (Ensure timely access to care)</td>
</tr>
<tr>
<td>Status</td>
<td>Final</td>
</tr>
<tr>
<td>Version number</td>
<td>1.5</td>
</tr>
<tr>
<td>Scope</td>
<td>All patients on the elective surgery wait list as defined by the Medicare agreement.</td>
</tr>
<tr>
<td>Goal</td>
<td>Greater certainty concerning the amount of activity to be performed in a year.</td>
</tr>
<tr>
<td>Desired outcome</td>
<td>To ensure a minimum level of elective surgery is undertaken. To achieve greater accountability for management of resources and performance</td>
</tr>
<tr>
<td>Primary point of collection</td>
<td>Waiting List/Booking Clerk: Receipt of inbound Recommendation for Admission Form (RFA) to a public hospital for patient registration on waiting list.</td>
</tr>
<tr>
<td>Data Collection Source/System</td>
<td>Patient Admission System (PAS)/Waiting List Collection On-Line System (WLCOS)</td>
</tr>
<tr>
<td>Primary data source for analysis</td>
<td>WLCOS/Wait List / Scheduling Data Stream (via EDWARD)</td>
</tr>
<tr>
<td>Indicator definition</td>
<td>Elective surgery activity for the year to date expressed as the difference between YTD activity in the current financial year compared to the same period in the previous financial year. Where activity is measured as the Total number of elective surgery patients in the NSW Ministry of Health Waiting Times Collection who have been admitted for treatment within the reporting period; measured by removal from the waiting list with removal status = 1, 2, 7, 8.</td>
</tr>
<tr>
<td>Data source</td>
<td>WLCOS</td>
</tr>
<tr>
<td>Data availability</td>
<td>Available monthly</td>
</tr>
<tr>
<td>Inclusions</td>
<td>Removal date within the period</td>
</tr>
<tr>
<td></td>
<td>Note:</td>
</tr>
<tr>
<td></td>
<td>• Includes: Staged patients. (Refer to Waiting Time and Elective Surgery Policy for management of staged patients)</td>
</tr>
<tr>
<td></td>
<td>• Emergency admissions for their recorded waitlist procedure</td>
</tr>
<tr>
<td>Exclusions</td>
<td>• Patients whose Waiting List Category is not ‘Elective Surgery’</td>
</tr>
</tbody>
</table>
2018-19 Service Performance Agreements
Strategy 2 IMs: Integrate Systems to Deliver Truly Connected Care

- Elective surgery patients with an Indicator Procedure Code of 277 (Peritonectomy)

<table>
<thead>
<tr>
<th>Targets</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Context</td>
<td>To ensure timely access for Elective Surgery to achieve the NSW Elective Surgery Access Performance targets.</td>
</tr>
<tr>
<td>Related Policies/ Programs</td>
<td>NSW Episode Funding</td>
</tr>
<tr>
<td>Useable data available from</td>
<td>2009/10</td>
</tr>
<tr>
<td>Frequency of Reporting</td>
<td>Monthly</td>
</tr>
<tr>
<td>Time lag to available data</td>
<td>Reporting required by the 10th working day of each month, data available for previous month.</td>
</tr>
<tr>
<td>Business owners</td>
<td></td>
</tr>
<tr>
<td>Contact - Policy</td>
<td>Executive Director, System Purchasing Branch</td>
</tr>
<tr>
<td>Contact - Data</td>
<td>Executive Director, System Information and Analytics</td>
</tr>
</tbody>
</table>

Representation

<table>
<thead>
<tr>
<th>Data type</th>
<th>Numeric</th>
</tr>
</thead>
<tbody>
<tr>
<td>Form</td>
<td>Number</td>
</tr>
<tr>
<td>Representational layout</td>
<td>N{NNNNN}</td>
</tr>
<tr>
<td>Minimum size</td>
<td>1</td>
</tr>
<tr>
<td>Maximum size</td>
<td>6</td>
</tr>
</tbody>
</table>

Related National Indicator
<table>
<thead>
<tr>
<th>INDICATOR: SSA112</th>
<th>Elective Surgery Theatre Utilisation: Operating Room Occupancy (%)</th>
</tr>
</thead>
</table>

Previous ID: 9C7, 0023

- Theatre Utilisation For Elective Sessions measured as operating room occupancy (previously known as “planned surgery utilisation”)

**Shortened Title**

Elective Surgery Theatre Utilisation

**Service Agreement Type**

Improvement Measure

**Framework Strategy**

Strategy 2: Provide World-Class Clinical Care Where Patient Safety Is First

**Framework Objective**

2.4 (Ensure timely access to care)

**Status**

Final

**Version number**

1.31

**Scope**

Patients treated in dedicated elective theatre sessions.

**Goal**

Maximise the productivity of operating theatres in hospitals, reduce cancellations and improve the flow of patients through the hospital.

**Desired outcome**

Efficient access and throughput for emergency and elective surgery patients and reduction in waiting lists.

**Primary point of collection**

Operating Theatres

**Data Collection Source/System**

Patient Administration System (PAS), Operating Theatre Systems, e.g. SurgiNet, Manual Collection.

**Primary data source**

Provided directly by LHDs and Networks to Ministry of Health.

**Indicator definition**

The percentage of time allocated to elective theatre sessions where the operating theatre (operating room) was occupied by surgery patients receiving active treatment.

**Numerator**

- **Numerator definition**
  
  The sum of ([Patient out of (operating theatre/operating room) date/time] – [Patient in (operating theatre/operating room) date/time]) for all patients treated during an elective theatre session.

  **Note:**

  - When a patient enters the operating theatre/operating room (within the Theatre suite) before the session start time, the actual session start time should be treated as the [patient in room date/time] for this indicator.
  - The time spent in the theatre suite **but not in the operating theatre/operating room** before the session start time is considered “out-of-session” time.
  - Patient in room time commences when the patient physically enters the operating theatre/operating room assigned to the elective session. This applies even when an anaesthetic or other procedure is commenced prior to the patient entering in the operating theatre/operating room.
  - Similarly, when a patient leaves the theatre operating room after the allocated session end time, the session end time should be treated as the [patient out of room date/time] for this indicator. (The time spent in the theatre after the session end time is considered “out-of-session” time.)

- **Numerator source**

  Operating Theatre System
Numerator availability: Variable across sites

### Denominator

- **Denominator definition:** The time allocated to elective theatre sessions.
- **Denominator source:** Operating theatre data collection
- **Denominator availability:** Variable across sites

#### Inclusions

Elective or non-elective patients treated in operating theatres during elective sessions.

#### Exclusions

- Surgery performed outside elective surgery session.
- Periods of anaesthesia that occurred outside the operating room allocated to the session.

#### Targets

80%

#### Comments

- This indicator is intended as a measure of operating theatre/operating room use during sessions routinely allocated for elective surgery only. Activity performed outside of the operating theatre/operating room and these sessions is not included in the indicator.
- The indicator specifically relates to the time the patient is physically in the operating theatre/operating room, if the patient is anaesthetised outside the actual operating theatre/operating room, (e.g. in the anaesthetic bay/room) before the patient enters the theatre, the time is NOT counted towards utilisation of the session.

#### Context

In order to estimate operating theatre productivity and efficiency, a number of performance indicators are required. Surgery cannot be performed without a number of support activities, which need to be viewed in combination for a true picture of utilisation to be obtained. Operating theatre/operating room, occupancy during elective session hours is one of a number of indicators of theatre utilisation.

#### Related Policies/ Programs

- Clinical Services Redesign Program
- Waiting Time and Elective Surgery Policy 2012
- Operating Theatre Efficiency Guidelines (December 2014)

#### Useable data available from


#### Frequency of Reporting

Monthly

#### Time lag to available data

Reporting required by the 10th working day of each month, data available for previous month

#### Business owners

System Purchasing Branch

- **Contact - Policy:** Executive Director, System Purchasing Branch
- **Contact - Data:** Executive Director, System Information and Analytics

#### Representation

- **Data type:** Numeric
- **Form:** Number, presented as a percentage (%)
Maximum size 5

Related National Indicator
### Indicator: SURG-001, SURG-002

#### Surgical Services - Elective Surgery:

- Admissions from Elective Surgery Waiting List (Number) *(SURG-001)*
- Paediatric Admissions from Elective Surgery Waiting List (Number) *(SURG-002)*

#### Shortened Title(s)

- Admissions from Elective Surgery Waiting List
- Paediatric Admissions from Elective Surgery Waiting List

#### Service Agreement Type

- Improvement Measure

#### Framework Strategy

- Strategy 2: Provide World-Class Clinical Care Where Patient Safety is First

#### Framework Objective

- 2.4 (Ensure timely access to care)

#### Status

- Final

#### Version number

- 1.01

#### Scope

- All elective surgery

#### Goal

- Greater certainty concerning the amount of activity to be performed in a year.

#### Desired outcome

- To ensure that appropriate volume of Elective surgery is provided.

#### Primary point of collection

- Patient Medical Record

#### Data Collection Source/System

- Hospital PAS systems, Admitted Patient Data Collection,

#### Primary data source for analysis

- HIE

#### Indicator definition

**SURG-001**: Total number of surgical patients in the NSW Ministry of Health Waiting Times Collection who have been admitted for treatment within the reporting period.

**SURG-002**: Total number of Paediatric surgical patients in the NSW Ministry of Health Waiting Times Collection who have been admitted for treatment within the reporting period.

#### Numerator

**Numerator definition**

**SURG-001**: Total number of surgical patients in the NSW Ministry of Health Waiting Times Collection who have been admitted for treatment within the reporting period.

**SURG-002**: A subset of SURG-001, identifying the total number of Paediatric surgical patients in the NSW Ministry of Health Waiting Times Collection who have been admitted for treatment within the reporting period.

Paediatric surgical patients are defined as all children aged 0 to 16 years (cutoff is the child's 16th birthday).

**Numerator source**

- HIE

**Numerator availability**

- Coded data available 2 months after the end of the period of measurement.
**Denominator**

Denominator definition: N/A

Denominator source

Denominator availability

**Inclusions**

- Acute episodes (care type 1 or 5)
- Episode end date within the period
- All facilities performing surgery
- Any service contracted to a private hospital

**Exclusions**

- Interstate patients/interstates hospitals
- Justice Health / Forensic Mental Health Network patients
- Removals from the wait list where no service was provided (e.g., patients no longer requiring service, could not be contacted, treated elsewhere (but not related to the hospital booking)).

**Targets**

Target: N/A

**Context**

**Related Policies/Programs**

Useable data available from: 2001

**Frequency of Reporting**

Monthly

**Time lag to available data**

6 – 7 weeks

**Business owners**

Health and Social Policy Branch

- Contact - Policy: Executive Director, Health and Social Policy Branch
- Contact - Data: Executive Director, System Information and Analytics

**Representation**

- Data type: Numeric
- Form: Number
- Representational layout: NNN{NNNN}
- Minimum size: 3
- Maximum size: 7
- Data domain
- Date effective: July 2013

**Related National Indicator**

N/A
INDICATOR: KS2410
Previous IDs:

Aboriginal Paediatric Patients Undergoing Otitis Media Procedures (number)

Shortened Title
Paediatric Aboriginal Otitis Media Procedures

Service Agreement Type
Improvement Measure

Framework Strategy
Strategy 2: Provide World-Class Clinical Care Where Patient Safety Is First

Framework Objective
2.4 (Ensure timely access to care)

Status
Final

Version number
1.0

Scope
Aboriginal children aged 0 to 15 years with a planned admission for an otitis media surgical procedure

Goal
Increase the number of Aboriginal children treated surgically for otitis media surgical procedures

 Desired outcome
Reduce the burden of hearing loss in the population by increasing surgical treatment rates

Primary point of collection
Administrative and clinical patient data collected at admission and discharge

Data Collection Source/System
Hospital PAS system, Admitted Patient Data Collection

Primary data source for analysis
Health Information Exchange (HIE)

Indicator definition
Number of Aboriginal children receiving a surgical procedure for chronic otitis media as a planned procedure

Chronic otitis media = primary diagnosis of ICD-10-AM codes: H65.x, H66.x, H67.0, H67.8 or H72.x

Surgical procedure = one of the following procedure codes: 41635-01, 41527-00, 41530-00, 41533-01, 41542-00, 41638-01, 41551-00, 41560-00, 41560-01, 41554-00, 41563-00, 41563-01, 41626-00, 41626-01, 41632-00 and 41632-01

Numerator
Numerator definition
Number of Aboriginal children 0-15 years receiving a surgical procedure for chronic otitis media as a planned procedure

Numerator source
HIE/IQ

Numerator availability
Monthly

Denominator
Denominator definition
N/A

Denominator source
N/A

Denominator availability
N/A

Inclusions
As per numerator definition above

Exclusions
As per Inclusions above
2018-19 Service Performance Agreements
Strategy 2 IMs: Integrate Systems to Deliver Truly Connected Care

Targets
Target
5% of the estimated burden of bilateral hearing impairment due to otitis media in the LHD Aboriginal paediatric population. Progress reported quarterly against an annual target to be negotiated with each LHD. Current number of procedures for the non-Aboriginal paediatric population to be maintained.

Context
Aboriginal children have a higher rate of chronic otitis media than non-Aboriginal children. Chronic otitis media leads to hearing loss and developmental delay. Current evidence indicates that the burden of chronic otitis media in Aboriginal children is at least double that of non-Aboriginal children. As early intervention is required to minimise adverse consequences of hearing loss.

Related Policies/Programs
NSW Aboriginal Health Plan 2013 – 2023

Useable data available from
1 July 2017

Frequency of Reporting
Quarterly

Time lag to available data
6 weeks to 3 months

Business owners
Centre for Aboriginal Health, Ministry of Health
Contact - Policy
Executive Director, Centre for Aboriginal Health, Ministry of Health
Contact - Data
Executive Director, System Information and Analytics, Ministry of Health

Representation
Data type
Numeric
Form
Number
Representational layout
NNNNN
Minimum size
1
Maximum size
5
Data domain
N/A
Date effective
1 July 2018

Related National Indicator
N/A
**INDICATOR: SSA113, SSA114**

**Surgery for Children** - Proportion of children (0 to 16 years) treated within their LHD of residence:

- Emergency Surgery (%) (SSA114)
- Planned Surgery (%) (SSA113)

**Shortened Title(s)**

Emergency Surgery for children within LHD
Planned Surgery for children within LHD

**Service Agreement Type**
Improvement Measure

**Framework Strategy**
Strategy 2: Provide World-Class Clinical Care Where Patient Safety Is First

**Framework Objective**
2.4 (Ensure timely access to care)

**Status**
Final

**Version number**
1.31

**Scope**
All acute admissions of Children from 0 up to 16 years of age.

**Goal**
Greater certainty concerning the amount of activity to be performed in a year.

**Desired outcome**
To improve and monitor the proportion of children receiving appropriate planned surgery within the LHD of residence. To document, monitor and increase capacity to undertake emergency surgery for children within the LHD of residence.

**Primary point of collection**
Patient Medical Record

**Data Collection Source/System**
Hospital PAS systems, Admitted Patient Data Collection,
HIE

**Primary data source for analysis**
HIE

**Indicator definition**
The percentage of LHD resident aged 0 to 16 years who had a surgical procedure and that surgery was performed at a facility in their LHD of residence. Reported by:

- Emergency: Urgency of admission "1" = Emergency
- Planned: Urgency of Admission = “2”, “3”, “4” or “5”

**Numerator**

**Numerator definition**
Number of surgeries undertaken at LHD of residence where:

- The count is based on patient stays (ie formal admission to formal discharge) not episode
- Surgical DRGs are assigned based on the first episode of care and recorded using AN-DRG surgical partition, version 8.0 AN-DRGs

**Numerator source**
HIE

**Numerator availability**
Coded data available 2 months after the end of the period of measurement.

**Denominator**

**Denominator definition**
Total number of surgeries for LHD residents x 100

**Denominator source**
HIE
Denominator availability: Coded data available 2 months after the end of the period of measurement.

**Inclusions**
- Acute episodes (care type 1 or 5)
- Episode end date within the period
- All facilities performing surgery
- All children aged 0 to 16 years (cutoff is the child’s 16th birthday)
- LHD of residence of the patient is based on the SLA of the patient and the December 2010 boundaries

**Exclusions**
- Children 16 years and older
- interstate patients/interstates hospitals
- Justice Health / Forensic Mental Health Network patients

**Targets**
- Target: N/A

**Context**

**Related Policies/ Programs**
- “Surgery for Children in Metropolitan Sydney – Strategic Framework”

**Useable data available from**
- 2001

**Frequency of Reporting**
- Monthly

**Time lag to available data**
- 6 – 7 weeks

**Business owners**
- Health and Social Policy Branch
  - Contact - Policy: Executive Director, Health and Social Policy Branch
  - Contact - Data: Executive Director, Health System Information and Performance Reporting

**Representations**

**Data type**
- Numeric

**Form**
- Number, presented as a percentage (%)

**Representational layout**
- NNN.N

**Minimum size**
- 3

**Maximum size**
- 4

**Data domain**

**Date effective**
- July 2013

**Related National Indicator**
- N/A
<table>
<thead>
<tr>
<th>INDICATOR: MS2405</th>
<th>One-Year Survival after Surgery for Colon or Rectal Cancer (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous IDs:</td>
<td>One-Year Survival Colon or Rectal Cancer Surgery</td>
</tr>
<tr>
<td>Shortened Title</td>
<td>One-Year Survival Colon or Rectal Cancer Surgery</td>
</tr>
<tr>
<td>Service Agreement Type</td>
<td>Improvement Measure</td>
</tr>
<tr>
<td>Framework Strategy</td>
<td>Strategy 2: Provide World-Class Clinical Care Where Patient Safety Is First</td>
</tr>
<tr>
<td>Framework Objective</td>
<td>2.4 (Ensure timely access to care)</td>
</tr>
<tr>
<td>Status</td>
<td>Final</td>
</tr>
<tr>
<td>Version number</td>
<td>1.1</td>
</tr>
<tr>
<td>Scope</td>
<td>People undergoing surgery with curative intent for colon or rectal cancer in NSW.</td>
</tr>
<tr>
<td>Goal</td>
<td>Improved case selection, improved quality surgery and improved post-surgical care and outcomes</td>
</tr>
<tr>
<td>Desired outcome</td>
<td>Consistently high one year survival</td>
</tr>
<tr>
<td>Primary point of collection</td>
<td>Patient Medical Record and Patient Administration Systems</td>
</tr>
<tr>
<td>Data Collection Source/System</td>
<td>Admitted Patient Data Collection (APDC) sourced from the Health Information Exchange (HIE) for public hospitals; Registry of Births, Deaths and Marriages for death data</td>
</tr>
<tr>
<td>Primary data source for analysis</td>
<td>Admitted Patient, Emergency Department Attendance and Deaths Register (APEDDR), NSW Ministry of Health Secure Analytics for Population Health Research and Intelligence (SAPHaRI)</td>
</tr>
<tr>
<td>Indicator definition</td>
<td>The proportion of people with colon or rectal cancer who underwent surgery with curative intent and who remained alive one year after surgery.</td>
</tr>
<tr>
<td><strong>Numerator</strong></td>
<td></td>
</tr>
<tr>
<td>Numerator definition</td>
<td>The number of people with colon or rectal cancer who underwent surgery with curative intent and who remained alive 365 days after the index surgical episode.</td>
</tr>
<tr>
<td>Numerator source</td>
<td>Admitted Patient, Emergency Department Attendance and Deaths Register (APEDDR).</td>
</tr>
<tr>
<td>Numerator availability</td>
<td>Data availability subject to availability of APEDDR dataset</td>
</tr>
<tr>
<td><strong>Denominator</strong></td>
<td></td>
</tr>
<tr>
<td>Denominator definition</td>
<td>The number of people with colon or rectal cancer who underwent surgery with curative intent.</td>
</tr>
<tr>
<td>Denominator source</td>
<td>Admitted Patient, Emergency Department Attendance and Deaths Register (APEDDR).</td>
</tr>
<tr>
<td>Denominator availability</td>
<td>Data availability subject to availability of APEDDR dataset</td>
</tr>
<tr>
<td><strong>Inclusions</strong></td>
<td>People with a diagnosis of colon or rectal cancer (ICD-10-AM C18.x, C19.x, C20.x, or C21.x) undergoing surgery with curative intent, defined using the following procedure codes:</td>
</tr>
<tr>
<td></td>
<td>• 32000-00 Limited excision of large intestine with formation of</td>
</tr>
</tbody>
</table>
2018-19 Service Performance Agreements
Strategy 2 IMs: Integrate Systems to Deliver Truly Connected Care

• 32000-01 Right hemicolecotomy with formation of stoma
• 32000-02 Laparoscopic limited excision of large intestine with formation of stoma
• 32000-03 Laparoscopic right hemicolecotomy with formation of stoma
• 32003-00 Limited excision of large intestine with anastomosis
• 32003-01 Right hemicolecotomy with anastomosis
• 32003-02 Laparoscopic limited excision of large intestine with anastomosis
• 32003-03 Laparoscopic right hemicolecotomy with anastomosis
• 32004-00 Subtotal colectomy with formation of stoma
• 32004-01 Extended right hemicolecotomy with formation of stoma
• 32004-02 Laparoscopic subtotal colectomy with formation of stoma
• 32004-03 Laparoscopic extended right hemicolecotomy with formation of stoma
• 32005-00 Subtotal colectomy with anastomosis
• 32005-01 Extended right hemicolecotomy with anastomosis
• 32005-02 Laparoscopic subtotal colectomy with anastomosis
• 32005-03 Laparoscopic extended right hemicolecotomy with anastomosis
• 32006-00 Left hemicolecotomy with anastomosis
• 32006-01 Left hemicolecotomy with formation of stoma
• 32006-02 Laparoscopic left hemicolecotomy with anastomosis
• 32006-03 Laparoscopic left hemicolecotomy with formation of stoma
• 32009-00 Total colectomy with ileostomy
• 32009-01 Laparoscopic total colectomy with ileostomy
• 32012-00 Total colectomy with ileorectal anastomosis
• 32012-01 Laparoscopic total colectomy with ileorectal anastomosis
• 32015-00 Total proctocolectomy with ileostomy
• 32024-00 High anterior resection of rectum
• 32025-00 Low anterior resection of rectum
• 32026-00 Ultra low anterior resection of rectum
• 32028-00 Ultra low anterior resection of rectum with hand sutured coloanal anastomosis
• 32030-00 Rectosigmoidectomy with formation of stoma
• 32030-01 Laparoscopic rectosigmoidectomy with formation of stoma
• 32039-00 Abdominoperineal proctectomy
• 32047-00 Perineal proctectomy
• 32051-00 Total proctocolectomy with ileo-anal anastomosis
• 32051-01 Total proctocolectomy with ileo-anal anastomosis and formation of temporary ileostomy
• 32060-00 Restorative proctectomy
• 32112-00 Perineal rectosigmoidectomy
• 92208-00 Anterior resection of rectum, level unspecified

Exclusions

Targets Improvement on previous reporting period (as appropriate and feasible).
2018-19 Service Performance Agreements
Strategy 2 IMs: Integrate Systems to Deliver Truly Connected Care

Context
One-year survival is a well-accepted and documented measure of medium-term outcome for people with many types of cancer.

Related Policies/Programs
Reporting for Better Cancer Outcomes (RBCO)

Useable data available from
July 2001

Frequency of Reporting
This is computed quarterly and reported as a 3 period rolling average by LHD of hospital

Time lag to available data
Dependent upon frequency of updates to APEDDR.

Business owners
Cancer Institute NSW
- Contact - Policy
  Chief Executive Officer, Cancer Institute NSW
- Contact - Data
  Director, Cancer Services and Information, Cancer Institute NSW

Representation
- Data type
  Numeric
- Form
  Percentage
- Representational layout
  NN.N%
- Minimum size
  3
- Maximum size
  4
- Data domain
- Date effective
  1 July 2017

Related National Indicators

Components
<table>
<thead>
<tr>
<th>INDICATOR:</th>
<th>MS2404</th>
<th><strong>One-Year Survival after Surgery for Lung Cancer (%)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous IDs:</td>
<td></td>
<td>One-Year Survival Lung Cancer Surgery</td>
</tr>
<tr>
<td>Shortened Title</td>
<td></td>
<td>One-Year Survival Lung Cancer Surgery</td>
</tr>
<tr>
<td>Service Agreement Type</td>
<td></td>
<td>Improvement Measure</td>
</tr>
<tr>
<td>Framework Strategy</td>
<td></td>
<td>Strategy 2: Provide World-Class Clinical Care Where Patient Safety Is First</td>
</tr>
<tr>
<td>Framework Objective</td>
<td></td>
<td>2.4 (Ensure timely access to care)</td>
</tr>
<tr>
<td>Status</td>
<td></td>
<td>Final</td>
</tr>
<tr>
<td>Version number</td>
<td></td>
<td>1.1</td>
</tr>
<tr>
<td>Scope</td>
<td></td>
<td>People undergoing surgery with curative intent for lung cancer in NSW.</td>
</tr>
<tr>
<td>Goal</td>
<td></td>
<td>Improved case selection, improved quality surgery and improved post-surgical care and outcomes</td>
</tr>
<tr>
<td>Desired outcome</td>
<td></td>
<td>Consistently high one year survival</td>
</tr>
<tr>
<td>Primary point of collection</td>
<td></td>
<td>Patient Medical Record and Patient Administration Systems</td>
</tr>
<tr>
<td>Data Collection Source/System</td>
<td></td>
<td>Admitted Patient Data Collection (APDC) sourced from the Health Information Exchange (HIE) for public hospitals; Registry of Births, Deaths and Marriages for death data</td>
</tr>
<tr>
<td>Primary data source for analysis</td>
<td></td>
<td>Admitted Patient, Emergency Department Attendance and Deaths Register (APEDDR), NSW Ministry of Health Secure Analytics for Population Health Research and Intelligence (SAPHaRI)</td>
</tr>
<tr>
<td>Indicator definition</td>
<td></td>
<td>The proportion of people with lung cancer who underwent surgery with curative intent and who remained alive one year after surgery.</td>
</tr>
<tr>
<td><strong>Numerator</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Numerator definition</td>
<td></td>
<td>The number of people with lung cancer who underwent surgery with curative intent and who remained alive 365 days after the index surgical episode.</td>
</tr>
<tr>
<td>Numerator source</td>
<td></td>
<td>Admitted Patient, Emergency Department Attendance and Deaths Register (APEDDR).</td>
</tr>
<tr>
<td>Numerator availability</td>
<td></td>
<td>Data availability subject to availability of APEDDR dataset</td>
</tr>
<tr>
<td><strong>Denominator</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Denominator definition</td>
<td></td>
<td>The number of people with lung cancer who underwent surgery with curative intent.</td>
</tr>
<tr>
<td>Denominator source</td>
<td></td>
<td>Admitted Patient, Emergency Department Attendance and Deaths Register (APEDDR).</td>
</tr>
<tr>
<td>Denominator availability</td>
<td></td>
<td>Data availability subject to availability of APEDDR dataset</td>
</tr>
<tr>
<td><strong>Inclusions</strong></td>
<td></td>
<td>People with a diagnosis of lung cancer (ICD-10-AM C34.x) undergoing surgery with curative intent, defined using the following procedure codes:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 38438-00 Segmental resection of lung</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 38438-01 Lobectomy of lung</td>
</tr>
</tbody>
</table>
2018-19 Service Performance Agreements
Strategy 2 IMs: Integrate Systems to Deliver Truly Connected Care

- 38438-02  Pneumonectomy
- 38440-00  Wedge resection of lung
- 38440-01  Radical wedge resection of lung
- 38441-00  Radical lobectomy
- 38441-01  Radical pneumonectomy

Exclusions

Targets
Improvement on previous reporting period (as appropriate and feasible).

Context
One-year survival is a well-accepted and documented measure of medium-term outcome for people with many types of cancer.

Related Policies/ Programs
Reporting for Better Cancer Outcomes (RBCO)

Useable data available from
July 2001

Frequency of Reporting
This is computed quarterly and reported as a 3 period rolling average by LHD of hospital

Time lag to available data
Dependent upon frequency of updates to APEDDR.

Business owners
Cancer Institute NSW
Contact - Policy
Chief Executive Officer, Cancer Institute NSW
Contact - Data
Director, Cancer Services and Information, Cancer Institute NSW

Representation
Data type
Numeric
Form
Percentage
Representational layout
NN.N%
Minimum size
3
Maximum size
4
Data domain

Date effective
1 July 2017

Related National Indicators

Components
INDICATOR: MS2403
Previous ID:

**Stroke Care Quality Improvement:** Patients with a final diagnosis of acute stroke who have documented treatment in a stroke unit (%)

**Shortened Title**
Stroke Care Quality Improvement

**Service Agreement Type**
Improvement Measure

**Framework Strategy**
Strategy 2: Provide World-Class Clinical Care Where Patient Safety is First

**Framework Objective**
2.4 (Ensure timely access to care)

**Status**
Final

**Version number**
1.01

**Scope**
All acute stroke acute inpatient episodes

**Goal**
To increase the number of stroke patients that are treated in Stroke Units

**Desired outcome**
- Improve outcomes for stroke patients and stroke services.
- Reduce length of stay in hospital.
- Decrease death and dependency caused by stroke.
- Improve efficiency and productivity in stroke units and services

**Primary point of collection**
Patient Administration Systems; EMR

**Data Collection Source/System**
HIE

**Primary data source for analysis**
Cross reference to BHI data

**Indicator definition**
Proportion of patients with a final diagnosis of acute stroke who have documented treatment in a stroke unit at any time during their hospital stay.

\[
\text{Proportion} = \left( \frac{\text{Numerator}}{\text{Denominator}} \right) \times 100
\]

The codes and criteria for “acute stroke” are located here:
[http://meteor.aihw.gov.au/content/index.phtml/itemId/629525](http://meteor.aihw.gov.au/content/index.phtml/itemId/629525)

For the numerator, a ‘stroke unit’ is defined as care provided in a hospital ward with the following minimum elements:
- co-located beds within a geographically defined unit
- dedicated, multidisciplinary team with members who have a special interest in stroke or rehabilitation
- a multidisciplinary team that meets at least once per week to discuss patient care
- the team has access to regular professional development and education relating to stroke.

There are two types of stroke units that treat acute stroke patients:
1. Acute stroke unit, which accepts patients acutely but separates patients early (usually within 7 days).
2. Comprehensive stroke unit, which accepts patients acutely but also provides rehabilitation for at least several weeks.

Each model has a service provided in a discrete ward or dedicated beds within a larger ward, with a specialised multidisciplinary team with allocated staff for the care
of patients with stroke. The numerator includes patients admitted to either type of stroke unit.

<table>
<thead>
<tr>
<th><strong>Numerator</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Numerator definition</strong></td>
<td>Number of patients with a final diagnosis of acute stroke who separated from hospital with documented evidence of treatment in a stroke unit at any time during their acute hospital stay.</td>
</tr>
<tr>
<td><strong>Numerator source</strong></td>
<td>TBA</td>
</tr>
<tr>
<td><strong>Numerator availability</strong></td>
<td>TBA</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Denominator</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Denominator definition</strong></td>
<td>Number of patients with a final diagnosis of acute stroke who separated from hospital.</td>
</tr>
<tr>
<td><strong>Denominator source</strong></td>
<td>HIE</td>
</tr>
<tr>
<td><strong>Denominator availability</strong></td>
<td>TBA</td>
</tr>
</tbody>
</table>

**Inclusions**
See [http://meteor.aihw.gov.au/content/index.phtml/itemId/629525](http://meteor.aihw.gov.au/content/index.phtml/itemId/629525)

**Exclusions**
See [http://meteor.aihw.gov.au/content/index.phtml/itemId/629525](http://meteor.aihw.gov.au/content/index.phtml/itemId/629525)

**Targets**
TBA

**Context**
There is strong evidence that specialised stroke units, staffed with a multidisciplinary team of stroke specialists, improve patient outcomes and reduce stroke mortality.

**Related Policies/ Programs**
Useable data available from TBA

**Frequency of Reporting**
Quarterly

**Time lag to available data**
3 months

**Business owners**
Contact - Policy Executive Director, Agency for Clinical Innovation
Contact - Data Executive Director, Agency for Clinical Innovation

**Representation**
Data type Numeric
Form Number
Representational layout NNN.NN
Minimum size 4
Maximum size 6
Data domain
Date effective 1 July 2017

**Related National Indicators**
Components Meteor ID 627765 Acute stroke clinical care standard indicators: 3a-Proportion of patients with a final diagnosis of acute stroke who have documented treatment in a
stroke unit
http://meteor.aihw.gov.au/content/index.phtml/itemId/627765

Meteor ID 629525 Acute stroke (Acute stroke clinical care standard)
http://meteor.aihw.gov.au/content/index.phtml/itemId/629525
<table>
<thead>
<tr>
<th>Indicator: RTX001</th>
<th>Radiotherapy – Courses, New and Old (Number)</th>
</tr>
</thead>
</table>

### Previous ID:

Radiotherapy – Courses, New and Old

### Service Agreement Type

Improvement Measure

### Framework Strategy

Strategy 2: Provide World-Class Clinical Care Where Patient Safety Is First

### Framework Objective

2.4 (Ensure timely access to care)

### Status

Final

### Version number

1.1

### Scope

This indicator measures new and retreatment megavoltage courses of radiotherapy delivered by NSW Health radiation oncology treatment centres. Patients are almost entirely non-admitted.

### Goal

Linear accelerators (linacs) to be used at their optimal rate to deliver new and retreatment radiotherapy megavoltage courses to patients.

### Desired outcome

Improve on current level of megavoltage radiotherapy courses delivered per linac by NSW Health radiation oncology treatment centres.

### Primary point of collection

NSW Health radiation oncology treatment centres.

### Data Collection Source/System

Radiation oncology information systems on each linear accelerator or at each NSW Health radiation oncology treatment centre.

### Primary data source for analysis

The oncology information systems at each radiation oncology treatment centre. Note: the data extraction tools used to provide the data for inclusion in the Cancer Institute’s ‘Radiotherapy treatment services to NSW residents’ annual report can be used for this purpose.

### Indicator definition

Number of new and re-treatment patients treated with megavoltage radiotherapy by each NSW Health radiation oncology treatment centre.

**Numerator**

**Numerator definition**

Total number of new and re-treatment megavoltage radiotherapy courses delivered by each NSW Health radiation oncology treatment centre.

A course of radiotherapy is considered to be a **New Course of Radiotherapy** if it is the FIRST course of radiotherapy delivered to a patient for a new Primary diagnosis or related metastasis that has not been previously treated with Radiotherapy in any facility.

A **retreatment course of radiotherapy** is the provision of a second course of radiotherapy after the patient has already previously received a course of radiotherapy for the same primary diagnosis. A second course of radiotherapy is classified as a retreatment when it is provided for the same primary diagnosis, regardless of the body site treated or the radiation oncology treatment centre in which the first course was provided.

**Numerator source**

Oncology information systems at each radiation oncology treatment centre.
**2018-19 Service Performance Agreements**

**Strategy 2 IMs: Integrate Systems to Deliver Truly Connected Care**

**Numerator availability**

6 monthly

**Denominator**

**Denominator definition**

Number of linacs at each centre.

**Denominator source**

Oncology information systems at each radiation oncology treatment centre

**Denominator availability**

6 monthly

**Inclusions**

New and re-treatment megavoltage radiotherapy courses.

**Exclusions**

**Targets**

Minimum 360 courses per linac.

**Context**

Planning target of 414 courses per Linear Accelerator (linac) is the optimal treatment rate, based on agreed national planning parameters. Minimum 360 courses per linac.

The minimum target has been considered in relation to the average number of courses per linac for public sector services in 2016.

Services at individual sites are to be at a level not less than activity in 2016/17.

**Related Policies/ Programs**

Nil

**Useable data available from**

1995 (Radiotherapy Management Information System annual reports – pdf)

**Frequency of Reporting**

Annual

**Time lag to available data**

Currently, NSW Cancer Institute collects data annually, for calendar year, about 6-9 months later. Data could be provided within 6 months or possibly earlier on request.

**Business owners**

- **Contact - Policy**
  
  Executive Director, Health System Planning & Investment

- **Contact - Data**
  
  Chief Executive, NSW Cancer Institute

**Representation**

- **Data type**
  
  Numeric

- **Form**
  
  Number

- **Representational layout**
  
  NN(9)

- **Minimum size**
  
  2

- **Maximum size**
  
  9

- **Data domain**
  
  N/A

- **Date effective**
  
  Page 353
Related National Indicators

Indicator

Source
<table>
<thead>
<tr>
<th><strong>INDICATOR:</strong> KF-012</th>
<th><strong>Statewide Infant Screening – Hearing – Newborn hearing screens provided (Number)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Previous ID:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Shortened Title</strong></td>
<td>Statewide Infant Screening – Hearing</td>
</tr>
<tr>
<td><strong>Service Agreement Type</strong></td>
<td>Improvement Measure</td>
</tr>
<tr>
<td><strong>Framework Strategy</strong></td>
<td>Strategy 2: Provide World-Class Clinical Care Where Patient Safety Is First</td>
</tr>
<tr>
<td><strong>Framework Objective</strong></td>
<td>2.4 (Ensure timely access to care)</td>
</tr>
<tr>
<td><strong>Status</strong></td>
<td>Final</td>
</tr>
<tr>
<td><strong>Version number</strong></td>
<td>1.01</td>
</tr>
</tbody>
</table>

**Scope**

The NSW Statewide Infant Screening - Hearing (SWISH) Program is aimed at identifying all babies born in NSW with significant permanent hearing loss by 3 months of age, and for those children to be able to access appropriate intervention with services outside of NSW Health by 6 months of age. Identification is achieved through offering universal hearing screening to all newborns.

**Goal**

Maintain current level of service delivery.

**Desired outcome**

Universal hearing screening of all newborns

**Primary point of collection**

SWISH Screeners

**Data Collection Source/System**

Excel spreadsheet OR CHOC system where LHD/Network has installed the update that includes the extract.

**Primary data source for analysis**

Excel spreadsheets submitted by LHDs/Network

**Indicator definition**

Total number of children that have completed a newborn hearing screening.

**Numerator**

- **Numerator definition**
  Total number of children that have completed a newborn hearing screening.
- **Numerator source**
  Excel spreadsheets submitted by LHDs/Network
- **Numerator availability**
  Monthly

**Denominator**

- **Denominator definition**
  N/A
- **Denominator source**
- **Denominator availability**

**Inclusions**

**Exclusions**

**Targets**

The number equal to 97% of eligible infants born in that Local Health District, which represents the minimum acceptable number.

The set target is estimated using data previously supplied by the District as part of its monthly reporting requirements.

**Context**

This is a universal screening service that should be provided to all eligible infants in NSW. This indicator is consistent with the minimum screening rate described in ‘National Performance Indicators for Neonatal Hearing Screening in Australia’.
SCHN provides this service for SESLHD.

### Related Policies/ Programs
- GL2010_002 Statewide Infant Screening – Hearing (SWISH) Program

### Useable data available from
- 2003

### Frequency of Reporting
- Monthly

### Time lag to available data
- 2 weeks

### Business owners
- **Health and Social Policy Branch**
  - Contact - Policy: Director, Maternity, Child Youth & Paediatrics
  - Contact - Data: Director, Maternity, Child Youth & Paediatrics

### Representation
- **Data type**: Numeric
- **Form**: Number
- **Representational layout**: N(9)
- **Minimum size**: 3
- **Maximum size**: 9
- **Data domain**: N/A
- **Date effective**: 2003

### Related National Indicators

### Source
- AIHW
**INDICATOR:** KF-010  
**Previous ID:**  

**Statewide Eyesight for Preschoolers Screening (StEPS)**  
- Eyesight screens provided to 4 year olds (Number)

<table>
<thead>
<tr>
<th>Shortened Title</th>
<th>Statewide Eyesight for Preschoolers Screening</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Service Agreement Type</strong></td>
<td>Improvement Measure</td>
</tr>
<tr>
<td><strong>Framework Strategy</strong></td>
<td>Strategy 2: Provide World-Class Clinical Care Where Patient Safety Is First</td>
</tr>
<tr>
<td><strong>Framework Objective</strong></td>
<td>2.4 (Ensure timely access to care)</td>
</tr>
</tbody>
</table>

**Status**  
Final  
**Version number**  
1.01

**Scope**  
The Statewide Eyesight Pre-schooler Screening program is delivered in all Local Health Districts. SCHN provides this service for ISLHD and SESLHD.

**Goal**  
Maintain current level of service delivery.

**Desired outcome**  
All NSW children have access to visual acuity screening from the age of four years.

**Primary point of collection**  
StEPS Screeners

**Data Collection Source/System**  
Excel spreadsheet OR CHOC system where LHD has installed the update that includes the extract.

**Primary data source for analysis**  
Excel spreadsheets submitted by LHDs

**Indicator definition**  
Total number of 4 year olds receiving an eyesight screen.

<table>
<thead>
<tr>
<th><strong>Numerator</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator definition</td>
<td>Total number of 4 year olds receiving an eyesight screen.</td>
</tr>
<tr>
<td>Numerator source</td>
<td>Excel spreadsheets submitted by LHDs</td>
</tr>
<tr>
<td>Numerator availability</td>
<td>Quarterly</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Denominator</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator definition</td>
<td>N/A</td>
</tr>
<tr>
<td>Denominator source</td>
<td></td>
</tr>
<tr>
<td>Denominator availability</td>
<td></td>
</tr>
</tbody>
</table>

**Inclusions**

**Exclusions**

**Targets**  
The set target is 80 per cent of the estimated 4 year old population. The estimated 4 year old population is calculated using a tool developed by the Centre for Epidemiology and Evidence, Ministry of Health.

**Context**  
This is a universal screening service that should be provided to all 4 year old children in NSW, consistent with the requirements of the Statewide Eyesight Preschoolers Screening Program policy directive, PD2012_001. The target is 80 per cent of the estimated four year old population. The target is 80 per cent rather than 100 per cent due to factors such as non-attendance to preschools/day care centres and parents declining due to child already being under the care of an eye health professional.
<table>
<thead>
<tr>
<th>Related Policies/ Programs</th>
<th>PD2012_001 Statewide Eyesight Preschooler Screening (StEPS) Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Useable data available from</td>
<td>2010</td>
</tr>
<tr>
<td>Frequency of Reporting</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Time lag to available data</td>
<td>Approx. 8 weeks</td>
</tr>
<tr>
<td>Business owners</td>
<td>Health and Social Policy Branch</td>
</tr>
<tr>
<td>Contact - Policy</td>
<td>Director, Maternity, Child Youth &amp; Paediatrics</td>
</tr>
<tr>
<td>Contact - Data</td>
<td>Director, Maternity, Child Youth &amp; Paediatrics</td>
</tr>
<tr>
<td>Representation</td>
<td></td>
</tr>
<tr>
<td>Data type</td>
<td>Numeric</td>
</tr>
<tr>
<td>Form</td>
<td>Number</td>
</tr>
<tr>
<td>Representational layout</td>
<td>NNNNN</td>
</tr>
<tr>
<td>Minimum size</td>
<td>2</td>
</tr>
<tr>
<td>Maximum size</td>
<td>5</td>
</tr>
<tr>
<td>Data domain</td>
<td>N/A</td>
</tr>
<tr>
<td>Date effective</td>
<td>2008/9</td>
</tr>
<tr>
<td>Related National Indicators</td>
<td></td>
</tr>
<tr>
<td>Indicator</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Source
### Universal Health Home Visits provided within 2 weeks of baby's birth (Number)

**Shortened Title**
Universal Health Home Visits

**Service Agreement Type**
Improvement Measure

**Framework Strategy**
Strategy 2: Provide World-Class Clinical Care Where Patient Safety Is First

**Framework Objective**
2.4 (Ensure timely access to care)

**Status**
Final

**Version number**
1.01

**Scope**
Every family in NSW is offered a home visit by a child and family health nurse within two weeks of the baby’s birth.

**Goal**
Facilitate universal uptake of the home visiting service as soon as possible after the baby’s birth.

**Desired outcome**
Every family in NSW is offered a home visit by a child and family health nurse within two weeks of the baby’s birth.

**Primary point of collection**
Child and Family Health services (child and family health nurses)

**Data Collection Source/System**
Excel spreadsheet OR CHOC system where LHD has installed the update that includes the extract.

**Primary data source for analysis**
Excel spreadsheet

**Indicator definition**
Number of families (with a newborn) who are eligible for enrollment in the program and receive Universal Health Home Visits within 2 weeks of the baby's birth.

**Numerator**
- **Numerator definition**
  Total number of families (with a newborn) who are eligible for enrollment in the program and receive Universal Health Home Visits within 2 weeks of the baby’s birth.
- **Numerator source**
  Excel spreadsheet
- **Numerator availability**
  Quarterly

**Denominator**
- **Denominator definition**
  N/A
- **Denominator source**
  N/A
- **Denominator availability**
  N/A

**Inclusions**

**Exclusions**

**Targets**
As agreed with the Health and Social Policy Branch.

The set target was estimated using the latest available data from the Perinatal Data Collection and data previously supplied by the District as part of its UHHV quarterly reporting requirements. While demographic considerations (foreseen and unforeseen) are unlikely to affect the overall target level for UHHV service provision...
statewide, there are likely to be regional differences. Therefore, the degree of accuracy of the birth estimates and consequently, the targets will vary across Districts. For this reason, the District’s UHHV performance will be ultimately measured against actual births. Specifically, it is expected that at least 75% of eligible newborn babies receive UHHV within two weeks of birth.

Context
Child and Family Health Services provide preventive, early detection and early intervention health care services to all NSW children aged 0-5 and their families including a home visit following the birth of every child to determine family risk and protective factors and determine the level of care each family will require.

Related Policies/Programs
PD2010_017 Maternal & Child Health Primary Health Care Policy

Useable data available from 2010

Frequency of Reporting Quarterly

Time lag to available data 8 weeks

Business owners Health and Social Policy Branch
Contact - Policy Director, Maternity, Child Youth & Paediatrics
Contact - Data Director, Maternity, Child Youth & Paediatrics

Representation
Data type Numeric
Form Number
Representational layout N[7]
Minimum size 2
Maximum size 7
Data domain N/A
Date effective 2010

Related National Indicators
Indicator N/A

Source
## 2018-19 Service Performance Agreements

### Strategy 2 IMs: Integrate Systems to Deliver Truly Connected Care

<table>
<thead>
<tr>
<th>INDICATOR:</th>
<th>MS2101, MS2102</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Efficiency by Specialty:</strong></td>
<td></td>
</tr>
<tr>
<td>• Adjusted Length of Stay by Specialty (Days) <em>(MS2101)</em></td>
<td></td>
</tr>
<tr>
<td>• Saved or Excess Bed Days (RSI) by Specialty (Number) <em>(MS2102)</em></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Previous IDs:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Efficiency by Specialty – Adjusted LOS</td>
</tr>
<tr>
<td>Efficiency by Specialty – RSI</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Shortened Title(s)</th>
<th>Efficiency by Specialty – Adjusted LOS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Agreement Type</td>
<td>Improvement Measure</td>
</tr>
<tr>
<td>Framework Strategy</td>
<td>Strategy 2: Provide World-Class Clinical Care Where Patient Safety is First</td>
</tr>
<tr>
<td>Framework Objective</td>
<td>2.5 (Use system performance information to drive reform)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Status</th>
<th>Final</th>
</tr>
</thead>
<tbody>
<tr>
<td>Version number</td>
<td>1.01</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Scope</th>
<th>All public hospital admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goal</td>
<td>Monitor relative stay index between hospitals with the same casemix</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Desired outcome</th>
<th>Allows local analysts to monitor relative hospital performance to the State, with adjustments for casemix.</th>
</tr>
</thead>
<tbody>
<tr>
<td>• RSI &lt; 1: Performance above state average</td>
<td></td>
</tr>
<tr>
<td>• RSI = 1: Performance equal state average</td>
<td></td>
</tr>
<tr>
<td>• RSI &gt; 1: Performance below state average</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Primary point of collection</th>
<th>Administrative and clinical patient data collected at admission and discharge.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data Collection Source/System</td>
<td>Diagnosis codes / Hospital Patient Admission Systems (PAS), Admitted Patient Data Collection</td>
</tr>
</tbody>
</table>

| Primary data source for analysis | HIE |

<table>
<thead>
<tr>
<th>Indicator definition</th>
<th><strong>MS2101</strong>: The average length of stay, reported by specialty as at discharge, with adjustments for casemix.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>For any reporting period, only the top and bottom six specialties will be reported.</td>
</tr>
<tr>
<td></td>
<td><strong>MS2102</strong>: The difference (measured in bed days) between the actual patient bed days and the expected patient bed days, reported by specialty as at discharge, with adjustments for casemix.</td>
</tr>
<tr>
<td></td>
<td>DRG in hospital-level aggregations are mapped to SRGs to monitor the performance of each clinical division of hospital activity.</td>
</tr>
<tr>
<td></td>
<td>Specialty is derived by mapping specialty_unit_code in the HIE to a state Specialty codeset. Mappings are provided by the LHD.</td>
</tr>
<tr>
<td></td>
<td>For any reporting period, only the top and bottom six specialties will be reported.</td>
</tr>
</tbody>
</table>
Saved/Excess bed days = Actual bed days – Expected bed days

**Numerator**

Numerator definition

MS2101: Sum of all patient episode length of stays in the period for each specialty at discharge.

MS2102: Actual patient bed days in a hospital aggregated at DRG level for each specialty at discharge.

Numerator source: HIE

Numerator availability: HIE available monthly

**Denominator**

Denominator definition

MS2101: The total number of completed patient episodes in the reporting period for each specialty at discharge.

MS2102: Expected patient bed days in a hospital aggregated at DRG level for each specialty at discharge. The expected bed days are calculated by multiplying the hospital separations grouped by:

- Hospital peer groups
- DRG
- Age groups
- Admission urgency (elective, emergency, etc)
- Same day admission

with the State Average Length of Stay (ALoS)

ALoS is the rate of patient bed days per episode under the same grouping at the State level.

Denominator source: HIE

Denominator availability: Monthly

**Inclusions**

Episodes with the following:

- Care type is 'Acute' or 'Mental Health' - Care types = 1 or M

**Exclusions**

Episodes with ANY of the following:

- ED-only episodes – ed_status = 1 or 4
- Separation mode is transfer (3, 4) or death (6, 7) with length of stay less than 2
- Same-day haemodialysis - DRG V8: L61Z
- Other same-day or with day specified DRG V8, e.g., B40Z, B70D, R63Z, etc.
- Rehabilitation DRG V8: Z60A and Z60B

**Targets**

Target: N/A

**Context**

**Related Policies/ Programs**
<table>
<thead>
<tr>
<th>Useable data available from</th>
<th>2000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency of Reporting</td>
<td>3 monthly</td>
</tr>
<tr>
<td>Time lag to available data</td>
<td>Varies between 1 month and 3 months</td>
</tr>
</tbody>
</table>

**Business owners**

- **Contact - Policy**: Executive Director, Finance Branch
- **Contact - Data**: Executive Director, System Information and Analytics

**Representation**

- **Data type**: Numeric
- **Form**: Number
- **Representational layout**: N.N
- **Minimum size**: 3
- **Maximum size**: 3
- **Data domain**: 
- **Date effective**: 1st July 2017

**Related National Indicator**
### 2018-19 Service Performance Agreements
#### Strategy 2 IMs: Integrate Systems to Deliver Truly Connected Care

<table>
<thead>
<tr>
<th>INDICATOR:</th>
<th>MS2306</th>
</tr>
</thead>
</table>

#### Previous IDs:
- Unplanned Hospital Readmission Distributions: all unplanned admissions within 28 days of separation (%):
  - Aboriginal compared to non-Aboriginal
  - By Relative Socio-economic Disadvantage Index (IRSD)
  - Remoteness Areas

#### Shortened Title
- Unplanned Hospital Readmission – Aboriginal
- Unplanned Hospital Readmission – IRSD
- Unplanned Hospital Readmission – Remoteness

#### Service Agreement Type
Improvement Measure

#### Framework Strategy
Strategy 2: Provide World-Class Clinical Care Where Patient Safety is First

#### Framework Objective
2.5 (Use system performance information to drive reform)

#### Status
Final

#### Version number
1.01

#### Scope
All patient admissions to public facilities in peer groups A1 – D1b.

#### Goal
To identify and manage the number of unnecessary unplanned readmissions. To increase the focus on the safe transfer of care, coordinated care in the community and early intervention.

#### Desired outcome
Improved efficiency, effectiveness, quality and safety of care and treatment, with reduced unplanned events.

#### Primary point of collection
Administrative and clinical patient data collected at admission and discharge

#### Data Collection Source/System
Admitted Patient Data Collection, Hospital Patient Admission Systems (PAS)

#### Primary data source for analysis
HIE / IQ

#### Indicator definition
(i) The percentage of aboriginal compared to non-Aboriginal admissions that are an unplanned readmission to the same facility within 28 days following discharge for any purpose.

(ii) The percentage of admissions that are an unplanned readmission to the same facility within 28 days following discharge for any purpose, disaggregated by the Relative Socio-economic Disadvantage Index (IRSD).

(iii) The percentage of admissions that are an unplanned readmission to the same facility within 28 days following discharge for any purpose, disaggregated by Remoteness Areas.

Aboriginal = indigenous_status codes of 1, 2 or 3

Non-Aboriginal = indigenous_status codes of 4, 8 or 9

The IRSD and Remoteness Areas are based upon the SLA of the patient’s home address.

Remoteness Areas uses the [ASGC Remoteness Areas classification](#):
2018-19 Service Performance Agreements
Strategy 2 IMs: Integrate Systems to Deliver Truly Connected Care

- 0 = Major Cities
- 1 = Inner Regional
- 2 = Outer Regional
- 3 = Remote
- 4 = Very Remote.

**Numerator**

Numerator definition

(i) a) The total number of aboriginal unplanned admissions (counted as stays not episodes) with admission date within reference period and patient previously discharged from same facility in previous 28 days for any purpose.

b) The total number of non-aboriginal unplanned admissions (counted as stays not episodes) with admission date within reference period and patient previously discharged from same facility in previous 28 days for any purpose.

(ii) The total number of unplanned admissions (counted as stays not episodes) with admission date within reference period and patient previously discharged from same facility in previous 28 days for any purpose, disaggregated by the Relative Socio-economic Disadvantage Index (IRSD).

(iii) The total number of unplanned admissions (counted as stays not episodes) with admission date within reference period and patient previously discharged from same facility in previous 28 days for any purpose, disaggregated by Remoteness Areas.

Where: Unplanned is defined as Urgency of Admission (emergency_status) = 1.

A readmission is defined as an admission with an admission_date within 28 days of the discharge_date of a previous stay for the same patient at the same facility (identified by MRN and facility_identifier).

Numerator source HIE/ IQ

Numerator availability HIE/ IQ Available monthly

Inclusions Readmissions that result in death

Exclusions Transfers in from other hospitals (source of referral = 4 or 5)

Transfers are not counted in the Numerator as these are for the purposes of this indicator as patients who are continuing their care in this new location.

**Denominator**

Denominator definition

(i) a) Total number of aboriginal admissions (counted as stays not episodes) with admission dates within the reference period.

b) Total number of non-aboriginal admissions (counted as stays not episodes) with admission dates within the reference period.

(ii) Total number of admissions (counted as stays not episodes) with admission dates within the reference period.

(iii) Total number of admissions (counted as stays not episodes) with admission dates within the reference period.

Denominator source HIE/ IQ

Denominator availability HIE/ IQ Available monthly
Inclusions  Transfers from other hospitals (source of referral = 4 or 5)
Transfers in are included in the denominator as these Stays can potentially result in a patient readmission to the same hospital following discharge.

Exclusions  Admissions that result in death

**Inclusions**
- each index/initial admission can have at most one readmission;
- a readmission can be an index/initial admission to another readmission.

**Exclusions**
- Additional episodes created through a change of care type;
- Hospital boarders and organ procurement (episode of care type 0 or 9);
- Facilities in peer groups below D1b.

**Targets**
**Target**
Reduction on previous year.

**Comments**
- This definition is measurable with current data available in the ISC.
- The inclusions and exclusions have been changed and it no longer is based on the UK definition. Unlike the previous version of this indicator, if a patient has more than one unplanned readmission within the period, they will all be counted.
- While the use of administrative data can be used to identify unplanned readmissions it cannot clearly identify that the unplanned readmission was either related to the previous admissions or unexpected or preventable.
- The definition does not correspond with the ACHS Clinical Indicators 2005 which requires clinical decision;
- Not all readmissions are related to the previous admission and some may be potentially avoidable.
- Transfers from another hospital are not counted as readmissions as they can reasonably be seen as a continuation of a patients care in this new location and therefore excluded from the numerator. However these patients who transfer in to a facility are still included in the denominator as at discharge the potential exists for these patients to represent for care after their care had previously been considered to be complete.

**Context**
A low readmission rate may indicate good patient management practices and post-discharge care; facilities with a high readmission rate may indicate a problem with a clinical care pathway.

**Useable data available from**
2001/02

**Frequency of Reporting**
- Monthly/Annual, financial year, biannual
- State Plan - quarterly

**Time lag to available data**
- HIE/IQ data have a 6 month lag, available December for previous financial year
- Availability depends on refresh frequency
Business owners
Contact - Policy: Executive Director, System Performance Support
Contact - Data: Executive Director, System Information and Analytics

Representation
- Data type: Numeric
- Form: Number, presented as a percentage (%)
- Representational layout: NNN.N%
- Minimum size: 4
- Maximum size: 6
- Data domain: N/A
- Date effective: National Healthcare Agreement: PI 23-Unplanned hospital readmission rates, 2018

Related National Indicator
- http://meteor.aihw.gov.au/content/index.phtml/itemId/658485
Unplanned and Emergency Re-presentations - to same ED within 48 hours (%)

- All persons (SSQ112)
- Aboriginal persons (SSQ113)
- ABF hospitals (rate in NWAU) (SSQ125)

Shortened Title(s)
- Unplanned and Emergency Re-presentations – All
- Unplanned and Emergency Re-presentations – Aboriginal
- Unplanned and Emergency Re-presentations – ABF

Service Agreement Type
- Improvement Measure

Framework Strategy
- Strategy 2: Provide World-Class Clinical Care Where Patient Safety is First

Framework Objective
- 2.5 (Use system performance information to drive reform)

Status
- Final

Version number
- 2.31

Scope
- SSQ112 and SSQ113: All emergency visits to the Emergency Department.
- SSQ125: All emergency visits to the Emergency Department for ABF hospitals only.

Goal
- To reduce the number of re-presentations to Emergency Departments

Desired outcome
- Improve the efficiency of Emergency Department care
- Encourage adequate and proper follow up in primary care

Primary point of collection
- Emergency Department Clerk

Data Collection Source/System
- Emergency Department Data Collection

Primary data source for analysis
- HIE (ED_Visit_mrn)

Indicator definition
- **SSQ112 and SSQ113**: The percentage of emergency presentations to an Emergency Department where the patient returns to their place of usual residence following treatment and then re-presents at the same facility within 48 hours of departure from the Emergency Department.

This is reported for all persons (SSQ112), and separately for Aboriginal persons (SSQ113).

Note that Aboriginal persons include people who identify as Aboriginal and/or Torres Strait Islander.

- **SSQ125**: The rate of emergency presentations to an Emergency Department where the patient returns to their place of usual residence following treatment and then re-presents at the same facility within 48 hours, expressed in NWAU per 100 weighted presentations. Rates are standardised by:
  - 5 year age group
  - Aboriginality
  - Sex

Indirect standardisation adjustments have been used to compare the LHD/SHN populations against the NSW population. The link below details the methodology in...
the context of age-standardisation:

http://meteor.aihw.gov.au/content/index.phtml/itemId/327276

**Numerator**

**Numerator definition**
The number of emergency presentations with actual_departure_date within the reference period where the previous emergency presentation of the same patient to the same facility was in the 48 hours and resulted in the patient returning to their place of usual residence following treatment where:

- **Departure time** is measured using ED departure date/time from the Emergency Department record
- The time difference is measured from departure date/time of the first record to arrival date/time of the subsequent record.

The subsequent record has:

- Visit type in (‘1’, ‘3’), i.e. Emergency presentation or Unplanned return visit for continuing condition
- Any separation mode

The immediately previous record has:

- The same MRN and facility_id
- Is within 48 hours of the following presentation
- Mode of Separation is (‘2’, ‘4’) i.e. Admitted and discharged as an inpatient in ED or Departed treatment completed
- Visit type is (‘1’, ‘3’, ‘11’)

All persons includes all ED presentations

Aboriginal includes ED presentations with indigenous status in (‘1’, ‘2’, ‘3’) only

**Numerator source**
HIE (Emergency Department Data Collection)

**Numerator availability**
Available

**Denominator**

**Denominator definition**
The number of emergency presentations with actual_departure_date within the reference period, where the patient returns to their usual place of residence following treatment:

- Visit type is (‘1’, ‘3’, ‘11’) i.e. Emergency presentation, Unplanned return visit for continuing condition or Disaster
- Separation mode is (‘2’, ‘4’) i.e. Admitted and discharged as an inpatient in ED or Departed treatment completed

All persons includes all ED presentations

Aboriginal includes ED presentations with indigenous status in (‘1’, ‘2’, ‘3’) only

**Denominator source**
HIE (Emergency Department Data Collection)

**Denominator availability**
Available

**Inclusions**
Emergency visit type in (‘1’, ‘3’, ‘11’)

**Exclusions**
- Records where total time in ED is missing.
- Records where total time in ED is less than zero or greater than 99,998 minutes.
- Overlapping records i.e. where the arrival date/time of the second record is before the departure date/time of the first record. In such circumstances, the second record is not included in the calculation of the indicator with respect to the ED visit preceding it.
- Records where the separation mode on the initial presentation was not ‘2’ or ‘4’
- Duplicate with same facility, MRN, arrival date, arrival time and birth date
- Records where Mode of Separation is null or = ‘99’.
2018-19 Service Performance Agreements
Strategy 2 IMs: Integrate Systems to Deliver Truly Connected Care

Targets
Context
Related Policies/ Programs
• Whole of Health Program
• Centre for Health Care Redesign

Useable data available from
July 2001

Frequency of Reporting
Monthly/Weekly

Time lag to available data
Reporting required by the 10th day of each month, data available for previous month

Business owners
Contact - Policy
Executive Director, System Purchasing Branch
Contact - Data
Executive Director, System Information and Analytics

Representation
Data type
Numeric
Form
Number
Representational layout
NNNNNN
Minimum size
3
Maximum size
6
Data domain

Related National Indicators
Components
### 2018-19 Service Performance Agreements
#### Strategy 2 IMs: Integrate Systems to Deliver Truly Connected Care

<table>
<thead>
<tr>
<th>Indicator:</th>
<th>Potentially Preventable Hospitalisations (Rate per 100,000)</th>
</tr>
</thead>
</table>
| SIC101, SIC102, SIC103, SIC104 | - Vaccine-preventable conditions (SIC101)  
- Chronic conditions (SIC102)  
- Acute conditions (SIC103)  
- All potentially preventable hospitalisations (SIC104) |

**Previous IDs:** SSA119

**Shortened Title(s):**
- Vaccine Potentially Preventable Hospitalisations  
- Chronic Potentially Preventable Hospitalisations  
- Acute Potentially Preventable Hospitalisations  
- All Potentially Preventable Hospitalisations

**Scope:** All completed admitted inpatient episodes

**Goal:** Reduction of hospital admissions for selected conditions

**Desired outcome:** Improved health and increased independence for people who can be kept well at home, while reducing unnecessary demand on hospital services.

**Primary point of collection:** Patient Medical Record

**Data Collection Source/System:** Hospital PAS systems, Admitted Patient Data Collection

**Primary data source for analysis:** Health Information Exchange (HIE) (episode_table_separations)

**Indicator definition:** The number of potentially preventable hospitalisations, expressed as a rate per 100,000, further disaggregated by condition type.

The following are the list of ICD10AM diagnosis codes (applicable for 8th, 9th, and 10th editions) that are to be used for the calculation of this service measure. They are relevant to this measure only when they are recorded as the principal diagnosis for an inpatient episode of care, except where its presence as an additional diagnosis is explicitly identified in the [Inclusion and Exclusion rules for Potentially Avoidable Hospitalisations](#) document.

Note that any code that has a ".x" after it means that it includes all codes that have a fourth or fifth digit subdivision (eg. I20.x will include codes I20.0, I20.8 and I20.9).

**Vaccine-preventable conditions (SIC101):**
- J10.x Influenza due to other identified influenza virus  
- J11.x Influenza, virus not identified  
- J13 Pneumonia due to Streptococcus pneumoniae  
- J14 Pneumonia due to Haemophilus influenza  
- A08.0 Rotaviral enteritis  
- A35 Other tetanus
2018-19 Service Performance Agreements
Strategy 2 IMs: Integrate Systems to Deliver Truly Connected Care

A36.x  Diphtheria
A37.x  Whooping cough
A80.x  Acute poliomyelitis
B01.x  Varicella [chicken pox]
B05.x  Measles
B06.x  Rubella [German measles]
B16.1  Acute hepatitis B with delta-agent (coinfection) without hepatic coma
B16.9  Acute hepatitis B without delta-agent and without hepatic coma
B18.0  Chronic viral hepatitis B with delta-agent
B18.1  Chronic viral hepatitis B without delta-agent
B26.x  Mumps
G00.0  Haemophilus meningitis

**Chronic conditions (SIC102):**
J45.x  Asthma
J46  Status asthmaticus
I50.x  Heart failure
I11.0  hypertensive heart disease with (congestive) heart failure
J81  Pulmonary oedema
E10.0x–E10.9x  Type 1 diabetes mellitus
E11.0x–E11.9x  Type 2 diabetes mellitus
E13.0x–E13.9x  Other specified diabetes mellitus
E14.0x–E14.9x  Unspecified diabetes mellitus
J20.x  Acute bronchitis
J41.x  Simple and mucopurulent chronic bronchitis
J42  Unspecified chronic bronchitis
J43.x  Emphysema
J44.x  Other chronic obstructive pulmonary disease
J47  Bronchiectasis
I20.x  Angina pectoris
I24.0  Coronary thrombosis not resulting in myocardial infarction
I24.8  Other forms of acute ischaemic heart disease
I24.9  Acute ischaemic heart disease, unspecified
D50.1  Sideropenic dysphagia
D50.8  Other iron deficiency anaemias
D50.9  Iron deficiency anaemia, unspecified
I10  Essential (primary) hypertension
I11.9  Hypertensive heart disease without (congestive) heart failure
E40  Kwashiorkor
E41  Nutritional marasmus
E42  Marasmic kwashiorkor
E43  Unspecified severe protein-energy malnutrition
E55.0  Rickets, active
E64.3  Sequelae of rickets
I00  Rheumatic fever without mention of heart involvement
I01.x  Rheumatic fever with heart involvement
I02.x  Rheumatic chorea
I05.x  Rheumatic mitral valve diseases
I06.x  Rheumatic aortic valve diseases
I07.x  Rheumatic tricuspid valve diseases
I08.x  Multiple valve diseases
I09.x  Other rheumatic heart diseases

**Acute conditions (SIC103):**
J15.3 Pneumonia due to streptococcus, group B
J15.4 Pneumonia due to other streptococci
J15.7 Pneumonia due to Mycoplasma pneumoniae
J16.0 Chlamydial pneumonia
N10 Acute tubulo-interstitial nephritis
N11.x Chronic tubulo-interstitial nephritis
N12 Tubulo-interstitial nephritis, not specified as acute or chronic
N13.6 Pyonephrosis
N15.1 Renal and perinephric abscess
N15.9 Renal tubulo-interstitial disease, unspecified
N28.9 Disorders of kidney and ureter, unspecified
N39.0 Urinary tract infection, site not specified
N39.9 Disorder or urinary system, unspecified
K25.0 Gastric ulcer, acute with haemorrhage
K25.1 Gastric ulcer, acute with perforation
K25.2 Gastric ulcer, acute with both haemorrhage and perforation
K25.4 Gastric ulcer, chronic or unspecified with haemorrhage
K25.5 Gastric ulcer, chronic or unspecified with perforation
K25.6 Gastric ulcer, chronic or unspecified with both haemorrhage and perforation
K26.0 Duodenal ulcer, acute with haemorrhage
K26.1 Duodenal ulcer, acute with perforation
K26.2 Duodenal ulcer, acute with both haemorrhage and perforation
K26.4 Duodenal ulcer, chronic or unspecified with haemorrhage
K26.5 Duodenal ulcer, chronic or unspecified with perforation
K26.6 Duodenal ulcer, chronic or unspecified with both haemorrhage and perforation
K27.0 Peptic ulcer, site unspecified, acute with haemorrhage
K27.1 Peptic ulcer, site unspecified, acute with perforation
K27.2 Peptic ulcer, site unspecified, acute with both haemorrhage and perforation
K27.4 Peptic ulcer, site unspecified, chronic or unspecified with haemorrhage
K27.5 Peptic ulcer, site unspecified, chronic or unspecified with perforation
K27.6 Peptic ulcer, site unspecified, chronic or unspecified with both haemorrhage and perforation
K28.0 Gastrojejunal ulcer, acute with haemorrhage
K28.1 Gastrojejunal ulcer, acute with perforation
K28.2 Gastrojejunal ulcer, acute with both haemorrhage and perforation
K28.4 Gastrojejunal ulcer, chronic or unspecified with haemorrhage
K28.5 Gastrojejunal ulcer, chronic or unspecified with perforation
K28.6 Gastrojejunal ulcer, chronic or unspecified with both haemorrhage and perforation
L02.x Cutaneous abscess, furuncle and carbuncle
L03.x Cellulitis
L04.x Acute lymphadenitis
L08.x Other local infections of skin and subcutaneous tissue
L88 Pyoderma gangrenosum
L98.0 Pyogenic granuloma
L98.3 Eosinophilic cellulitis [Wells]
N70.x Salpingitis and oophoritis
N73.x Other female pelvic inflammatory diseases
N74.x Female pelvic inflammatory disorders in diseases classified elsewhere
H66.x Suppurative and unspecified otitis media
J02.x Acute pharyngitis
J03.x Acute tonsillitis
J06.x Acute upper respiratory infections of multiple and unspecified sites
J31.2 Chronic pharyngitis
K02.x Dental caries
K03.x Other diseases of hard tissues of teeth
K04.x Diseases of pulp and periapical tissues
K05.x Gingivitis and periodontal diseases
K06.x Other disorders of gingiva and edentulous alveolar ridge
K08.x Other disorders of teeth and supporting structures
K09.8 Other cysts of oral region, not elsewhere classified
K09.9 Cyst of oral region, unspecified
K12.x Stomatitis and related lesions
K13.x Other diseases of lip and oral mucosa
K14.0 Glossitis
G40.x Epilepsy
G41.x Status epilepticus
R56.x Convulsions, not elsewhere classified
O15.x Eclampsia
R02 Gangrene, not elsewhere classified
I70.24 Atherosclerosis of arteries of extremities with gangrene
E09.52 Intermediate hyperglycaemia with peripheral angiopathy, with gangrene

**Numerator**

Numerator definition: Total number of completed potentially preventable inpatient episodes in a financial year, further disaggregated by condition type.

Numerator source: HIE / Admitted Patient Data Collection

Numerator availability: Available

**Denominator**

Denominator definition: Total estimated resident population of the Local Health District / NSW


Denominator source: ABS; Health System Planning and Investment

Denominator availability

**Inclusions**

- Hospital in the Home (HiTH) episodes are included.

**Exclusions**


**Targets**

Target: N/A

**Context**

Admission to hospital for a condition where the hospitalisation could have potentially been prevented through the provision of appropriate individualised preventative health interventions and early disease management usually delivered in primary care and community-based care settings (including by general practitioners, medical specialists, dentists, nurses and allied health professionals).

For example, hospitalisations for conditions such as measles and tetanus can be prevented by primary health care through vaccination to prevent the conditions from occurring. Hospitalisations for patients presenting with acute pharyngitis can be prevented through timely treatment in primary health care settings using antibiotics, and hospitalisations for
diabetes complications can be prevented through appropriate, long-term management of diabetes by primary and community health practitioners.

The above definition excludes conditions that are preventable predominately through population health interventions, such as those for clean air and water.

<table>
<thead>
<tr>
<th>Related Policies/Programs</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Useable data available from</td>
<td>2000/01</td>
</tr>
<tr>
<td>Frequency of Reporting</td>
<td>Monthly</td>
</tr>
<tr>
<td>Time lag to available data</td>
<td>2 months to allow for coding to be completed.</td>
</tr>
<tr>
<td>Business owners</td>
<td>System Performance Support</td>
</tr>
<tr>
<td>Contact - Policy</td>
<td>Executive Director, System Performance Support</td>
</tr>
<tr>
<td>Contact - Data</td>
<td>Executive Director, System Information and Analytics</td>
</tr>
</tbody>
</table>

**Representation**

- Data type: Decimal
- Form: Number, presented as a rate per 100,000 population
- Representational layout: NN[NN].N
- Minimum size: 4
- Maximum size: 6
- Data domain: 1 July 2015

**Related National Indicator**

National Healthcare Agreement: PI 18–Selected potentially preventable hospitalisations, 2018
Meteor ID: 658499
INDICATOR: SSA132

| Previous IDs: |
| Home Based Dialysis – Proportion of renal dialysis service events that are home based (%) |

| Shortened Title | Home Based Dialysis |
| Service Agreement Type | Improvement Measure |
| Framework Strategy | Strategy 2: Provide World-Class Clinical Care Where Patient Safety is First |
| Framework Objective | 2.5 (Use system performance information to drive reform) |
| Status | Final |
| Version number | 1.3 |

| Scope | All renal dialysis patients |
| Goal | 50% of non-admitted/ambulatory or ambulatory-equivalent dialysis service events to be home dialysis |
| Desired outcome | Increased uptake of home dialysis |
| Primary point of collection | Patient medical record |
| Data Collection Source/System | NAP Datamart, Cerner, iPM, CorePAS, Admitted Patient Data Collection, Non-Admitted Patient Data Collection |
| Primary data source for analysis | NAP Datamart, EDWARD, HIE/IQ Server |

| Indicator definition | Percentage of non-admitted/ambulatory and ambulatory-equivalent dialysis service events that are home based. |

| Numerator |
| Numerator definition | Total number of home based dialysis service events |
| Numerator source | NAP Datamart |
| Numerator availability | Monthly |

| Denominator |
| Denominator definition | Total number of non-admitted/ambulatory dialysis service events plus same day admitted dialysis service events. For the purposes of this service measure, same-day dialysis admissions are considered to be ambulatory-equivalent service events. |
| Denominator source | NAP Datamart, EDWARD, HIE/IQ Server |
| Denominator availability | Monthly |

| Inclusions | All non-admitted dialysis service events and same-day admitted dialysis service events. |
| Exclusions | Patients receiving dialysis during an overnight/multiday admitted patient episode. |

| Targets | |

---
<table>
<thead>
<tr>
<th><strong>Target</strong></th>
<th>50% of all dialysis service events to be home based</th>
</tr>
</thead>
</table>

**Context**

<table>
<thead>
<tr>
<th><strong>Related Policies/ Programs</strong></th>
<th>ACI <em>Home first</em> dialysis model of care, October 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Useable data available from</strong></td>
<td>1 July 2013</td>
</tr>
<tr>
<td><strong>Frequency of Reporting</strong></td>
<td>Annual</td>
</tr>
<tr>
<td><strong>Time lag to available data</strong></td>
<td>Monthly</td>
</tr>
</tbody>
</table>

**Business owners**

<table>
<thead>
<tr>
<th><strong>Contact - Policy</strong></th>
<th>Executive Director, Health System Planning and Investment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Contact - Data</strong></td>
<td>Executive Director, Health System Information and Performance Reporting</td>
</tr>
</tbody>
</table>

**Representation**

<table>
<thead>
<tr>
<th><strong>Data type</strong></th>
<th>Numeric</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Form</strong></td>
<td>Number, presented as a percentage (%)</td>
</tr>
<tr>
<td><strong>Representational layout</strong></td>
<td>NN.N</td>
</tr>
<tr>
<td><strong>Minimum size</strong></td>
<td>3</td>
</tr>
<tr>
<td><strong>Maximum size</strong></td>
<td>4</td>
</tr>
<tr>
<td><strong>Data domain</strong></td>
<td>Percentage</td>
</tr>
</tbody>
</table>

**Related National Indicator**

N/A
Average Length of Episode Stay - Overnight Acute Patients (Days)

Previous known as:
- Average Length of Episode Stay - Overnight Patients (days)

Shortened Title
Average Length of Episode Stay

Service Agreement Type
Improvement Measure

Framework Strategy
Strategy 2: Provide World-Class Clinical Care Where Patient Safety Is First

Framework Objective
2.5 (Use system performance information to drive reform)

Status
Final

Version number
1.11

Scope
Acute admitted patients, all public hospitals

Goal
To monitor and manage Health Services

Desired outcome
High quality patient outcomes and effective service management

Primary point of collection
Patient Medical Record

Data Collection Source/System
Hospital PAS system, Admitted Patient Data Collection

Primary data source for analysis
HIE/IQ server.

Indicator definition
The average number of patient days for acute admitted patient episodes during the reporting period. Patients admitted and separated on the same day are excluded.

\[ \text{ALOS}_{\text{episodes}} = \frac{\text{sum of episode_length_of_stay}}{\text{Number of episodes}} \]

Average length of episode stay (ALOS) is computed by dividing the total number of in-patient hospital days, in all hospitals, counted from the date of admission to the date of discharge by the total number of discharges (including deaths) in all hospitals during a given period. A hospital day (or bed-day or in-patient day) is a day, during which a person admitted as an in-patient, is confined to a bed and stays overnight in a hospital.

Numerator

Numerator definition
Sum of all acute patients episode length of stay in the period.

- Where length of stay of a patient measured in days
- The calculation is inclusive of records with admission and separation dates.
- Total contracted days are included in the length of stay.
- All leave days are not included in length of stay calculation.

Numerator source
HIE (Facility and Episode Table)
Numerator availability  
Fed to HIE weekly but data entry into source systems may not be up-to-date.

**Denominator**

Denominator definition  
The total number of completed patient episodes in the reporting period.

Denominator source  
HIE

Denominator availability  
Fed to HIE weekly but data entry into source systems may not be up-to-date.

**Inclusions**

- facility_type in ('H', 'S', 'M', 'C') from HIE Facility table
- episode_of_care_type (Service Category) in ('1') in the HIE Episode Table
- Patients admitted with the intention of discharge on the same day, but who subsequently stay in hospital overnight, are included.

**Exclusions**

- Day-cases (patients formally admitted for a medical procedure or surgery in the morning and discharged before the evening) are excluded.
- Leave days

**Targets**

Comments  
Average length of stay in hospital is one of the indicators of the health and long-term care strand of the Open Method of Coordination on Social Inclusion and Social Protection.

Data are not age-standardized

**Useable data available from**  
2000/2001

**Time lag to available data**  
Data fed to HIE weekly, but data entry may be several months late.

**Business owners**

Contact - Policy  
Executive Director, System Purchasing Branch

Contact - Data  
Executive Director, System Information and Analytics

**Representation**

Data type  
Numeric

Form  
Number

Representational layout  
NNN.NN

Minimum size  
1

Maximum size  
6

Data domain  
Integer

Unit of Measure  
Day

Date effective  
01/07/2011 (this definition for NSW Health purposes only)

**Related National Indicator**

Source  
Meteor

Source identification  
329889 (Episode of admitted patient care—length of stay (including leave days), total N[NN])
INDICATOR: MS2504
Previous IDs:

**Acute separations - overnight (Number)**

**Shortened Title**
Acute separations - overnight

**Service Agreement Type**
Improvement Measure

**Framework Strategy**
Strategy 2: Provide World-Class Clinical Care Where Patient Safety Is First

**Framework Objective**
2.5 (Use system performance information to drive reform)

**Status**
Final

**Version number**
1.1

**Scope**
Acute admitted patients, all public hospitals

**Goal**
To monitor and manage Health Services

**Desired outcome**
High quality patient outcomes and effective service management

**Primary point of collection**
Patient Medical Record

**Data Collection Source/System**
Hospital PAS system, Admitted Patient Data Collection

**Primary data source for analysis**
HIE/IQ server.

**Indicator definition**
The total number of completed acute overnight admitted patient episodes in the reporting period.

**Numerator**
- **Numerator definition**
The total number of completed acute overnight admitted patient episodes in the reporting period.

- **Numerator source**
HIE (Facility and Episode Table)

- **Numerator availability**
Fed to HIE weekly but data entry into source systems may not be up-to-date.

**Denominator**
- **Denominator definition**
N/A

- **Denominator source**

- **Denominator availability**

**Inclusions**
- Facility_type in (‘H’, ‘S’, ‘M’, ‘C’) from HIE Facility table
- Episodes with episode_of_care_type (Service Category) value of (‘1’) in the HIE Episode Table
- Patients admitted with the intention of discharge on the same day, but who subsequently stay in hospital overnight, are included.

**Exclusions**
- Day-cases (patients formally admitted for a medical procedure or surgery in the morning and discharged before the evening) are excluded.

**Targets**
N/A

**Context**
Related Policies/ Programs

Useable data available from 2000/2001

Frequency of Reporting Data fed to HIE weekly, but data entry may be several months late.

Time lag to available data

Business owners

Contact - Policy Executive Director, System Purchasing Branch
Contact - Data Executive Director, System Information and Analytics

Representation

<table>
<thead>
<tr>
<th>Data type</th>
<th>Numeric</th>
</tr>
</thead>
<tbody>
<tr>
<td>Form</td>
<td>Number</td>
</tr>
<tr>
<td>Representational layout</td>
<td>N{10}</td>
</tr>
<tr>
<td>Minimum size</td>
<td>1</td>
</tr>
<tr>
<td>Maximum size</td>
<td>10</td>
</tr>
<tr>
<td>Data domain</td>
<td></td>
</tr>
<tr>
<td>Date effective</td>
<td>1 July 2012</td>
</tr>
</tbody>
</table>

Related National Indicators

Components
**INDICATOR:** MS2505

<table>
<thead>
<tr>
<th>Shortened Title</th>
<th>Acute separations – same day</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Service Agreement Type</strong></td>
<td>Improvement Measure</td>
</tr>
<tr>
<td><strong>Framework Strategy</strong></td>
<td>Strategy 2: Provide World-Class Clinical Care Where Patient Safety Is First</td>
</tr>
<tr>
<td><strong>Framework Objective</strong></td>
<td>2.5 (Use system performance information to drive reform)</td>
</tr>
<tr>
<td><strong>Status</strong></td>
<td>Final</td>
</tr>
<tr>
<td><strong>Version number</strong></td>
<td>1.1</td>
</tr>
</tbody>
</table>

**Scope**
Acute admitted patients, all public hospitals

**Goal**
To monitor and manage Health Services

**Desired outcome**
High quality patient outcomes and effective service management

**Primary point of collection**
Patient Medical Record

**Data Collection Source/System**
Hospital PAS system, Admitted Patient Data Collection

**Primary data source for analysis**
HIE/IQ server.

**Indicator definition**
The total number of completed acute same day admitted patient episodes in the reporting period.

**Numerator**
- **Numerator definition**
The total number of completed acute same day admitted patient episodes in the reporting period.
- **Numerator source**
HIE (Facility and Episode Table)
- **Numerator availability**
Fed to HIE weekly but data entry into source systems may not be up-to-date.

**Denominator**
- **Denominator definition**
N/A
- **Denominator source**
- **Denominator availability**

**Inclusions**
- Episodes with episode_of_care_type (Service Category) value of (‘1’) in the HIE Episode Table.
- Day-cases (patients formally admitted for a medical procedure or surgery in the morning and discharged before the evening) are included.

**Exclusions**
- Patients admitted with the intention of discharge on the same day, but who subsequently stay in hospital overnight, are excluded.

**Targets**
N/A

**Context**
2018-19 Service Performance Agreements
Strategy 2 IMs: Integrate Systems to Deliver Truly Connected Care

Related Policies/ Programs
Useable data available from 2000/2001
Frequency of Reporting Data fed to HIE weekly, but data entry may be several months late.
Time lag to available data

Business owners
  Contact - Policy Executive Director, System Purchasing Branch
  Contact - Data Executive Director, System Information and Analytics

Representation
  Data type Numeric
  Form Number
  Representational layout N{10}
  Minimum size 1
  Maximum size 10
  Data domain
  Date effective 1 July 2012

Related National Indicators

Components
INDICATOR: MS2503

Admitted Patient Separations (Number)

Previous IDs:
Admitted Patient Separations

Shortened Title
Admitted Patient Separations

Service Agreement Type
Improvement Measure

Framework Strategy
Strategy 2: Provide World-Class Clinical Care Where Patient Safety Is First

Framework Objective
2.5 (Use system performance information to drive reform)

Status
Final

Version number
1.01

Scope
All admitted patients, all public hospitals

Goal
To monitor and manage Health Services

Desired outcome
High quality patient outcomes and effective service management

Primary point of collection
Patient Medical Record

Data Collection Source/System
Hospital PAS system, Admitted Patient Data Collection

Primary data source for analysis
HIE/IQ server.

Indicator definition
The total number of completed admitted patient episodes in the reporting period.

Numerator
Numerator definition
The total number of completed admitted patient episodes in the reporting period.

Numerator source
HIE (Facility and Episode Table)

Numerator availability
Fed to HIE weekly but data entry into source systems may not be up-to-date.

Denominator
Denominator definition
N/A

Denominator source

Denominator availability

Inclusions

• Facility_type in ('H', 'S', 'M', 'C') from HIE Facility table

Exclusions

• Episodes with episode_of_care_type (Service Category) values of ('0' or '9') in the HIE Episode Table

Targets
N/A

Context

Related Policies/Programs

Useable data available from
2000/2001

Frequency of Reporting
Data fed to HIE weekly, but data entry may be several months late.

Time lag to available data
Business owners
Contact - Policy Executive Director, System Purchasing Branch
Contact - Data Executive Director, System Information and Analytics

Representation
Data type Numeric
Form Number
Representational layout N\{10\}
Minimum size 1
Maximum size 10
Data domain
Date effective 1 July 2012

Related National Indicators

Components
### 2018-19 Service Performance Agreements

#### Strategy 2 IMs: Integrate Systems to Deliver Truly Connected Care

<table>
<thead>
<tr>
<th>INDICATOR:</th>
<th>MS2502</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Previous IDs:</strong></td>
<td></td>
</tr>
</tbody>
</table>

#### Indicators

**Attendance Admitted from ED** (Number)

<table>
<thead>
<tr>
<th>Shortened Title</th>
<th>Attendance Admitted from ED</th>
</tr>
</thead>
</table>

**Improvement Measure**

**Strategy 2: Provide World-Class Clinical Care Where Patient Safety Is First**

**2.5 (Use system performance information to drive reform)**

**Status**

Final

**Version number**

1.01

**Scope**

All emergency presentations where treatment has been completed

**Goal**

To improve access to public hospital services

**Desired outcome**

- Improved patient satisfaction
- Improved efficiency of Emergency Department services

**Primary point of collection**

Emergency Department Clerk

**Data Collection Source/System**

Emergency Department Data Collection

**Primary data source for analysis**

HIE (ED_Visit)

**Indicator definition**

The number of ED attendances which resulted in the patient being admitted to a ward, ICU or theatre.

**Numerator**

**Numerator definition**

The number of ED attendances where the actual_departure_date occurs in the reporting period which resulted in the patient being admitted to a ward, ICU or theatre, as represented by one of the following separation modes: ‘1’, ‘10’, ‘11’

**Numerator source**

HIE (Emergency Department Data Collection)

**Numerator availability**

Available

**Denominator**

**Denominator definition**

N/A

**Denominator source**

N/A

**Denominator availability**

N/A

**Inclusions**

- All patients presenting to the emergency department at facilities that currently provide patient episode data to the non-admitted patients ED minimum data collection
- All patients that departed during the reporting period
- The following Emergency Department Modes of Separation values are included in calculation:
  - 1- Admitted to a ward/inpatient unit, not critical care
  - 10-Admitted to a critical care unit
  - 11-Admitted via operating suite
2018-19 Service Performance Agreements
Strategy 2 IMs: Integrate Systems to Deliver Truly Connected Care

Exclusions
- Where visit type is ('12' or '13') i.e. Telehealth presentation, current admitted patient presentation
- Duplicate with same facility, MRN, arrival date, arrival time and birth date

Targets
N/A

Context
Improved public patient access to emergency department (ED) services by improving efficiency and capacity in public hospitals

Related Policies/Programs
- Intergovernmental Agreement on Federal Financial Relations
- Whole of Health Program
- Centre for Health Care Redesign

Useable data available from
July 1996

Frequency of Reporting
Monthly

Time lag to available data
Reporting required by the 10th day of each month, data available for previous month

Business owners
Contact - Policy
Executive Director, System Purchasing Branch
Contact - Data
Executive Director, System Information and Analytics

Representation
Data type
Numeric
Form
Number
Representational layout
N{10}
Minimum size
1
Maximum size
10
Data domain

Date effective
1 July 2012

Related National Indicators

Components
<table>
<thead>
<tr>
<th>INDICATOR: PI-03</th>
<th><strong>Hospital in the Home: Admitted Activity (%)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous ID: 0026</td>
<td></td>
</tr>
<tr>
<td>Shortened Title</td>
<td>Hospital in the Home</td>
</tr>
<tr>
<td>Service Agreement Type</td>
<td>Improvement Measure</td>
</tr>
<tr>
<td>Framework Strategy</td>
<td>Strategy 2: Provide World-Class Clinical Care Where Patient Safety is First</td>
</tr>
<tr>
<td>Framework Objective</td>
<td>2.5 (Use system performance information to drive reform)</td>
</tr>
<tr>
<td>Status</td>
<td>Final</td>
</tr>
<tr>
<td>Version number</td>
<td>2.41</td>
</tr>
<tr>
<td>Scope</td>
<td>All patients commencing Hospital in the Home (HITH) services as Admitted (Daily) HITH</td>
</tr>
<tr>
<td>Goal</td>
<td>To treat an increased number of patients receiving acute care in Hospital in the Home as a substitution for hospitalisation</td>
</tr>
</tbody>
</table>
| Desired outcome  | • Increased number of people who receive acute substitution and clinical care in the home and ambulatory settings  
|                  | • Reduction in hospitalisation for select conditions  
|                  | • Reduction of demand for inpatient hospital services  |
| Primary point of collection | Patient administration clerical staff |
| Data Collection Source/System | Admitted patient data collection |
| Primary data source for analysis | HIE (Ward_Episode) |
| Indicator definition | The % of overnight separations with all or part of the episode in Bed Type ’25’ |
| **Numerator**     |                                               |
| Numerator definition | The number of Bed Type ’25’ acute overnight separations |
| Numerator source   | HIE (Ward_Episode)                           |
| Numerator availability | Available                                   |
| **Denominator**   |                                               |
| Denominator definition | The number of acute overnight separations |
| Denominator source | HIE (Ward_Episode)                           |
| Denominator availability | Available                                   |
| **Inclusions**    | Peer Group A-C facilities, plus APAC facilities and Balmain Hospital Episodes with a Bed Type ’25’ at any time during a patient episode. |
| **Exclusions**    | Justice Health and Forensic Mental Health Network |
| Targets           |                                               |
### Context
Evidence shows that patients/carers and the health system benefit from acute care provided in an alternate location to a hospital facility.

### Related Policies/Programs
- NSW Hospital in the Home Guideline 2018

### Useable data available from
July 2001

### Frequency of Reporting
Monthly

### Time lag to available data
Reporting required by the 10th day of each month, data available for previous month

### Business owners
- Contact - Policy: Executive Director, System Purchasing Branch
- Contact - Data: Executive Director, System Information and Analytics Branch

### Representation
- Data type: Percentage
- Form: Number
- Representational layout: NNNNN
- Minimum size: 1
- Maximum size: 5
- Data domain: 
- Date effective: 

### Related National Indicators
- Components: Hospital-in-the-home care
- Meteor ID: 327308
  
  [http://meteor.aihw.gov.au/content/index.phtml/itemId/327308](http://meteor.aihw.gov.au/content/index.phtml/itemId/327308)
## STRATEGY 3 IMs: Integrate Systems to Deliver Truly Connected Care

<table>
<thead>
<tr>
<th>INDICATOR:</th>
<th>PI-02</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Com Packs - Packages</strong> (Number)</td>
<td></td>
</tr>
</tbody>
</table>

### Previous ID:
- ComPacks - Packages

### Shortened Title
- ComPacks - Packages

### Service Agreement Type
- Improvement Measure

### Framework Strategy
- Strategy 3: Integrate Systems to Deliver Truly Connected Care

### Framework Objective
- 3.1 (Drive system integration through agreements)

### Status
- Final

### Version number
- 1.0

### Scope

#### Goal
- Improve on current level of service delivery.

#### Desired outcome
- To support a safe discharge from hospital, reduce a patient's unnecessary length of time in hospital and prevent avoidable readmission.

### Primary point of collection

### Data Collection Source/System
- CIMS (ComPacks Information Management System)

### Primary data source for analysis
- Collected from Compacks Service Providers

### Indicator definition
- Number of community care packages (ComPacks).

#### Numerator
- Numerator definition: Total number of community care packages (ComPacks) in the reporting period.
- Numerator source: CIMS (ComPacks Information Management System)
- Numerator availability: Monthly

#### Denominator
- Denominator definition: N/A
- Denominator source: N/A
- Denominator availability: N/A

### Inclusions

### Exclusions

### Targets
- Targets are based on each District's/Network's ComPacks budget.

### Context
- ComPacks are non-clinical case-managed community care packages available for people discharged home from a participating New South Wales Public Hospital. Each package is available for up to 6 weeks from the package start date.

### Related Policies/ Programs
- NSW ComPacks Program Guidelines and Resources – Sept 2016

### Useable data available from
- Compacks Program Office – System performance Support
2018-19 Service Performance Agreements
Strategy 3 IMs: Integrate Systems to Deliver Truly Connected Care

**Frequency of Reporting**
- Monthly

**Time lag to available data**
- Can be up to one month

**Business owners**

- **System Performance Support**
  - Contact - Policy
    - Anne-Maree Chant Compacks Program Manager (achan@doh.health.nsw.gov.au)
  - Contact - Data
    - Archi Salinas ComPacks Coordinator (asali@doh.health.nsw.gov.au)

**Representation**
- **Data type**
  - Numeric
- **Form**
  - Number
- **Representational layout**
  - N(9)
- **Minimum size**
  - 2
- **Maximum size**
  - 9
- **Data domain**
  - N/A
- **Date effective**

**Related National Indicators**
- **Indicator**

Source
## 2018-19 Service Performance Agreements
### Strategy 3 IMs: Integrate Systems to Deliver Truly Connected Care

<table>
<thead>
<tr>
<th>Indicator:</th>
<th>SSA106</th>
<th><strong>Patients with Total time in ED &lt;= 4hrs: Mental Health (%)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous IDs:</td>
<td></td>
<td>• Mental health patients admitted (to a ward/ICU/theatre from ED) (%)</td>
</tr>
</tbody>
</table>

### Shortened Title
Mental health patients in ED <= 4hrs

### Service Agreement Type
Improvement Measure

### Framework Strategy
Strategy 3: Integrate Systems to Deliver Truly Connected Care

### Framework Objective
3.2 (Deliver mental health reforms)

### Status
Final

### Version number
4.22

### Scope
All emergency presentations where treatment has been completed

### Goal
To improve access to public hospital services

### Desired outcome
• Improved patient satisfaction
• Improved efficiency of Emergency Department services

### Primary point of collection
Emergency Department Clerk

### Data Collection Source/System
Emergency Department Data Collection

### Primary data source for analysis
HIE (ED_Visit_mrn)

### Indicator definition
The percentage of ED mental health patients whose clinical care in the ED has ceased as a result of their physically leaving the ED, or where clinical care has ceased as a result of their being ready for departure following discharge from the ED, and whose ED stay length is <= 4 hours, and who are admitted to a ward, to ICU or to theatre from ED.

ED stay length is calculated as subtracting presentation date/time from ED physical departure date/time, where:

- **Presentation date/time in the ED** is the time and date of the first recorded contact with an emergency department staff member. The first recorded contact can be the commencement of the clerical registration or triage process, whichever happens first and;

- **Departure date/time** is measured using the following business rules:
  - If the patient is subsequently admitted to this hospital (either short stay unit, hospital-in-the-home or non-emergency department hospital ward), then record the time the patient leaves the emergency department to go to the admitted patient facility. For NSW, this corresponds to Mode of Separation codes ‘01’, ‘10’ or ‘11’, and is calculated using the “Actual Departure Date and Time” field in source systems.
  - If the service episode is completed without the patient being admitted, and the patient is referred to another hospital for admission, then record the time the patient leaves the emergency department. For NSW, this corresponds to Mode of Separation code ‘05’ and is calculated using the “Actual Departure Date and Time” field in source systems.
  - If the service episode is completed without the patient being admitted,
including where the patient is referred to another clinical location, then record the time the patient's emergency department non-admitted clinical care ended. For NSW, this corresponds to Mode of Separation codes '04' or '09' and is calculated using the earlier of "Departure Ready Date and Time", or "Actual Departure Date and Time" fields in source systems.

- If the patient did not wait, then record the time the patient leaves the emergency department or was first noticed as having left. For NSW, this corresponds to Mode of Separation code '06' and is calculated using the "Actual Departure Date and Time" field in source systems.

- If the patient leaves at their own risk, then record the time the patient leaves the emergency department or was first noticed as having left. For NSW, this corresponds to Mode of Separation codes '07' and is calculated using the "Actual Departure Date and Time" field in source systems.

- If the patient died in the emergency department, then record the time the body was removed from the emergency department. For NSW, this corresponds to Mode of Separation code '03' and is calculated using the "Actual Departure Date and Time" field in source systems.

- If the patient was dead on arrival, then record the time the body was removed from the emergency department. If an emergency department physician certified the death of the patient outside the emergency department, then record the time the patient was certified dead. For NSW, this corresponds to Mode of Separation code '08' and is calculated using the "Actual Departure Date and Time" field in source systems.

**NOTE:** For the purposes of this Measure, an ED presentation is defined as the totality of an ED visit, from the date and time of the first recorded contact with an emergency department staff member to the point where the visit has concluded and the clinical care in the ED has ceased.

### Numerator

**Numerator definition**

All mental health patients, whose actual departure date falls within the reporting period, and who have a length of stay from presentation time to departure time of less than or equal to 4 hours, and who are admitted to a ward, to ICU or to theatre from ED, as represented by the combination of one of the following separation modes:

- '1', '10', '11';

Mental health patients are identified using ED principal diagnosis codes as follows:

**ICD9CM:**
- First three characters "294"-"301" or "306"-"314";
- whole codes "V71.01"-"V71.09";
- whole code "799.2";
- whole codes "E950.00"-"E959.99".

**ICD10AM:**
- First three characters "F20"-"F51" or "F53"-"F63" or "F65"-"F69" or "F80"-"F99" or "R44"-"R45" or "X60"-"X84";
- For codes with first two characters "F1", include only those of from "F1n.5" where n is an integer 0-9.

Numerator source: HIE (Emergency Department Data Collection)
Numerator availability: Available

**Denominator**

Denominator definition: The total number of emergency department mental health presentations who are admitted to a ward, to ICU or to theatre from ED, where the actual_departure_date falls within the reporting period.

Denominator source: HIE (Emergency Department Data Collection)
Denominator availability: Available

**Inclusions**
- All patients presenting to the emergency department at facilities that currently provide patient episode data to the non-admitted patients ED minimum data collection
- All patients that departed during the reporting period
- Only records where “Presentation time” (i.e. triage or arrival time) and actual Departure date/time are present
- The following Emergency Department Modes of Separation values are included in calculation:
  - 1- Admitted to a ward/inpatient unit, not critical care
  - 10-Admitted to a critical care unit
  - 11-Admitted via operating suite
- Mental health patients are identified using ED principal diagnosis codes from ICD 9, ICD 10 or SNOMED CT.

**Exclusions**
- Records where total time in ED is missing, less than zero or greater than 99,998 minutes
- Visit type in (‘12’,’13’) i.e. Telehealth presentation, current admitted patient presentation
- Separation mode = ‘99’ i.e. Registered in error
- Duplicate with same facility, MRN, arrival date, arrival time and birth date

**Targets**
N/A

**Context**
Improved public patient access to emergency department (ED) services by improving efficiency and capacity in public hospitals

**Related Policies/ Programs**
- Intergovernmental Agreement on Federal Financial Relations
- Whole of Health Program
- Centre for Health Care Redesign

**Useable data available from**
July 1996

**Frequency of Reporting**
Monthly

**Time lag to available data**
Reporting required by the 10th day of each month, data available for previous month
2018-19 Service Performance Agreements
Strategy 3 IMs: Integrate Systems to Deliver Truly Connected Care

<table>
<thead>
<tr>
<th>Business owners</th>
<th>Contact - Policy</th>
<th>Executive Director, System Purchasing Branch</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Contact - Data</td>
<td>Executive Director, System Information and Analytics</td>
</tr>
</tbody>
</table>

**Representation**

<table>
<thead>
<tr>
<th>Data type</th>
<th>Numeric</th>
</tr>
</thead>
<tbody>
<tr>
<td>Form</td>
<td>Number, presented as a percentage (%)</td>
</tr>
<tr>
<td>Representational layout</td>
<td>NNN.N</td>
</tr>
<tr>
<td>Minimum size</td>
<td>3</td>
</tr>
<tr>
<td>Maximum size</td>
<td>5</td>
</tr>
</tbody>
</table>

| Date effective  | 1 July 2012 |

**Related National Indicators**

- National Healthcare Agreement: PI 21b–Waiting times for emergency hospital care: proportion of patients whose length of emergency department stay is less than or equal to four hours, 2018
  Meteor ID: 658489
  [http://meteor.aihw.gov.au/content/index.phtml/itemId/658489](http://meteor.aihw.gov.au/content/index.phtml/itemId/658489)

- National Health Performance Authority, Hospital Performance: Waiting times for emergency hospital care: Percentage completed within four hours, 2014
  Meteor ID: 558277
  [http://meteor.aihw.gov.au/content/index.phtml/itemId/558277](http://meteor.aihw.gov.au/content/index.phtml/itemId/558277)

**Components**

- Meteor ID 474181 Non-admitted patient emergency department service episode—service episode length, total minutes NNNNN
  The amount of time, measured in minutes, between when a patient presents at an emergency department, and when the non-admitted emergency department service episode has concluded
  [http://meteor.aihw.gov.au/content/index.phtml/itemId/474181](http://meteor.aihw.gov.au/content/index.phtml/itemId/474181)

- Meteor ID 471889 Emergency department stay—presentation time, hhmm
  The time of patient presentation at the emergency department is the time of first recorded contact with an emergency department staff member. The first recorded contact can be the commencement of the clerical registration or triage process, whichever happens first
  [http://meteor.aihw.gov.au/content/index.phtml/itemId/471889](http://meteor.aihw.gov.au/content/index.phtml/itemId/471889)
Emergency Department Extended Stays: Mental Health Presentations staying in ED > 12 hours (number)

Shortened Title: MH ED Extended Stays > 12hrs

Service Agreement Type: Improvement Measure
Framework Strategy: Strategy 3: Integrate Systems to Deliver Truly Connected Care
Framework Objective: 3.2 (Deliver mental health reforms)

Status: Final
Version number: 1.03

Scope: Emergency Department mental health patients.

Goal: To improve access to mental health inpatient services (where this is required) from Emergency Department.

Desired outcome: Improve patient satisfaction and availability of services with reduced waiting time for admission to acute patient care in a Mental Health unit from the Emergency Department and to improve the availability of Emergency Department services for other patients.

Primary point of collection: Emergency Department clerk

Data Collection Source/System: Emergency Department Information System (EDIS)/Cerner First Net/other electronic Emergency Department Information Systems

Primary data source for analysis: HIE (Table ED_Visit, ED_diagnosis, ED_diagnosis_sct)

Indicator definition: Number of Mental Health presentations where the patient's stay in ED from Presentation time to actual departure is longer than 12 hours, where the actual_departure_date falls within the reporting period.

Where:
- **Presentation time in the ED** is the triage time. If the triage time is missing it is the arrival time and;
- **Departure time** is the earliest of departure ready date/time or actual departure date/time for non-admitted patients with a mode of separation 2, 4 or 9; otherwise it is the actual departure date/time.

Mental health patients are identified using ED principal diagnosis codes as follows:

**ICD9CM:**
- First three characters “294”-“301” or “306”-“314”;
- whole codes “V71.01”-“V71.09”;
- whole code “799.2”;
- whole codes “E950.00”-“E959.99”.

**ICD10AM:**
- First three characters “F20”-“F51” or “F53”-“F63” or “F65”-“F69” or “F80”-“F99” or “R44”-“R45” or “X60”-“X84”;
- For codes with first two characters “F1”, include only those of form “F1n.5”
where \( n \) is an integer 0-9.


**NOTE:** For the purposes of this Measure, an *ED presentation* is defined as the totality of an ED visit, from the date and time of Triage (or arrival time if missing) to the point where the visit has concluded and the clinical care in the ED has ceased.

**Data Availability**
Available. Note that some EDIS systems include the decimal point in the ICD9 diagnosis code and some do not.

**Inclusions**
- Mental health patients as identified using ED principal diagnosis codes ICD 9, ICD 10 and SNOMED CT.
- Emergency type visits (type of visit codes 1, 3 and 11).

**Exclusions**
- Departure status was Did not wait, Left at own risk or Dead on arrival i.e. Modes of separation 6, 7, 8, and 99.
- Records with negative or missing length of stay.

**Targets**
N/A

**Lower / upper age limit**
All ages

**Context**
Timely admission to a hospital bed, for those Emergency Department patients who require inpatient treatment, contributes to patient comfort and improves outcomes and the availability of Emergency Department services for other patients.

**Related Policies/Programs**
- Clinical Services Redesign Program
- Whole of Health program

**Useable data available from**
July 2006

**Frequency of Reporting**
Monthly

**Time lag to available data**
Reporting required by the 10th day of each month, data available for previous month

**Business owners**
Mental Health Branch
- Contact - Policy
  Director, Mental Health Branch
- Contact - Data
  Executive Director, System Information and Analytics

**Representation**
- Data type: Numeric
- Form: Number
- Representational layout: NNNN
- Minimum size: 1
- Maximum size: 4

**Related National Indicator**
Components

Meteor ID 474181 Non-admitted patient emergency department service episode—service episode length, total minutes NNNNNN
The amount of time, measured in minutes, between when a patient presents at an emergency department, and when the non-admitted emergency department service episode has concluded
http://meteor.aihw.gov.au/content/index.phtml/itemId/474181

Meteor ID 471889 Emergency department stay—presentation time, hh:mm
The time of patient presentation at the emergency department is the time of first recorded contact with an emergency department staff member. The first recorded contact can be the commencement of the clerical registration or triage process, whichever happens first
http://meteor.aihw.gov.au/content/index.phtml/itemId/471889
INDICATOR: SSQ124

Mental Health: Frequency of Seclusion (%)

- Percentage of acute mental-health admitted care episodes with seclusion

Previous IDs:

Mental Health: Frequency of Seclusion

Shortened Title

Mental Health: Frequency of Seclusion

Service Agreement Type

Improvement Measure

Framework Strategy

Strategy 3: Integrate Systems to Deliver Truly Connected Care

Framework Objective

3.2 (Deliver mental health reforms)

Status

Final

Version number

1.11

Scope

Mental health public hospital acute services

Goal

To reduce the use of seclusion in public sector mental health services

 Desired outcome

The reduction, and where possible, elimination of seclusion in mental health services

Primary point of collection

Administrative and clinical staff in NSW public hospitals (including stand-alone psychiatric hospitals) with mental health units/beds.

Data Collection Source/System

Inpatient data; Patient Administration Systems and local seclusion registers

Primary data source for analysis

Local seclusion registers. Inpatient data from Admitted Patient Data Collection – HIE/IQ server.

Indicator definition

Percent of acute mental-health admitted care episodes where seclusion occurs

Numerator

Numerator definition

Number of hospital admissions in all acute mental health units with at least one episode of seclusion during the reporting period

Numerator source

Local seclusion register

Numerator availability

Data available since the statewide collection commenced in January 2008

Denominator

Denominator definition

Number of hospital admissions in acute mental health units

Denominator source

Admitted Patient Data Collection – HIE/IQ server

Denominator availability

Available

Inclusions

- Acute mental health units in facilities with seclusion rooms/facilities
- Acute beds of some facilities without seclusion rooms/facilities are included in the calculation of LHD and NSW percentage

Exclusions

Targets

Target

N/A

Context

Seclusion data is manually reported by LHDs. Apparent differences in
rate between units may be due to local differences in counting or reporting.

Related Policies/ Programs
Annual National Mental Health Seclusion and Restraint forums convened by the Safety and Quality Partnership Standing Committee (SQPSC).

Useable data available from
Data have been available since January 2008.

Frequency of Reporting
Quarterly

Time lag to available data
Admitted Patient reporting is required by the 13th calendar day of each month for previous month. Data available in HIE/IQ Server by following Tuesday. Submission of local seclusion episodes data may take up to one month after the end of reporting period.

Business owners
Health Systems Information Performance & Reporting, Ministry of Health

Contact - Policy
Director, Mental Health Branch

Contact - Data
Associate Director Performance Analysis and Reporting, InforMH

Representation

Data type
Numeric

Form
Number, presented as a percentage

Representational layout
NNN.N

Minimum size
2

Maximum size
6

Data domain
2015

Related National Indicator
Meteor ID 573022 Specialised mental health service—number of episodes of admitted care, total episodes N[NNNN]
The total number of episodes of admitted care within the reference period for a specialised mental health service. http://meteor.aihw.gov.au/content/index.phtml/itemId/573022

Meteor ID 572980 Specialised mental health service—number of episodes with seclusion, total episodes N[NNNN]
The total number of episodes with at least one seclusion event within the reference period for a specialised mental health service. http://meteor.aihw.gov.au/content/index.phtml/itemId/572980
INDICATOR: SSQ121

**Mental Health: Outcome Readiness – HoNOS Completion Rates (%)**

- The proportion of mental health episodes with completed HoNOS outcome measures, stratified by service setting (community, acute inpatient).

**Shortened Title**
Outcome Readiness – HoNOS Completion Rates

<table>
<thead>
<tr>
<th>Service Agreement Type</th>
<th>Improvement Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Framework Strategy</td>
<td>Strategy 3: Integrate Systems to Deliver Truly Connected Care</td>
</tr>
<tr>
<td>Framework Objective</td>
<td>3.2 (Deliver mental health reforms)</td>
</tr>
</tbody>
</table>

**Status**
Final

**Version number**
1.11

**Scope**
All acute inpatient episodes of care;
- Separated from an acute MH inpatient unit and
- with length of stay > 3 days and
- with a State Unique Patient Identifier (SUPI)

All ambulatory statistical episodes of care within an LHD (where the statistical episode is a fixed three-month calendar quarter: Jan-Mar, Apr-Jun, Jul-Sep, Oct-Dec);
- with 2 or more treatment in which the client was present (Client Present Status = Yes) for at least one contact and
- with a SUPI.

**Goal**
To increase the proportion of mental health episodes which have a Health of the Nation Outcome Scale (HoNOS) measure completed and available to inform clinical care and service management. Reasonable performance is required on this indicator before the HoNOS measure can reliably be used as a measure of change in clinical outcomes.

**Desired outcome**
Improved quality and capability of a service in recording a consumer’s progress to improved mental health and well-being.

**Primary point of collection**
Clinical staff at designated facilities with inpatient mental health unit/beds, psychiatric hospitals and outpatient and community mental health teams/services.

**Data Collection Source/System**
Inpatient data: Patient Administration Systems, Community data: SCI-MHOAT, CHIME, CERNER, FISCH.

**Primary data source for analysis**
Inpatient data: Admitted Patient Data Collection – HIE/IQ server; Community data: Community Mental Health Data Collection (CH-AMB) – HIE/IQ server
Outcomes data: Mental Health Outcomes and Assessment Tools (MH-OAT) Data Collection – HIE/IQ server
State Unique Patient Identifier (SUPI) – HIE/IQ Server.

**Indicator definition**
Percentage of mental health episodes within an LHD, reported separately for acute inpatient and ambulatory settings, with completed HoNOS measures
### Numerator

**Numerator definition**

Numerator: Acute inpatient episodes of care
- Completed HoNOS.
- HoNOS collection date must be within the inpatient episode start date and end date, where the separation date is within the reporting period.
- MH service setting for HoNOS must be inpatient.
- LHD completing the HoNOS must be the same as the LHD providing the acute inpatient episode.

Numerator: Ambulatory episodes of care
- Completed HoNOS.
- HoNOS collection date between quarter start and end dates.
- MH service setting for HoNOS must be ambulatory.
- LHD completing the HoNOS must be the same as the LHD providing the service contacts.

**Note:** Health of the Nation Outcome Scales (HoNOS) family includes HoNOS, HoNOS 65+ and HoNOS Children and Adolescents (HoNOSCA).

A completed HoNOS is defined as having at least 10 of the 12 items having valid clinical ratings (0 to 4) for HoNOS/65+ or 11 of the first 13 items with valid clinical ratings (0 to 4) for HoNOSCA.

**Numerator source**

Admitted Patient Data Collection and Community Mental Health Data Collection in HIE linked to MH-OAT Data Collection in HIE via SUPI

**Numerator availability**

Admitted data available
MH-AMB and MH-OAT since 2007/08.

### Denominator

**Denominator definition**

Acute mental health inpatient episodes of care which end by separation within the reporting period;

Ambulatory mental health episodes of care.

**Note:** mental health separations are selected from NSW HIE Inpatient tables where the ward identifier = designated MH unit from the Mental Health Service Entity register (MH-SER) ward tables

**Denominator source**

Admitted Patient Data Collection and Community Mental Health Data Collection (CH-AMB)– HIE/IQ server;

**Denominator availability**

Admitted data available
MH-AMB since 2007/08

### Inclusions

Inpatient episodes of care;
- Separations from any acute MH inpatient unit in reporting period
- Length of stay > 3 days
- Must have an inpatient SUPI.

Ambulatory episodes of care
Ambulatory statistical episode is a fixed three-month period: Jan-Mar, Apr-Jun, Jul-Sep, Oct-Dec, i.e. standard calendar quarters.

A person has an ambulatory episode of care if they were seen with 2 or more treatment days by an LHD within a statistical episode.

A treatment day is any day on which 1 or more community contacts (with Client Present Status = Yes) are recorded for a registered client. NB Client Present Status measures client participation in the contact (Yes = face-to-face, by phone, telemedicine etc).

Must have an ambulatory SUPI.

**Exclusions**

- Acute inpatient episodes ending in death (mode of separation 6 or 7).
- Consultation and liaison, i.e. ambulatory activity with service recipient type = 2 (inpatient) are not counted towards a treatment day.
- Assessment only episodes, i.e. one treatment day episodes in ambulatory services or acute inpatient episodes with LOS ≤ 3 days.
- Episodes or activity with no SUPI.
- Incomplete HoNOS.
- Community based residential services.

**Targets**

**Target**

Interim Target: 80%

**Context**

**Related Policies/ Programs**

This KPI is related to the National interim measure MHS PI 14: Outcomes readiness (Key Performance Indicators Australian Public Mental Health Services 3rd edition 2013). The national indicator requires a complete measure at both admission and discharge in the inpatient episode and for ambulatory episodes.

**Useable data available from**

Data have been available since 2007/08.

**Frequency of Reporting**

Quarterly

**Time lag to available data**

Admitted Patient reporting is required by the 13th calendar day of each month for previous month. Data available in HIE/IQ Server by following Tuesday. Community Mental Health data is fed to HIE weekly, but data entry into source systems may be several months late.

**Business owners**

Health Systems Information Performance & Reporting, Ministry of Health

**Contact - Policy**

Director, Mental Health Branch

**Contact - Data**

Associate Director Performance Analysis and Reporting, InforMH

**Representation**

**Data type**

Numeric

**Form**

Number, presented as a percentage (%)

**Representational layout**

NNN.NN
<table>
<thead>
<tr>
<th>Minimum size</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum size</td>
<td>6</td>
</tr>
<tr>
<td>Data domain</td>
<td>Effective</td>
</tr>
<tr>
<td>Tables used in the construction of this indicator:</td>
<td></td>
</tr>
<tr>
<td>- HIE Inpatient tables: days_episode, episode_ats</td>
<td></td>
</tr>
<tr>
<td>- HIE Community table: community_visit, community_activity</td>
<td></td>
</tr>
<tr>
<td>- HIE MH-OAT Collection tables: mh_collection_occasion and subsidiary tables for individual outcome measures.</td>
<td></td>
</tr>
<tr>
<td>- Other HIE tables: patient_contact, service_unit, facility</td>
<td></td>
</tr>
<tr>
<td>- Mental Health Ward table - maintained in-house by InforMH.</td>
<td></td>
</tr>
<tr>
<td>Date effective</td>
<td>2015</td>
</tr>
<tr>
<td>Related National Indicator</td>
<td>KPIs for Australian Public Mental Health Services: PI 14J – Outcomes readiness, 2016</td>
</tr>
<tr>
<td></td>
<td><a href="http://meteor.aihw.gov.au/content/index.phtml/itemId/630394">http://meteor.aihw.gov.au/content/index.phtml/itemId/630394</a></td>
</tr>
<tr>
<td></td>
<td>Meteor ID: 630394</td>
</tr>
</tbody>
</table>
INDICATOR: SSQ122

Previous IDs:

| Mental Health Consumer Experience Measure (YES) - Completion rate (%) |

Shortened Title: Mental Health YES Completion Rate

Service Agreement Type: Improvement Measure

Framework Strategy: Strategy 3: Integrate Systems to Deliver Truly Connected Care

Framework Objective: 3.2 (Deliver mental health reforms)

Status: Final

Version number: 1.31

Scope: Acute and non-acute specialist mental health services for adolescents, adults and older persons, stratified by service setting (inpatient, community)

Goal: To measure the percentage of mental health consumers who complete the “Your Experience of Service” (YES) measure within the reporting period

Desired outcome: Regular feedback from mental health consumers should be available to service managers, clinicians and consumers and be used in the evaluation of service effectiveness and the improvement of services

Primary point of collection: The YES questionnaire is completed by mental health service users

Data Collection Source/System: Completed YES questionnaires are scanned and data sent to InforMH, HSIPR Branch, NSW MoH for collation, analysis and reporting.

Primary data source for analysis: YES database, InforMH

Indicator definition: The estimated rate of YES completion in the reporting period, reported separately for inpatient and community mental health clients and episodes.

**Numerator**

Numerator definition: Ambulatory: the number of completed YES measures received in the period from identified ambulatory and community residential mental health service units

Inpatient: the number of completed YES measures received in the period from identified non-acute inpatient mental health service units

Numerator source: YES database

Numerator availability: Implementation and database construction from April 2015

**Denominator**
Denominator definition

Ambulatory: number of three month statistical ambulatory care episodes, defined as a calendar quarter in which, within an LHD, a person had at least two days (treatment days) on which they received at least one ambulatory mental health service contact in which they participated (defined by HIE “Client present status”).

Inpatient: number of hospital episodes ending in separation from in-scope units in the reporting period, plus number of non-discharged stays remaining open at the end of the reporting period (non-acute units only).

Denominator source
Admitted patient collection, CHAMB collection, NSW HIE IQ Server

Denominator availability
Data available in NSW HIE.

Inclusions
- Persons aged 11 and over are included in the calculation. Age should be defined as at first contact/episode in reporting period.
- YES questionnaires are counted as compete if a valid response is returned for at least one question and a valid mental health service identifier is provided

Exclusions
- Persons aged under 11
- Incomplete YES measures

Targets
Target
Increase on previous year

Context
The routine collection and use of consumer experience is an important strategy in ensuring effective ad recovery-focused mental health services. In 2015 NSW is implementing the new YES Measure, a nationally developed measure based on the recovery standards of the National Mental Health Service Standards. This replaces the previous MH-CoPES Measure. Completion rate is included as an interim service measure, and will be replaced with overall consumer experience scores.

The YES questionnaire is anonymous and cannot be linked to an individual person or episode of care, and therefore the measure is an estimate of completion rates.

Related Policies/ Programs
National and NSW policies and programs related to improving the recovery focus of mental health services

Useable data available from
April 2015

Frequency of Reporting
Quarterly. LHD collection protocols vary, and some services use periodic “snapshot” surveys in ambulatory settings, hence quarterly rates may vary for those LHDs

Time lag to available data
Data available within 4 weeks of close of reporting period.

Business owners
InformMH, HSIPR Branch, NSW Ministry of Health

Contact - Policy
Manager, Clinical Measurement and Benchmarking, InformMH (02-8877 5120)

Contact - Data
Manager Performance and Reporting, InformMH (8877 5120)

Representation
Data type
Numeric
### 2018-19 Service Performance Agreements
**Strategy 3 IMs: Integrate Systems to Deliver Truly Connected Care**

<table>
<thead>
<tr>
<th>Form</th>
<th>Number (percentage), presented separately for inpatient and ambulatory</th>
</tr>
</thead>
<tbody>
<tr>
<td>Representational layout</td>
<td>NN%</td>
</tr>
<tr>
<td>Minimum size</td>
<td>1</td>
</tr>
<tr>
<td>Maximum size</td>
<td>3</td>
</tr>
<tr>
<td>Data domain</td>
<td></td>
</tr>
<tr>
<td>Date effective</td>
<td>April 2015</td>
</tr>
<tr>
<td>Related National Indicator</td>
<td>Nil</td>
</tr>
</tbody>
</table>
**2018-19 Service Performance Agreements**  
**Strategy 3 IMs: Integrate Systems to Deliver Truly Connected Care**

**INDICATOR:** DMH_3203  
**Previous IDs:**

**Shortened Title**  
Community Mental Health Enhancements

**Service Agreement Type**  
Improvement Measure

**Framework Strategy**  
Strategy 3: Integrate Systems to Deliver Truly Connected Care

**Framework Objective**  
3.2 (Deliver mental health reforms)

**Status**  
Final

**Version number**  
1.01

**Scope**  
Mental Health Services

**Goal**  
Support reform of NSW mental health services by strengthening community care and reducing need for hospital care

** Desired outcome**  
Effective implementation of community enhancement programs by LHDs, demonstrating increased community activity commensurate with enhanced staffing for each LHD

**Primary point of collection**  
Recording of community mental health activity in LHD community data systems

**Data Collection Source/System**  
Varies by LHD: NSW Cerner EMR state based build (SBB), local variations on SBB, CHIME, Legacy systems (SCI-MHOAT). Systems transitioning

**Primary data source for analysis**
- NSW HIE Community_visit and Community_activity tables
- NSW Mental Health Establishments data collection

**Indicator definition**  
Number of community contact hours recorded by specific enhanced community teams, as a percentage of expected hours

**Numerator**

- **Numerator definition**  
Number of community contact hours recorded by enhanced teams
- **Numerator source**  
NSW HIE Community_visit and Community_activity tables
- **Numerator availability**  
Updated weekly. No data currently available for some LHDs due to delayed community data extracts during eMR Connect Program (CHOC) implementation

**Denominator**

- **Denominator definition**  
Expected community hours
- **Denominator source**  
To be calculated based on (i) target additional clinical hours advised to LHDs by MH Branch at time of CLS budget provision (ii) baseline staffing of relevant teams as advised by LHDs in the MH Establishments (MHE) collection (iii) manual confirmation of baseline staffing with LHDs.
- **Denominator availability**  
Available

**Inclusions**

- All services funded within specific community enhancements for
  - “Got it” child and adolescent mental health services
  - Adult assertive outreach services
  - Enhanced older persons community mental health services
### Exclusions
N/A

### Targets
100%

### Context

<table>
<thead>
<tr>
<th>Related Policies/ Programs</th>
<th>NSW Mental Health Reform</th>
</tr>
</thead>
</table>

### Useable data available from
July 2017

### Frequency of Reporting
Quarterly

### Time lag to available data
3 months

### Business owners
- **Contact - Policy**: Executive Director, Mental Health Branch
- **Contact - Data**: Director, InforMH

### Representation

<table>
<thead>
<tr>
<th>Data type</th>
<th>Numeric</th>
</tr>
</thead>
<tbody>
<tr>
<td>Form</td>
<td>Number, presented as a percentage (%)</td>
</tr>
<tr>
<td>Representational layout</td>
<td>NNN</td>
</tr>
<tr>
<td>Minimum size</td>
<td>1</td>
</tr>
<tr>
<td>Maximum size</td>
<td>3</td>
</tr>
<tr>
<td>Date effective</td>
<td>July 2017</td>
</tr>
</tbody>
</table>

### Related National Indicators
N/A

### Components
INDICATOR: MS3201

Previous IDs:

Mental Health: Acute mental health service overnight separations (Number)

Shortened Title
Mental Health Acute Overnight Separations

Service Agreement Type
Improvement Measure

Framework Strategy
Strategy 3: Integrate Systems to Deliver Truly Connected Care

Framework Objective
3.2 (Deliver mental health reforms)

Status
Draft

Version number
1.01

Scope
Acute admitted mental health patients, all public hospitals

Goal
To monitor and manage Health Services

Desired outcome
High quality patient outcomes and effective service management

Primary point of collection
Patient Medical Record

Data Collection Source/System
Hospital PAS system, Admitted Patient Data Collection

Primary data source for analysis
HIE/IQ server.

Indicator definition
The total number of completed acute overnight admitted mental health patient episodes in the reporting period.

Numerator
Numerator definition
The total number of completed acute overnight admitted mental health patient episodes in the reporting period.

Numerator source
HIE (Facility and Episode Table)

Numerator availability
Fed to HIE weekly but data entry into source systems may not be up-to-date.

Denominator
Denominator definition
N/A

Denominator source

Denominator availability

Inclusions
- Episodes with episode_of_care_type (Service Category) values of (‘M’) in the HIE Episode Table.
- Episodes where the patient was discharged or statistically separated from an acute mental health ward (Bed types: ‘04’, ‘12’, ‘21’, ‘22’, ‘64’, ‘85’).
- Patients admitted with the intention of discharge on the same day, but who subsequently stay in hospital overnight, are included.

Exclusions
- Day-cases (patients formally admitted for a medical procedure or surgery in the morning and discharged before the evening) are excluded.

Targets
N/A
## Context

### Related Policies/ Programs

<table>
<thead>
<tr>
<th>Useable data available from</th>
<th>2000/2001</th>
</tr>
</thead>
</table>

### Frequency of Reporting

Data fed to HIE weekly, but data entry may be several months late.

### Time lag to available data


## Business owners

<table>
<thead>
<tr>
<th>Contact - Policy</th>
<th>Executive Director, System Purchasing Branch</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact - Data</td>
<td>Executive Director, System Information and Analytics</td>
</tr>
</tbody>
</table>

## Representation

<table>
<thead>
<tr>
<th>Data type</th>
<th>Numeric</th>
</tr>
</thead>
<tbody>
<tr>
<td>Form</td>
<td>Number</td>
</tr>
<tr>
<td>Representation layout</td>
<td>N{10}</td>
</tr>
<tr>
<td>Minimum size</td>
<td>1</td>
</tr>
<tr>
<td>Maximum size</td>
<td>10</td>
</tr>
<tr>
<td>Data domain</td>
<td></td>
</tr>
<tr>
<td>Date effective</td>
<td>1 July 2012</td>
</tr>
</tbody>
</table>

## Related National Indicators

Components
INDICATOR: MS3202

Previous IDs: Mental Health: non-acute mental health inpatient days (Number)

<table>
<thead>
<tr>
<th>Shortened Title</th>
<th>Mental Health Non-Acute Inpatient Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Agreement Type</td>
<td>Improvement Measure</td>
</tr>
<tr>
<td>Framework Strategy</td>
<td>Strategy 3: Integrate Systems to Deliver Truly Connected Care</td>
</tr>
<tr>
<td>Framework Objective</td>
<td>3.2 (Deliver mental health reforms)</td>
</tr>
</tbody>
</table>

**Status**

<table>
<thead>
<tr>
<th>Version number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Final 1.01</td>
</tr>
</tbody>
</table>

**Scope**

Non-acute admitted mental health patients, all public hospitals

**Goal**

To monitor and manage Health Services

**Desired outcome**

High quality patient outcomes and effective service management

**Primary point of collection**

Patient Medical Record

**Data Collection Source/System**

Hospital PAS system, Admitted Patient Data Collection

**Primary data source for analysis**

HIE/IQ server.

**Indicator definition**

The total number of non-acute admitted mental health inpatient days in the reporting period.

**Numerator**

- **Numerator definition**: The total number of non-acute admitted mental health inpatient days in the reporting period.
- **Numerator source**: HIE (Facility and Episode Table)
- **Numerator availability**: Fed to HIE weekly but data entry into source systems may not be up-to-date.

**Denominator**

- **Denominator definition**: N/A
- **Denominator source**
- **Denominator availability**

**Inclusions**

- Facility_type is ('H', 'S', 'M', 'C') from HIE Facility table.
- Episodes with episode_of_care_type (Service Category) values of ('M') in the HIE Episode Table.
- Days where the patient was occupying a non-acute mental health bed (Bed types: 05, 06, 20, 65).

**Exclusions**

- Days where the patient was only occupying an acute mental health bed.

**Targets**

N/A

**Context**

**Related Policies/Programs**
<table>
<thead>
<tr>
<th><strong>Useable data available from</strong></th>
<th>2000/2001</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Frequency of Reporting</strong></td>
<td>Data fed to HIE weekly, but data entry may be several months late.</td>
</tr>
<tr>
<td><strong>Time lag to available data</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Business owners</strong></td>
<td></td>
</tr>
<tr>
<td>Contact - Policy</td>
<td>Executive Director, System Purchasing Branch</td>
</tr>
<tr>
<td>Contact - Data</td>
<td>Executive Director, System Information and Analytics</td>
</tr>
<tr>
<td><strong>Representation</strong></td>
<td></td>
</tr>
<tr>
<td>Data type</td>
<td>Numeric</td>
</tr>
<tr>
<td>Form</td>
<td>Number</td>
</tr>
<tr>
<td>Representational layout</td>
<td>N{10}</td>
</tr>
<tr>
<td>Minimum size</td>
<td>1</td>
</tr>
<tr>
<td>Maximum size</td>
<td>10</td>
</tr>
<tr>
<td>Data domain</td>
<td></td>
</tr>
<tr>
<td>Date effective</td>
<td>1 July 2012</td>
</tr>
</tbody>
</table>

**Related National Indicators**

Components
**INDICATOR: MS3204**  
**Mental Health Line Call Abandonment (%)**

**Previous IDs:**  
Mental Health Line Call Abandonment

**Shortened Title**  
Mental Health Line Call Abandonment

**Service Agreement Type**  
Improvement Measure

**Framework Strategy**  
Strategy 3: Integrate Systems to Deliver Truly Connected Care

**Framework Objective**  
3.2 (Deliver mental health reforms)

**Status**  
Final

**Version number**  
1.0

**Scope**  
All calls received by LHDs and St Vincent’s Health Network from the Mental Health Line and for Murrumbidgee LHD from the Access Line.

**Goal**  
To improve service delivery for the Mental Health Line

**Desired outcome**  
Not more than 5% of calls are abandoned after a call is accepted by the LHD system and before answered by an operator.

**Primary point of collection**  
Manual collection from LHDs

**Data Collection Source/System**  
LHDs provide data monthly

**Primary data source for analysis**  
The percentage of calls accepted by the LHD mental health call line that are abandoned before the call is answered by an operator.

**Indicator definition**  
The number of calls abandoned after being accepted by the LHD system and before answered by an operator.

**Numerator**  
Numerator definition: The number of calls abandoned after being accepted by the LHD system and before answered by an operator.

**Numerator source**  
Manual collection from LHDs

**Numerator availability**  
Monthly

**Denominator**  
Denominator definition: The number of calls accepted by the LHD system.

**Denominator source**  
Manual collection from LHDs

**Denominator availability**  
Monthly

**Inclusions**  
Any calls abandoned during a pre-recorded message played by the LHD system.

**Exclusions**  
Any calls where a call-back option has been chosen.

**Targets**  
Target: Interim target: <5%

**Context**

**Related Policies/ Programs**
Useable data available from

**Frequency of Reporting**
- Monthly

**Time lag to available data**

**Business owners**
- System Performance Support Branch
- Executive Director, Mental Health Branch
- Executive Director, System Information and Analytics Branch

**Contact - Policy**

**Contact - Data**

**Representation**

- **Data type**: Numeric
- **Form**: Number, expressed as a percentage
- **Representational layout**: $N_{NN}$
- **Minimum size**: 1
- **Maximum size**: 3
- **Data domain**
- **Date effective**: 1 July 2018

**Related National Indicator**
### 2018-19 Service Performance Agreements

#### Strategy 3 IMs: Integrate Systems to Deliver Truly Connected Care

<table>
<thead>
<tr>
<th>INDICATOR:</th>
<th>DPALC_3303</th>
<th><strong>Last-Days-of-Life Home Support - Patients referred to support service who died at home (%)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Previous ID:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Shortened Title</strong></td>
<td></td>
<td>Last-Days-of-Life Home Support – Died at home</td>
</tr>
<tr>
<td><strong>Service Agreement Type</strong></td>
<td>Improvement Measure</td>
<td></td>
</tr>
<tr>
<td><strong>Framework Strategy</strong></td>
<td>Strategy 3: Integrate Systems to Deliver Truly Connected Care</td>
<td></td>
</tr>
<tr>
<td><strong>Framework Objective</strong></td>
<td>3.3 (Integrate approach to End of Life and Palliative Care)</td>
<td></td>
</tr>
<tr>
<td><strong>Status</strong></td>
<td>Final</td>
<td></td>
</tr>
<tr>
<td><strong>Version number</strong></td>
<td>1.01</td>
<td></td>
</tr>
</tbody>
</table>

**Scope**

All patients referred to a Service Provider under Service Agreement with Health Administration Corporation, for Last-Days-of-Life Home Support Service.

**Goal**

To monitor number and trends in patient choice to die at home.

**Desired outcome**

To increase community-based options for patients requiring palliative care support.

**Primary point of collection**

Service providers are required to collect data under contract with Health Administration Corporation.

**Data Collection Source/System**

Service providers’ reports

**Primary data source for analysis**

Service providers’ reports

**Indicator definition**

Percentage (%) of patients who have been referred to a Last-Days-of-Life home support service who died at home

**Numerator**

Numerator definition

Number of deaths at home as reported in the quarter.

**Note**: all patient deaths reported in the quarter regardless of when they received the Last-Days-of-Life home support package.

**Note**: ‘at home’ is defined as the usual residence of the patient. This includes Residential Aged Care Facilities or Multi-Purpose-Service facilities if appropriate. It does not include patients who die in a small community hospital that is close to their home.

Numerator source

Service providers’ reports

Numerator availability

Service providers provide data Monthly and Quarterly. However, Quarterly data will be used for this indicator because the data is more stable.

**Denominator**

Denominator definition

All deaths in the quarter for patients who have been referred to a Last-Days-of-Life program. This is equal to the number of patients who die at home in the quarter plus the number of patients who died in hospital in the quarter.

**Note**: This includes patients who die before receiving part of a package. Patients may die only hours after being referred. This is a normal part of the program. However, work is done by the provider immediately a patient is referred. The fact the patient dies prior to receipt of a package is incidental to the intent of providing...
the package to the patient.

Denominator source: Service providers’ reports

Denominator availability: Service providers provide data Monthly and Quarterly. However, Quarterly data will be used for this indicator because the data is more stable.

**Inclusions**: All patient deaths for patients who have been referred to a provider regardless to how long a patient dies after a package has been completed

**Exclusions**: Deaths of patients who have left the program.

**Targets**: N/A

**Context**: Increase community-based palliative care options for patients

**Related Policies/ Programs**: NSW Government Plan to increase access to palliative care 2012-2016

**Useable data available from**: July 2017

**Frequency of Reporting**: Quarterly

**Time lag to available data**: Quarterly reports from Service Providers are required by the 15th working day after the end of the quarter

**Business owners**

- **Contact - Policy**: Executive Director, Health and Social Policy Branch
- **Contact - Data**: Director, Primary & Community Care Unit

**Representation**

- **Data type**: Numeric
- **Form**: Number, expressed as a percentage
- **Representational layout**: NNN.NN
- **Minimum size**: 4
- **Maximum size**: 6
- **Data domain**:
- **Date effective**: 1 July 2017

**Related National Indicators**

- **Indicator**

**Source**
INDICATOR: DPALC_3302
Previous ID:

Last-Days-of-Life Home Support - Completed packages in the quarter (Number)

Shortened Title
Last-Days-of-Life Home Support - Completed packages

Service Agreement Type
Improvement Measure

Framework Strategy
Strategy 3: Integrate Systems to Deliver Truly Connected Care

Framework Objective
3.3 (Integrate approach to End of Life and Palliative Care)

Status
Final

Version number
1.01

Scope
All patients referred to a Service Provider under Service Agreement with Health Administration Corporation, for Last-Days-of-Life Home Support Service.

Goal
To increase community-based options for patients requiring palliative care support.

Desired outcome
To improve equity in access to community based palliative care services across NSW.

Primary point of collection
Service providers are required to collect data under contract with Health Administration Corporation.

Data Collection Source/System
Service providers’ reports

Primary data source for analysis
Service providers’ reports

Indicator definition
Number of completed packages ended or closed during the quarter.

Note: Where a package has been extended, this is counted as two or more packages.

Numerator
Numerator definition
Total number of completed packages completed in a quarter.

A package is deemed to be completed when one of the following four events occurs:

1. A patient dies regardless to how much of a package the patient has used. The amount used of a package can be zero if the patient dies before commencing a package.
2. A patient uses all the services available from the package.
3. A patient is categorised as 'Extended Hold'. This occurs when a patient has received a package but has lived for a defined period after the full package was delivered. This time may vary based on Service Providers. A reasonable time is three months.
4. A patient is categorised as 'No longer required'. This occurs when a patient or a patient's carer(s) decides the service is no longer required.

Numerator source
Service providers’ reports

Numerator availability
Available

Denominator
Strategy 3 IMs: Integrate Systems to Deliver Truly Connected Care

Denominator definition: N/A

Inclusions
Exclusions

Targets

To ensure timely availability of home support packages as required by the community

Useable data available from July 2017

Related Policies/Programs
NSW Government Plan to increase access to palliative care 2012-2016

Frequency of Reporting Quarterly

Time lag to available data
Quarterly reports from Service Providers are required by the 15th working day after the end of the quarter

Business owners
Contact - Policy Executive Director, Health and Social Policy Branch
Contact - Data Director, Primary & Community Care Unit

Representation
Data type Numeric
Form Number
Representational layout NNN{NNN}
Minimum size 3
Maximum size 6
Date effective 1 July 2017

Related National Indicators
Indicator

Source
### End of Life Care - Advance Care Directives (ACDs) - Patients in acute facilities who die with a valid ACD (Number)

<table>
<thead>
<tr>
<th>INDICATOR:</th>
<th>MS3301</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous ID:</td>
<td></td>
</tr>
</tbody>
</table>

**Shortened Title**
End of Life Care – Patients with a valid ACD

**Service Agreement Type**
Improvement Measure

**Framework Strategy**
Strategy 3: Integrate Systems to Deliver Truly Connected Care

**Framework Objective**
3.3 (Integrate approach to End of Life and Palliative Care)

**Status**
Initial draft

**Version number**
1.0

**Scope**
All patients who die in Peer Grouped facilities A1 to D1b.

**Goal**
Reduce uncertainty and relieve burden on families and staff for those patients who are dying.

**Desired outcome**
All patients who die have a valid Advance Care Directive in place.

**Primary point of collection**
TBA

**Data Collection Source/System**
TBA

**Primary data source for analysis**
TBA

**Indicator definition**
Number of patients who have died in an acute facility with a valid advance care directive.

**Numerator**

<table>
<thead>
<tr>
<th>Numerator definition</th>
<th>Total number of patients who have died in an acute facility with a valid advance care directive in the reporting period.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator source</td>
<td>TBA</td>
</tr>
<tr>
<td>Numerator availability</td>
<td>TBA</td>
</tr>
</tbody>
</table>

**Denominator**

<table>
<thead>
<tr>
<th>Denominator definition</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator source</td>
<td></td>
</tr>
<tr>
<td>Denominator availability</td>
<td></td>
</tr>
</tbody>
</table>

**Inclusions**
Facilities in Peer Groups A1 to D1b

**Exclusions**
Facilities in Peer Groups E to F9

**Targets**
TBA

**Context**
TBA

**Related Policies/Programs**
TBA
### Useable data available from
- TBA

### Frequency of Reporting
- TBA

### Time lag to available data
- TBA

### Business owners
- **Contact - Policy**: Executive Director, Health and Social Policy Branch
- **Contact - Data**: TBA

### Representation
- **Data type**: Numeric
- **Form**: Number
- **Representational layout**: N(6)
- **Minimum size**: 1
- **Maximum size**: 6
- **Data domain**: Date effective
- **Date effective**: 1 July 2017

### Related National Indicators
- **Indicator**: Source
<table>
<thead>
<tr>
<th>INDICATOR: MS3401</th>
<th>National Disability Insurance Scheme (NDIS) – Patients with an NDIS Status (Number)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous IDs:</td>
<td>• NDIS status reported to the Patient Flow Portal (Number)</td>
</tr>
<tr>
<td>Shortened Title</td>
<td>Patients with an NDIS Status</td>
</tr>
<tr>
<td>Service Agreement Type</td>
<td>Improvement Measure</td>
</tr>
<tr>
<td>Framework Strategy</td>
<td>Strategy 3: Integrate Systems to Deliver Truly Connected Care</td>
</tr>
<tr>
<td>Framework Objective</td>
<td>3.4 (Support people with disability)</td>
</tr>
<tr>
<td>Status</td>
<td>Final</td>
</tr>
<tr>
<td>Version number</td>
<td>1.1</td>
</tr>
<tr>
<td>Scope</td>
<td>All patients with an NDIS Status recorded and reported to the Patient Flow Portal</td>
</tr>
<tr>
<td>Goal</td>
<td>To monitor the roll out of the NDIS</td>
</tr>
<tr>
<td>Desired outcome</td>
<td>Identify all eligible NDIS patients</td>
</tr>
<tr>
<td>Primary point of collection</td>
<td>Patient Medical Record</td>
</tr>
<tr>
<td>Data Collection Source/System</td>
<td>Patient Administration System, PowerChart, iPM, CHIME</td>
</tr>
<tr>
<td>Primary data source for analysis</td>
<td>Patient Flow Portal</td>
</tr>
<tr>
<td>Indicator definition</td>
<td>The total number of patients who have an NDIS status within the reporting period.</td>
</tr>
<tr>
<td>Numerator</td>
<td>The total number of patients who have an NDIS status within the reporting period.</td>
</tr>
<tr>
<td>Numerator definition</td>
<td>The total number of patients who have an NDIS status within the reporting period.</td>
</tr>
<tr>
<td>Numerator source</td>
<td>Patient Flow Portal</td>
</tr>
<tr>
<td>Numerator availability</td>
<td>Available</td>
</tr>
<tr>
<td>Denominator</td>
<td>N/A</td>
</tr>
<tr>
<td>Denominator definition</td>
<td>N/A</td>
</tr>
<tr>
<td>Denominator source</td>
<td>N/A</td>
</tr>
<tr>
<td>Denominator availability</td>
<td>N/A</td>
</tr>
<tr>
<td>Inclusions</td>
<td></td>
</tr>
<tr>
<td>Exclusions</td>
<td></td>
</tr>
<tr>
<td>Targets</td>
<td>N/A</td>
</tr>
<tr>
<td>Context</td>
<td></td>
</tr>
<tr>
<td>Related Policies/ Programs</td>
<td>Useable data available from 1 July 2018</td>
</tr>
<tr>
<td>Useable data available from</td>
<td>1 July 2018</td>
</tr>
<tr>
<td>Frequency of Reporting</td>
<td>TBA</td>
</tr>
<tr>
<td>Time lag to available data</td>
<td>TBA</td>
</tr>
<tr>
<td>Business owners</td>
<td></td>
</tr>
</tbody>
</table>
2018-19 Service Performance Agreements
Strategy 3 IMs: Integrate Systems to Deliver Truly Connected Care

Contact - Policy
Executive Director, Government Relations

Contact - Data
Executive Director, Health System Information and Performance Reporting

Representation

Data type
Numeric

Form
Number

Representational layout
N{10}

Minimum size
1

Maximum size
10

Related National Indicators
### National Disability Insurance Scheme (NDIS) – Inpatients with an NDIS Related Wait Recorded (Number)

#### Shortened Title
Inpatients with NDIS Related Wait

#### Service Agreement Type
Improvement Measure

#### Framework Strategy
Strategy 3: Integrate Systems to Deliver Truly Connected Care

#### Framework Objective
3.4 (Support people with disability)

#### Scope
All inpatients that have an NDIS related Wait recorded

#### Goal
To monitor the roll out of the NDIS

#### Desired outcome
To identify all inpatients whose inpatient journey has been impacted by the NDIS

#### Primary point of collection
Patient Medical Record

#### Data Collection Source/System
Patient Flow Portal

#### Primary data source for analysis
Patient Flow Portal

#### Indicator definition
The total number of hospital inpatients who have an NDIS related Wait recorded within the reporting period.

#### Numerator

<table>
<thead>
<tr>
<th>Numerator definition</th>
<th>Numerator source</th>
<th>Numerator availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>The total number of hospital inpatients who have an NDIS related Wait recorded within the reporting period.</td>
<td>Patient Flow Portal</td>
<td>Available</td>
</tr>
</tbody>
</table>

#### Denominator

<table>
<thead>
<tr>
<th>Denominator definition</th>
<th>Denominator source</th>
<th>Denominator availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

#### Inclusions

#### Exclusions

#### Targets
N/A

#### Context

#### Related Policies/ Programs

#### Useable data available from
1 July 2018

#### Frequency of Reporting
TBA
### Time lag to available data
TBA

### Business owners
- **Contact - Policy**: Executive Director, Government Relations
- **Contact - Data**: Executive Director, Health System Information and Performance Reporting

### Representation
- **Data type**: Numeric
- **Form**: Number
- **Representational layout**: N{10}
- **Minimum size**: 1
- **Maximum size**: 10
- **Data domain**: 
- **Date effective**: 1 July 2018

### Related National Indicators
## Electronic Discharge Summary Performance: Created within 48 hours of patient discharge from hospital (%)

**INDICATOR:** MS3102

**Previous IDs:** Electronic Discharge Summary Performance

**Shortened Title**

**Service Agreement Type:** Improvement Measure

**Framework Strategy**

**Framework Objective**

3.5 (Leverage information & analytics to connect care across the system)

**Status**

**Version number**

Final 1.1

**Scope**

All admitted inpatient stays

**Goal**

All general practitioners to receive an electronic discharge summary after their patient has received care as a hospital inpatient within an acceptable timeframe.

**Desired outcome**

- To improve care coordination between hospitals and general practitioners
- To improve patient health outcomes

**Primary point of collection**

Patient Administration Systems

**Data Collection Source/System**

Cerner, iPM, CorePAS

**Primary data source for analysis**

HIE, Enterprise Service Bus, HealtheNet Clinical Repository

**Indicator definition**

The percentage of unique discharge summaries lodged electronically with HealtheNet Clinical Repository within 48 hours of a patient’s discharge from hospital within the reporting period.

**Numerator**

**Numerator definition**

Total number of unique electronic discharge summaries lodged with HealtheNet Clinical Repository within 48 hours of the patient’s discharge within the reporting period.

**Numerator source**

HealtheNet Statewide Infrastructure: Rhapsody, Enterprise Service Bus and Clinical Repository Databases

**Numerator availability**

Monthly

**Denominator**

**Denominator definition**

Total number of unique electronic discharge summaries lodged with HealtheNet Clinical Repository within the reporting period.

**Denominator source**

HealtheNet Clinical Repository/HIE

**Denominator availability**

Monthly

**Inclusions**

Admitted inpatient stays with a separation (end) date within the reporting period.
### Exclusions

#### Targets
- Target: N/A

#### Context

#### Related Policies/ Programs

#### Useable data available from
- 1 July 2015

#### Frequency of Reporting
- Monthly

#### Time lag to available data

### Business owners
- Contact - Policy: Executive Director, System Performance Support Branch
- Contact - Data: Executive Director, System Information and Analytics

### Representation
- Data type: Numeric
- Form: Number, expressed as a percentage
- Representational layout: NNN.N
- Minimum size: 3
- Maximum size: 5

### Related National Indicator
- Date effective: 1 July 2017
**INDICATOR:** MS3101  
**Previous ID:**  

<table>
<thead>
<tr>
<th><strong>Shortened Title</strong></th>
<th>Integrated Care Program: Patients Enrolled</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Service Agreement Type</strong></td>
<td>Improvement Measure</td>
</tr>
<tr>
<td><strong>Framework Strategy</strong></td>
<td>Strategy 3: Integrate Systems to Deliver Truly Connected Care</td>
</tr>
<tr>
<td><strong>Framework Objective</strong></td>
<td>3.5 (Leverage information &amp; analytics to connect care across the system)</td>
</tr>
<tr>
<td><strong>Status</strong></td>
<td>Final</td>
</tr>
<tr>
<td><strong>Version number</strong></td>
<td>1.1</td>
</tr>
</tbody>
</table>

**Scope**  
All Integrated Care enrollees (including previous CDMP enrollees)

**Goal**  
To identify number of patients enrolled in the NSW Integrated Care Program.

**Desired outcome**  
Provide integrated care to a significant number of patients that are eligible as per selection criteria.

**Primary point of collection**  
IC/CDMP Program Leads

**Data Collection Source/System**  
Patient Flow Portal

**Primary data source for analysis**  
Patient Flow Portal

**Indicator definition**  
Total number of patients risk stratified and enrolled under the Integrated Care model of care as defined by LHD.

**Numerator**

- **Numerator definition**  
  Total number of patients risk stratified and enrolled under the Integrated Care model of care as defined by LHD.
- **Numerator source**  
  Patient Flow Portal
- **Numerator availability**  
  Monthly

**Denominator**

- **Denominator definition**  
  N/A
- **Denominator source**  
  
- **Denominator availability**  
  

**Inclusions**

**Exclusions**

**Targets**

**Context**

**Related Policies/Programs**  
Integrated Care Strategy

**Useable data available from**  
1 July 2016

**Frequency of Reporting**  
Monthly
### Time lag to available data
Daily

### Business owners
**System Performance Support**
- **Contact - Policy**: Executive Director, System Performance Support
- **Contact - Data**: Executive Director, System Performance Support

### Representation
- **Data type**: Numeric
- **Form**: Number
- **Representational layout**: NN{6}
- **Minimum size**: 2
- **Maximum size**: 6
- **Data domain**: N/A

### Related National Indicators
**Indicator**

**Source**
INDICATOR: MS3103

Patient Reported Measures: Surveys Completed (Number)

- Patient Reported Outcome Measures: Initial (Number)
- Patient Reported Outcome Measures: Subsequent (Number)
- Patient Reported Outcome Measures: All (Number)
- Patient Reported Experience Measures: All (Number)

Previous ID:

Shortened Title(s)
Patient Reported Outcome Measures
Patient Reported Experience Measures

Service Agreement Type
Improvement Measure

Framework Strategy
Strategy 3: Integrate Systems to Deliver Truly Connected Care

Framework Objective
3.5 (Leverage information & analytics to connect care across the system)

Status
Final

Version number
1.01

Scope
All Integrated Care enrollees (including previous CDMP enrollees) and non-Integrated Care PRM proof of concept sites

Goal
To identify and monitor the number of patients completing the PRM tool across the enrolled cohort. This tool will act as the primary source of outcome and experience data.

Desired outcome
Provide data and information on experience and outcomes for the enrolled patient cohort.

Primary point of collection
Local Health Districts / Primary Health Networks

Data Collection Source/System
Redcap software

Primary data source for analysis
SAPHaRI, CHeReL

Indicator definition
Total number of Integrated Care enrolled patients (including patients in non-Integrated Care PRM proof of concept sites) that have completed at least one Patient Reported Measure survey which has been submitted/ captured through the REDCap tool, reported by:

- Patient Reported Outcome Measures: Initial PROM
- Patient Reported Outcome Measures: Subsequent PROM
- Patient Reported Outcome Measures: All PROMs
- Patient Reported Experience Measures: All

Numerator

Numerator definition
Total number of Integrated Care enrolled patients (including patient in non-Integrated Care PRM proof of concept sites) that have completed at least one Patient Reported Measure survey which has been submitted/ captured through the REDCap tool, reported by:

- Patient Reported Outcome Measures: Initial PROM
- Patient Reported Outcome Measures: Subsequent PROM
- Patient Reported Outcome Measures: All PROMs
- Patient Reported Experience Measures: All
### Numerator source
REDcap

### Numerator availability
Monthly

**Denominator**

- **Denominator definition**: N/A
- **Denominator source**: N/A
- **Denominator availability**: N/A

**Inclusions**: N/A

**Exclusions**: N/A

**Targets**: N/A

### Context

- **Related Policies/Programs**: Integrated Care Strategy
- **Useable data available from**: 1 January 2017
- **Frequency of Reporting**: Monthly
- **Time lag to available data**: Monthly

### Business owners

- **Contact - Policy**: Director, Integrated Care Branch
- **Contact - Data**: Senior Manager Integrated Care Monitoring and Evaluation

### Representation

- **Data type**: Numeric
- **Form**: Number
- **Representational layout**: N(6)
- **Minimum size**: 1
- **Maximum size**: 6
- **Data domain**: N/A
- **Date effective**: 01/12/2016

### Related National Indicators

- **Indicator**: Source
INDICATOR: KF-0081
Previous ID: 

**New Street Services – Primary clients completing treatment (%)**

<table>
<thead>
<tr>
<th>Shortened Title</th>
<th>New Street Services – Primary clients completing treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Agreement Type</td>
<td>Improvement Measure</td>
</tr>
<tr>
<td>Framework Strategy</td>
<td>Strategy 3: Integrate Systems to Deliver Truly Connected Care</td>
</tr>
<tr>
<td>Framework Objective</td>
<td>3.6 (Support vulnerable people)</td>
</tr>
<tr>
<td>Status</td>
<td>Final</td>
</tr>
<tr>
<td>Version number</td>
<td>1.0</td>
</tr>
</tbody>
</table>

**Scope**
All primary clients accepted by New Street Services and discharged.

**Goal**
To maintain a high rate of treatment completion to reduce repeat harm rates.

**Desired outcome**
Reduction in repeat harm rates.

**Primary point of collection**
NSW Health New Street Service providers in Local Health Districts.

**Data Collection Source/System**
Excel reporting template

**Primary data source for analysis**
NSW Health New Street Service providers in Local Health Districts.

**Indicator definition**
The percentage of primary clients discharged from the New Street Services program with treatment complete as reason for case closure.

**Numerator**

<table>
<thead>
<tr>
<th>Numerator definition</th>
<th>The number of primary clients discharged within the reporting period from the New Street Services program with treatment complete as reason for case closure.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator source</td>
<td>Excel reporting template</td>
</tr>
<tr>
<td>Numerator availability</td>
<td>Quarterly</td>
</tr>
</tbody>
</table>

**Denominator**

<table>
<thead>
<tr>
<th>Denominator definition</th>
<th>The number of primary clients discharged within the reporting period from the New Street Services program.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator source</td>
<td></td>
</tr>
<tr>
<td>Denominator availability</td>
<td></td>
</tr>
</tbody>
</table>

**Inclusions**
Primary clients with harmful sexual behaviours.

**Exclusions**
Other family members of the primary client.
Services to children with high and complex needs under separate contract with NSW Family and Community Services (Applies to New Street Sydney only).

**Targets**
90%

**Context**
Research shows clients who do not complete treatment have the highest repeat harm rates.
based treatment for non-adjudicated young people with sexually harmful
behaviours. Sexual Abuse in Australia and New Zealand, 6(1), 38-47).

Related Policies/ Programs
Useable data available from July 2017
Frequency of Reporting Quarterly
Time lag to available data 2 – 4 weeks
Business owners Health and Social Policy Branch
    Contact - Policy Director, Prevention and Response to Violence, Abuse, and Neglect Unit
    Contact - Data Senior Analyst, Data Management – Prevention and Response to Violence, Abuse, and Neglect Unit

Representation
  Data type Numeric
  Form Number
  Representational layout NNN
  Minimum size 1
  Maximum size 3
  Data domain N/A
  Date effective 1 July 2018

Related National Indicators
  Indicator N/A

Source
**INDICATOR:** KF-004  
**Previous ID:**  

<table>
<thead>
<tr>
<th>Service Agreement Type</th>
<th>Improvement Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Framework Strategy</td>
<td>Strategy 3: Integrate Systems to Deliver Truly Connected Care</td>
</tr>
<tr>
<td>Framework Objective</td>
<td>3.6 (Support vulnerable people)</td>
</tr>
</tbody>
</table>

**Status**  
Final  
**Version number**  
1.1

**Scope**  
All family referrals accepted by Child Protection Counselling Services.

**Goal**  
Maintain current level of service delivery.

**Desired outcome**  
It is made clear to the referrer, child and family/carer when they are accepted as a client of CPCS.

**Primary point of collection**  
NSW Health Child Protection Counselling Service providers in Local Health Districts/Specialty Health Networks

**Data Collection Source/System**  
Excel reporting template

**Primary data source for analysis**  
NSW Health Child Protection Counselling Service providers in Local Health Districts/Specialty Health Networks

**Indicator definition**  
The number of new referrals (families) to the NSW Health Child Protection Counselling Service who are allocated to a counsellor.

**Numerator**  

<table>
<thead>
<tr>
<th>Numerator definition</th>
<th>Total number of new referrals (families) to the NSW Health Child Protection Counselling Service who are allocated to a counsellor during the reporting period.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator source</td>
<td>Excel reporting template</td>
</tr>
<tr>
<td>Numerator availability</td>
<td>Quarterly</td>
</tr>
</tbody>
</table>

**Denominator**  

<table>
<thead>
<tr>
<th>Denominator definition</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator source</td>
<td></td>
</tr>
<tr>
<td>Denominator availability</td>
<td></td>
</tr>
</tbody>
</table>

**Inclusions**  
Referrals for families (children impacted by violence, abuse and neglect, their families and/or carers).

**Exclusions**  

**Targets**

**Comments:**

The NSW Health Child Protection Counselling Service provides specialist counselling and casework services to children, young people and their families, referred by Community Services, where abuse and neglect, including exposure to domestic violence have occurred.
Upon acceptance of a referral, CPCS ensures that clients and carers are aware of who is the nominated person responsible for co-ordinating their service and informing them about any changes in the provision of services.

**Related Policies/ Programs**


**Useable data available from**

January 2013

**Frequency of Reporting**

Quarterly

**Time lag to available data**

2 – 4 weeks

**Business owners**

Health and Social Policy Branch

- **Contact - Policy**
  Director, Prevention and Response to Violence, Abuse, and Neglect Unit

- **Contact - Data**
  Senior Analyst, Data Management – Prevention and Response to Violence, Abuse, and Neglect Unit

**Representation**

- **Data type**
  Numeric

- **Form**
  Number

- **Representational layout**
  NNN

- **Minimum size**
  1

- **Maximum size**
  3

- **Data domain**
  N/A

- **Date effective**
  1 July 2017

**Related National Indicators**

- **Indicator**
  N/A

**Source**
**INDICATOR:** MS3601

**Previous ID:**

<table>
<thead>
<tr>
<th>Shortened Title</th>
<th>JIRT Health Attendances</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Service Agreement Type</th>
<th>Improvement Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Framework Strategy</td>
<td>Strategy 3: Integrate Systems to Deliver Truly Connected Care</td>
</tr>
<tr>
<td>Framework Objective</td>
<td>3.6 (Support vulnerable people)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Status</th>
<th>Final</th>
</tr>
</thead>
<tbody>
<tr>
<td>Version number</td>
<td>1.0</td>
</tr>
</tbody>
</table>

**Scope**
All clients who are victims of violence, abuse or neglect accepted by JIRT Health and referred to a Sexual Assault Service, or Child Protection Unit.

**Goal**
Monitor service uptake for referrals facilitated by JIRT health clinicians.

**Desired outcome**
Follow up occurs on referrals to monitor counselling service uptake.

**Primary point of collection**
NSW Health JIRT health clinicians

**Data Collection Source/System**
NSW Health Sexual Assault Services/JIRT Senior Health Clinicians Data Collection

**Primary data source for analysis**
Kids and Families Data Warehouse

**Indicator definition**
Percentage of clients referred to Violence, Abuse and Neglect health services who attended within 6 weeks of referral.

**Numerator**

<table>
<thead>
<tr>
<th>Numerator definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>The number of clients referred to a Sexual Assault Service, or Child Protection Unit who attended the service within 6 weeks of the referral being made.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Numerator source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kids and Families Data Warehouse</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Numerator availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarterly</td>
</tr>
</tbody>
</table>

**Denominator**

<table>
<thead>
<tr>
<th>Denominator definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>The number of clients referred to a Sexual Assault Service, or Child Protection Unit within the reporting period.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Denominator source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kids and Families Data Warehouse</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Denominator availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarterly</td>
</tr>
</tbody>
</table>

**Inclusions**
Clients who are victims of sexual assault, physical abuse, or neglect.

**Exclusions**
Clients with sexually harmful behaviours, and other family members of the primary client.
Clients referred to Child Protection Counselling Services.

**Targets**
80%
## Context
The NSW Ombudsman has recommended NSW Health should monitor counselling service uptake for JIRT clients in its inquiry into the operation of the JIRT Program.

## Related Policies/ Programs

<table>
<thead>
<tr>
<th>Useable data available from</th>
<th>July 2017</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Frequency of Reporting</th>
<th>Quarterly</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Time lag to available data</th>
<th>6 weeks</th>
</tr>
</thead>
</table>

## Business owners

<table>
<thead>
<tr>
<th>Business owners</th>
<th>Health and Social Policy Branch</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Contact - Policy</th>
<th>Director, Prevention and Response to Violence, Abuse, and Neglect Unit</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Contact - Data</th>
<th>Senior Analyst, Data Management – Prevention and Response to Violence, Abuse, and Neglect Unit</th>
</tr>
</thead>
</table>

## Representation

<table>
<thead>
<tr>
<th>Data type</th>
<th>Numeric</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Form</th>
<th>Number</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Representational layout</th>
<th>NNN</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Minimum size</th>
<th>1</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Maximum size</th>
<th>3</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Data domain</th>
<th>N/A</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Date effective</th>
<th>1 July 2018</th>
</tr>
</thead>
</table>

## Related National Indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>N/A</th>
</tr>
</thead>
</table>

| Source |  |
**STRATEGY 4 IMs: Develop and Support our People & Culture**

<table>
<thead>
<tr>
<th>Indicator: SPC107</th>
<th>Recruitment: Improvement on baseline average time taken from request to recruit to decision to approve/decline/defer recruitment (days)</th>
</tr>
</thead>
</table>

**Shortened Title**
Recruitment Decision Timeliness Improvement

**Service Agreement Type**
Improvement Measure

**Framework Strategy**
Strategy 4: Develop and Support our People and Culture

**Framework Objective**
4.1 (Achieve a 'Fit for Purpose' workforce)

**Status**
Final

**Version number**
2.22

**Scope**

**Goal**
Improved recruitment timelines

**Desired outcome**
To achieve an average of 10 business days as the time taken to approve/decline or defer requests to recruit.

**Primary point of collection**
Mercury general e-Recruitment system / StaffLink Recruitment

**Data Collection Source/System**
Mercury general e-Recruitment system / StaffLink Recruitment

**Primary data source for analysis**
Mercury general e-Recruitment system StaffLink Recruitment

**Indicator definition**
Average business days for completion of recruitment approvals from submission of Approval to Recruit (ATR) submitted to the first approver to when a decision is made by the final decision-maker to either approve, decline or defer that request.

**Numerator**

- **Numerator definition**
The average number of business days for ATRs submitted and completed each calendar month, YTD.

- **Numerator source**
Mercury general e-Recruitment system / StaffLink Recruitment

- **Numerator availability**
Total number of business days for the completion of decisions from the date the Approval to Recruit (ATR) sent to first approver to the date of final decision to approve, decline or defer the ATR in the Mercury general e-Recruitment system / StaffLink Recruitment for all submitted ATRs YTD

**Denominator**

- **Denominator definition**
Total number of ATRs submitted YTD.

- **Denominator source**
Mercury general e-Recruitment system / StaffLink Recruitment

- **Denominator availability**

**Inclusions**
All ATRs processed through the Mercury general e-Recruitment system / StaffLink Recruitment, except exclusions

**Exclusions**
Rolling ads, casual ads, ATRs incomplete at the end of the month

**Targets**
### 2018-19 Service Performance Agreements

**Strategy 4 IMs: Develop and Support our People & Culture**

<table>
<thead>
<tr>
<th>Target</th>
<th>10 business days</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Performing: Decrease from previous year</td>
<td></td>
</tr>
<tr>
<td>• Under Performing: No change from previous year</td>
<td></td>
</tr>
<tr>
<td>• Not Performing: Increase on previous year</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Time frame for target</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comments</td>
<td>Achievement of appropriate recruitment times ensures that vacancies are not left unfilled, adversely affecting service provision and workplace culture.</td>
</tr>
</tbody>
</table>

**Context**

- Policy Directive 2015_026 “Recruitment and Selection of Staff to the NSW Health Service” sets out a timeline for standard approvals to recruitment of 10 business days. 10 days has therefore become a “de facto” target.
- The target was reviewed by the NSW Health e-Recruitment Governance and Reference Group, which advised on a realistic recruitment timeline which excludes time periods that are not within the employer’s control (applicants’ decision to accept offer, start date). This definition reflects those recommendations.

| Related Policies/ Programs | PD2015_026 “Recruitment and Selection of Staff to the NSW Health Service”. |

**Useable data available from**

- July 2013

**Frequency of Reporting**

- Monthly

**Time lag to available data**

- 3rd calendar working day of every month.

<table>
<thead>
<tr>
<th>Business owners</th>
<th>Workplace Relations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact - Policy</td>
<td>Executive Director, Workplace Relations</td>
</tr>
<tr>
<td>Contact - Data</td>
<td>HealthShare NSW (Sue McGovern or David Beck)</td>
</tr>
</tbody>
</table>

**Representation**

- Data type: Numeric
- Form: Number/graphic
- Representational layout: NNN.NN
- Minimum size: N.N
- Maximum size: NNNNN.NN
- Data domain: Mercury general e-Recruitment system / StaffLink Recruitment

**Related National Indicator**

- NA
## Additional Frontline Staff (Number):

- Additional Frontline Staff (from a 2015 Baseline) - Doctors (Number) (MS4101)
- Additional Frontline Staff (from a 2015 Baseline) - Nurses and Midwives (Number) (MS4102)
- Additional Frontline Staff (from a 2015 Baseline) - Allied Health (Number) (MS4103)
- Additional Frontline Staff (from a 2015 Baseline) - Clinical Support (Number) (MS4104)

### Shortened Title(s)
- Additional Frontline Staff – Doctors
- Additional Frontline Staff – Nursing
- Additional Frontline Staff – Allied Health
- Additional Frontline Staff – Support

### Service Agreement Type
- Improvement Measure

### Framework Strategy
- Strategy 4: Develop and Support our People and Culture

### Framework Objective
- 4.1 (Achieve a ‘Fit for Purpose’ workforce)

### Status
- Final

### Version number
- 1.1

### Scope
- All frontline health staff.

### Goal
- Improved service provision to patients.

### Desired outcome
- To increase the number of frontline staff employed in NSW Health

### Primary point of collection
- StaffLink

### Data Collection Source/System
- State Management Reporting Service (SMRS)

### Primary data source for analysis
- State Management Reporting Service (SMRS)

### Indicator definition
The number of additional frontline staff employed by NSW Health services, disaggregated by:

1. Medical Staff
2. Nursing Staff (including midwives)
3. Allied Health Staff
4. Clinical Support Officers

### Numerator

#### Numerator definition
The total number of frontline staff employed by NSW Health, including agency workers for the reporting period, disaggregated by:

1. Medical Staff
2. Nursing Staff (including midwives)
3. Allied Health Staff
4. Clinical Support Officers

#### Numerator source
- State Management Reporting Service (SMRS)

#### Numerator availability
- Monthly
**Denominator**

Denominator definition: The total number of frontline staff employed by NSW Health, including agency workers, as at 1 January 2015, disaggregated by:

i. Medical Staff

ii. Nursing Staff (including midwives)

iii. Allied Health Staff

iv. Clinical Support Officers

Denominator source: State Management Reporting Service (SMRS)

Denominator availability: Monthly

**Inclusions**

**Exclusions**

**Targets**

Target: Increase the number of frontline staff employed in NSW Health

Comments

**Context**

**Related Policies/ Programs**

NSW Election Commitments

**Useable data available from**

TBA

**Frequency of Reporting**

Monthly/Year to Date (SMRS)

**Time lag to available data**

Monthly

**Business owners**

Contact - Policy: Executive Director, Workforce Planning and Development Branch

Contact - Data: Director, Workforce Planning and Performance Unit, Workforce Planning and Development Branch

**Representation**

Data type: Numeric

Form: Number

Representational layout: NNN,NNN

Minimum size: 2

Maximum size: 6

**Related National Indicator**
### Skilled Workforce Growth: Increase in Enrolled Nurses (%)

<table>
<thead>
<tr>
<th>Shortened Title</th>
<th>Increase in Enrolled Nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Agreement Type</td>
<td>Improvement Measure</td>
</tr>
<tr>
<td>Framework Strategy</td>
<td>Strategy 4: Develop and Support our People and Culture</td>
</tr>
<tr>
<td>Framework Objective</td>
<td>4.1 (Achieve a 'Fit for Purpose' workforce)</td>
</tr>
<tr>
<td>Status</td>
<td>Final</td>
</tr>
<tr>
<td>Version number</td>
<td>1.01</td>
</tr>
</tbody>
</table>

**Scope**
Enrolled Nurses employed by NSW Health.

**Goal**
Ensure an integrated skilled workforce

**Desired outcome**
To lead Better Value Care through the Enrolled Nursing Supply

**Primary point of collection**
Payroll

**Data Collection Source/System**
StaffLink

**Primary data source for analysis**
All LHDs, Networks, and relevant agencies.

**Indicator definition**
The percentage increase in productive and non productive Full Time Equivalent (FTE) compared to the end of last Financial year for Enrolled Nurses

#### Numerator
- **Definition**
  Total number of enrolled nursing FTEs in the current reporting period
- **Source**
  Statewide Management Reporting Service (SMRS)
- **Availability**
  Annually

#### Denominator
- **Definition**
  Total number of enrolled nursing FTEs at the end of last financial year
- **Source**
  Statewide Management Reporting Service (SMRS)
- **Availability**
  Annually

**Inclusions**
Productive and non productive FTEs

**Exclusions**
Overtime FTEs

**Context**
To ensure Leading Better Value Care through the Enrolled Nursing supply

**Related Policies/ Programs**
Enrolled Nurse Scholarship Initiatives
## 2018-19 Service Performance Agreements
### Strategy 4 IMs: Develop and Support our People & Culture

**Useable data available from**: June 2015 onwards

**Frequency of Reporting**: Annually

**Time lag to available data**: N/A

### Business owners
- **Contact - Policy**: Chief Nursing and Midwifery Officer, Nursing and Midwifery Office
- **Contact - Data**: Director, Workforce Planning and Performance Unit, Workforce Planning and Development Branch

### Representation
- **Data type**: Numeric
- **Form**: Number, presented as a percentage
- **Representational layout**: NNN.NN%
- **Minimum size**: 4
- **Maximum size**: 6

### Related National Indicator
### Rural and Regional Medical Workforce Increase (%)

<table>
<thead>
<tr>
<th>INDICATOR:</th>
<th>MS4106, MS4107, MS4108</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous ID:</td>
<td>N/A</td>
</tr>
</tbody>
</table>
| Shortened Title(s) | VMO Rural Regional Increase  
Junior Medical FTE Rural Regional Increase  
Staff Specialist FTE Regional Increase |
| Service Agreement Type | Improvement Measure |
| Framework Strategy | Strategy 4: Develop and Support our People and Culture |
| Framework Objective | 4.1 (Achieve a ‘Fit for Purpose’ workforce) |
| Status | Final |
| Version number | 1.0 |
| Scope | Monitor the variance in the number of Rural and Regional Medical Workforce in LHDs |
| Goal | An increase in the rural and regional Medical Workforce in LHDs |
| Desired outcome | An increase in the number of clinical workforce who work in rural and regional NSW |
| Primary point of collection | VMoney, StaffLink |
| Data Collection Source/System | VMoney, StaffLink |
| Primary data source for analysis | VMoney, StaffLink |
| Indicator definition | The percentage change in productive and non-productive Full Time Equivalent (FTE) / Headcount in the reporting period compared to June of the previous financial year for:  
MS4106 - Headcount of Visiting Medical Officers (VMOs)  
MS4107 - Junior Medical Staff FTEs  
MS4108 - Staff Specialists FTEs |

**Numerator**

- Numerator definition:  
  MS4106 - Headcount of VMOs for the reporting period  
  MS4107 - Junior Medical Staff FTEs for the reporting period  
  MS4108 - Staff Specialist FTEs for the reporting period

- Numerator source: VMoney, StaffLink
- Numerator availability: Quarterly

**Denominator**

- Denominator definition:  
  MS4106 - Headcount of VMOs as at June of the previous financial year  
  MS4107 - Junior Medical Staff FTEs as at June of the previous financial year  
  MS4108 - Staff Specialist FTEs as at June of the previous financial year

- Denominator source: VMoney, StaffLink
- Denominator availability: Quarterly
Inclusions
Working in hospitals in Western NSW, Southern NSW, Far West, Murrumbidgee, Northern NSW, Mid North Coast, Central Coast, Illawarra Shoalhaven and Hunter New England.

Exclusions
- LHDs and SHNs not mentioned in the inclusions
- Medical staff not working in hospitals
- Unfilled vacancies

Targets
Target
Appropriate skilled workforce to meet demand

Comments
Context
In 2014, the NSW Government released the NSW Rural Health Plan: Towards 2021, which will strengthen the capacity of NSW rural health services to provide connected and seamless care, as close to regional, rural and remote NSW communities as possible.

Related Policies/ Programs
NSW Election Commitment
NSW Rural Health Plan

Useable data available from
June 2016

Frequency of Reporting
Quarterly

Time lag to available data
1 month

Business owners
Contact - Policy
Director, Workforce Planning and Performance Unit, Workforce Planning and Development Branch

Contact - Data
Director, Workforce Planning and Performance Unit, Workforce Planning and Development Branch

Representation
Data type
Numeric
Form
Number
Representational layout
NNN
Minimum size
3
Maximum size
3

Related National Indicator
**INDICATOR:** SPC102, SPC103

**Previous ID:** 00120

**Shortened Title(s):** Premium Staff Usage – Medical
Premium Staff Usage - Nursing

**Service Agreement Type:** Improvement Measure

**Framework Strategy:** Strategy 4: Develop and Support our People and Culture

**Framework Objective:** 4.1 (Achieve a ‘Fit for Purpose’ workforce)

**Status:** Final

**Version number:** 3.2

### Scope

**Goal:** Effective management of premium staff in NSW Health

**Desired outcome:** To decrease or maintain the amount of Premium staff usage within acceptable limits

**Primary point of collection:** StaffLink

**Data Collection Source/System:** State Management Reporting Service (SMRS)

**Primary data source for analysis:** State Management Reporting Service (SMRS)

**Indicator definition:** Paid hours of premium staff usage per FTE worked. This includes all overtime and agency labour disaggregated by:

1. Medical Staff
2. Nursing Staff

**Numerator**

- **Numerator definition:** Total paid hours of premium staff usage. Includes overtime and agency labour, disaggregated by:
  1. Medical Staff
  2. Nursing Staff

- **Numerator source:** State Management Reporting Service (SMRS)

- **Numerator availability:** (i) and (ii) Monthly

**Denominator**

- **Denominator definition:** Total FTE of all staffing, inclusive of
  1. productive
  2. non productive
  3. overtime
  and disaggregated by:
  1. Medical Staff
  2. Nursing Staff

- **Denominator source:** State Management Reporting Service (SMRS)

- **Denominator availability:** (i) and (ii) Monthly
Inclusions

Exclusions

Targets

<table>
<thead>
<tr>
<th>Target</th>
<th>Maintain or decrease the amount of Premium staff usage within acceptable limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comments</td>
<td>The reduction or maintenance on the current usage of Premium staff usage indicates efficient use of the workforce by the Local Health Districts. This percentage will vary by setting and, will depend on other factors such as the composition of the workforce and seasonal factors.</td>
</tr>
</tbody>
</table>

Context

- Effective management and monitoring of the use of Premium staff (all overtime worked by staff and medical/nursing agency can ensure the efficient/effective use of these resources and assist with cost. This in turn should require the need for better management of the permanent workforce and reduce possible negative effects on service delivery and on other staff, with the engagement of Premium staff.

- From a Workforce and NaMo perspective, casual nursing staff are not considered Premium Staff. LHDs are encouraged to establish strong casual pools to manage peaks in activity and cover leave absences (e.g. sick leave). The utilisation of casual staff is significantly more cost effective than using agency staff or overtime.

- For nursing, establishing and maintaining a portion of its workforce as casual is encouraged as it provides flexibility and allows increased staffing options and ensure that sufficient experienced staff are available in order to maintain quality patient care and outcomes.

- Casual nursing staff are no longer included in this indicator as it distorts the true utilisation and cost of Premium Labour.

Related Policies/ Programs


Useable data available from

(i) and (ii) 2004/05

Frequency of Reporting

Monthly/Year to Date (SMRS)

Time lag to available data

monthly

Business owners

- Contact - Policy: Executive Director, Workforce Planning and Development Branch
- Contact - Data: Director, Workforce Planning and Performance Unit, Workforce Planning and Development Branch

Representation

- Data type: Numeric
- Form: Number
<table>
<thead>
<tr>
<th>Represenational layout</th>
<th>NNN.NN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum size</td>
<td>3</td>
</tr>
<tr>
<td>Maximum size</td>
<td>6</td>
</tr>
</tbody>
</table>

**Related National Indicator**
### Public Service Commission (PSC) People Matter Employee Survey Response Rate (%)

<table>
<thead>
<tr>
<th>INDICATOR:</th>
<th>SPC109</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous IDs:</td>
<td></td>
</tr>
<tr>
<td><strong>Shortened Title</strong></td>
<td>People Matter Employee Survey</td>
</tr>
<tr>
<td><strong>Service Agreement Type</strong></td>
<td>Improvement Measure</td>
</tr>
<tr>
<td><strong>Framework Strategy</strong></td>
<td>Strategy 4: Develop and Support our People and Culture</td>
</tr>
<tr>
<td><strong>Framework Objective</strong></td>
<td>4.3 (Strengthen the culture within Health to reflect CORE values)</td>
</tr>
<tr>
<td><strong>Status</strong></td>
<td>Final</td>
</tr>
<tr>
<td><strong>Version number</strong></td>
<td>2.2</td>
</tr>
<tr>
<td><strong>Scope</strong></td>
<td>All NSW Health staff who respond to the survey.</td>
</tr>
<tr>
<td><strong>Goal</strong></td>
<td>Improved response rates.</td>
</tr>
<tr>
<td><strong>Desired outcome</strong></td>
<td>To achieve a higher response rates and higher staff engagement index than achieved in the previous People Matter Employee Survey.</td>
</tr>
<tr>
<td><strong>Primary point of collection</strong></td>
<td>Staff completion and submission of survey</td>
</tr>
<tr>
<td><strong>Data Collection Source/System</strong></td>
<td>External survey provider: Public Service Commission</td>
</tr>
<tr>
<td><strong>Primary data source for analysis</strong></td>
<td>External survey provider: Public Service Commission</td>
</tr>
<tr>
<td><strong>Indicator definition</strong></td>
<td>Number of staff responding to survey as a percentage of NSW Health headcount.</td>
</tr>
</tbody>
</table>

#### Numerator
- **Definition**: Number of respondents to survey.
- **Source**: Survey data from external provider
- **Availability**: External provider.

#### Denominator
- **Definition**: NSW Health headcount.
- **Source**: Workforce Planning & Performance Unit data from SMRS
- **Availability**: Workforce Planning & Performance Unit

#### Inclusions
- All staff who complete the survey

#### Exclusions
- Nil

#### Targets
- **Target**: Statistically significant increase in indicator from previous survey results

#### Context
- The PSC instituted its People Matter Employee Survey in 2012 and has conducted it biennially since then. In 2017 the survey became annual.

#### Related Policies/ Programs
- NSW Health Workplace Culture Framework

#### Useable data available from
- Expected to be available September 2018 from external provider

#### Frequency of Reporting
- Annual - ongoing
Time lag to available data: Expected to be available September 2018

Business owners: Workforce Planning and Development
- Contact - Policy: Executive Director, Workforce Planning and Development
- Contact - Data: Michelle McNally (Workforce Planning and Development)

Representation:
- Data type: Numeric
- Form: Percentage
- Representational layout: NNN
- Minimum size: 1
- Maximum size: 3
- Data domain: External provider
- Date effective: 2011

Related National Indicator: N/A
### Workplace Diversity Improvement: Women in Senior Executive Roles (%)

<table>
<thead>
<tr>
<th>Shortened Title</th>
<th>Workplace Diversity Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous ID:</td>
<td></td>
</tr>
<tr>
<td>Service Agreement Type</td>
<td>Improvement Measure</td>
</tr>
<tr>
<td>Framework Strategy</td>
<td>Strategy 4: Develop and Support our People and Culture</td>
</tr>
<tr>
<td>Framework Objective</td>
<td>4.3 (Strengthen the culture within Health to reflect CORE values)</td>
</tr>
<tr>
<td>Status</td>
<td>Final</td>
</tr>
<tr>
<td>Version number</td>
<td>1.1</td>
</tr>
<tr>
<td>Scope</td>
<td>Staff employed within NSW Health Workforce.</td>
</tr>
<tr>
<td>Goal</td>
<td>Increase the proportion of women in senior leadership roles to 50% in the government sector over 10 years (2015-2025).</td>
</tr>
<tr>
<td>Desired outcome</td>
<td>&gt; 50% women in senior executive roles as a % of total defined NSW Health Executive Workforce</td>
</tr>
<tr>
<td>Primary point of collection</td>
<td>StaffLink</td>
</tr>
<tr>
<td>Data Collection Source/System</td>
<td>Public Service Commission Workforce Profile via the State Management Reporting Service (SMRS)</td>
</tr>
<tr>
<td>Primary data source for analysis</td>
<td>Public Service Commission Workforce Profile via the State Management Reporting Service (SMRS)</td>
</tr>
<tr>
<td>Indicator definition</td>
<td>The percentage of women in senior leadership roles in NSW health workforce.</td>
</tr>
</tbody>
</table>

### Numerator

- **Numerator definition**: Instances on payroll – identified as women in senior leadership roles
- **Numerator source**: Public Service Commission Workforce Profile via the State Management Reporting Service (SMRS)
- **Numerator availability**: Annual

### Denominator

- **Denominator definition**: Instances on payroll – identified women and men in senior roles
- **Denominator source**: Public Service Commission Workforce Profile via the State Management Reporting Service (SMRS)
- **Denominator availability**: Annual

### Inclusions

All employees identified as senior leaders

The first criteria, which has been set by the Public Service Commission is based on the base salary of an employee. All Senior Leaders must have a base salary greater than $157,763 per annum as of June 2018. This normally increases by 2.5% annually with the annual pay increase.
Below is a list of the specific criteria of employees deemed to be Senior Leaders in NSW Health:

<table>
<thead>
<tr>
<th>Treasury Group</th>
<th>Inclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>Staff Specialists with Managerial Allowances, Senior CMOs and DMSs</td>
</tr>
<tr>
<td>Nursing</td>
<td>Nurse Manager Grade 8 and 9</td>
</tr>
<tr>
<td>Ambulance</td>
<td>Superintendents and Operation Centre Managers</td>
</tr>
<tr>
<td>Dental</td>
<td>Area Directors and Dental Specialists who receive Managerial Allowance</td>
</tr>
<tr>
<td>Corporate Services – executives</td>
<td>HES/SES and Executive Bands</td>
</tr>
<tr>
<td>Corporate Services Health Managers</td>
<td>Health Managers Level 5 and 6 who have a base salary greater than $157,763 per annum as of June 2018</td>
</tr>
<tr>
<td>Scientific and Technical</td>
<td>Director Medical Physics Specialist and Principal Scientific Officer Year 7 – 10. N.B: Principal Scientific Officers do not receive a managerial allowance however have managerial responsibilities as they are in charge of a laboratory.</td>
</tr>
</tbody>
</table>

**Exclusions**

N/A

**Targets**

Target

Increase the proportion of women in senior leadership roles to 50% in NSW Health by 2025

**Comments**

Premier's priority driving public sector diversity

**Related Policies/ Programs**

Premier's priority driving public sector diversity

**Useable data available from**

Public Service Commission Workforce Profile via the State Management Reporting Service (SMRS)

**Frequency of Reporting**

Annual

**Time lag to available data**

3 months from end of financial year

**Business owners**

Contact - Policy

Director, Workforce Strategy and Culture, Workforce Planning and Development

Contact - Data

Executive Director, Workforce Planning and Development Branch

**Representation**

Data type

Numeric

Form

Number, presented as a percentage

Representational layout

NNN.NN%

Minimum size

4

Maximum size

6
Related National Indicator
**INDICATOR SPC112, SPC113, SPC114**

### Previous ID:

**Workplace Injuries: Return to work experience (days):**

- 6 month Continuous Average Duration rate (*SPC112*)
- 12 month Continuous Average Duration rate (*SPC113*)
- 18 month Continuous Average Duration rate (*SPC114*)

### Shortened Title

- Return to work experience – 6 month
- Return to work experience – 12 month
- Return to work experience – 18 month

### Service Agreement Type

Improvement Measure

### Framework Strategy

Strategy 4: Develop and Support our People and Culture

### Framework Objective

4.5 (Improve health, safety and wellbeing at work)

### Status

Final

### Version number

1.11

### Scope

All NSW Health employees

### Goal

To provide effective, proactive and timely management of injuries and necessary medical and vocational rehabilitation to assist injured workers and promote their safe and durable return to work.

### Desired outcome

An indicative improvement in experience for each CAD measure indicates an improvement in the emerging RTW experience.

### Primary point of collection

Treasury Managed Fund (TMF) Data Warehouse

**Data Collection Source/System**

Treasury Managed Fund (TMF) Data Warehouse

**Primary data source for analysis**

Treasury Managed Fund (TMF) Actuarial Reporting

### Indicator definition

**SPC112** - The average number of continuous days off work in the first 6 months following injury.

**SPC113** - The average number of continuous days off work between 7 and 12 months following injury.

**SPC114** - The average number of continuous days off work between 13 and 18 months following injury.

### Numerator

**Numerator definition**

Total number of continuous days off work following injury for NSW Health employees who have a work injury claim

**Numerator source**

Treasury Managed Fund (TMF) Actuarial Reporting

**Numerator availability**

Quarterly

### Denominator

**Denominator definition**

Number of NSW Health employees who are off work following injury and who have a work injury claim.

Claims include all ‘new’ occupational disease and workplace injury claims (both major and minor) where the claim results in a permanent disability or a
strategy 4 im's: develop and support our people & culture

Denominator source: Treasury Managed Fund (TMF) Actuarial Reporting
Denominator availability: Quarterly

**Inclusions**
The continuous average duration measures the average number of days off work over the three different cohorts of time.

**Exclusions**
Claims with less than 5 days off work are excluded from the measure.

**Targets**
A target of 10% below the CAD results for the 2013/14 fund year for each of the three RTW measure durations (ie 6, 12 and 18 months) as at 30 June 2017

**Context**
To monitor how successfully injured claimants have been able to return to work. The lower the CAD, the more successful the return to work has been.

**Useable data available from**
Baseline data is 2013/14 fund year

**Frequency of Reporting**
12 monthly (quarterly monitoring reporting is available from TMF Actuaries)

**Time lag to available data**
The CAD at any point in time represents time off work over a one year period. The calculation is lagged one quarter to allow for late payments.

**Business owners**
- Contact - Policy: Executive Director, Workplace Relations
- Contact - Data: Manager Insurance & Risk, Finance Branch

**Representation**
- Data type: Numeric
- Form: Decimal
- Representational layout: NNN.NN
- Minimum size: 3
- Maximum size: 6

**Related National Indicator**
### Work Health & Safety: Targeted staff required to attend Personal Safety Training that have attended (%)

<table>
<thead>
<tr>
<th>Shortened Title</th>
<th>Personal Safety Training Attendance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Agreement Type</td>
<td>Improvement Measure</td>
</tr>
<tr>
<td>Framework Strategy</td>
<td>Strategy 4: Develop and Support our People and Culture</td>
</tr>
<tr>
<td>Framework Objective</td>
<td>4.5 (Improve health, safety and wellbeing at work)</td>
</tr>
<tr>
<td>Status</td>
<td>Final</td>
</tr>
<tr>
<td>Version number</td>
<td>1.01</td>
</tr>
</tbody>
</table>

#### Scope
All NSW Health staff required to complete the program titled *Personal Safety (1 day)* as identified on HETI on-line.

#### Goal
To ensure all targeted staff complete the Personal Safety (1 day) training.

#### Desired outcome
To ensure all targeted staff have the required skills in de-escalation and evasive self-defence, where this has been identified as a requirement in response to an assessment of risk.

#### Primary point of collection
HETI on-line.

#### Data Collection Source/System
HETI on-line.

#### Primary data source for analysis
HETI on-line.

#### Indicator definition
The percentage (%) of targeted NSW Health staff who have completed 1 day Personal Safety training as recorded on HETI on-line.

#### Numerator
- **Numerator definition**
  Total accumulated number of targeted staff who have been recorded on HETI on-line as having completed the Personal Safety Training (1 day).
  
  Note: does not include, within a reporting period, NSW Health staff who are booked to attend but have not completed the program at the time of reporting

- **Numerator source**
  HETI on-line.

- **Numerator availability**
  Available 6 Monthly (to be confirmed with HETI)

#### Denominator
- **Denominator definition**
  Total number of NSW Health staff who have been targeted via HETI on-line to attend the Personal Safety Training (1 day).

- **Denominator source**
  HETI on-line

- **Denominator availability**
  Available

#### Inclusions
All NSW Health staff who are targeted via HETI online.

#### Exclusions
NSW Health staff who are not targeted to attend the Personal Safety Training.
Targets

July 2017 to June 2018:

- Target attendance rate (above 75%)
- Under performing: (\(\leq 75\% \text{ and } > 65\%\))
- Not performing: (<65%)

Note: This is not currently a target in the NSW Health Service Agreements. Attendance at Personal Safety Training for targeted staff is mandatory. A 2017/18 target of 75% or above is intended to reflect an incremental stage, prior to escalating the target to 100% compliance for 2018-19.

Comments

Context
To ensure completion of mandatory training in de-escalation and evasive techniques for targeted NSW Health staff.

Related Policies/ Programs
PD2012_008 Violence Prevention & Management Training Framework for the NSW Public Health System.

NSW Health 12 Point Security Action Plan (2016)

Useable data available from
July 2016

Frequency of Reporting
6 Monthly

Time lag to available data
Reporting required by the 14th day of January 2018 and 14th day of July 2018.

Business owners

Contact - Policy
Executive Director, Workplace Relations

Contact - Data
Chief Executive, Health Education and Training Institute

Representation

Data type
Numeric

Form
Number, presented as a percentage

Representational layout
NNN.NN%

Minimum size
4

Maximum size
6

Date Effective
1 July 2016

Related National Indicator
**Compensable Workplace Injuries:** Compensable Injuries by Occupational category and by Type (Number)

- Compensable injuries by occupational category split by stress (psychological) versus non-stress (non-psychological), reported per month (Number)

**Shortened Title**
Compensable Workplace Injuries

**Service Agreement Type**
Improvement Measure

**Framework Strategy**
Strategy 4: Develop and Support our People and Culture

**Framework Objective**
4.5 (Improve health, safety and wellbeing at work)

**Status**
Final

**Version number**
1.1

**Scope**
All NSW Health employees including emergency and non-emergency employees

**Goal**
To measure the success of proactive programs aimed at increasing personal safety awareness and reducing injuries in the workplace for NSW Health employees by occupational category:

- General Administration
- Hotel & Linen Services
- Maintenance
- Medical Support
- Ambulance (emergency)
- Nurses

**Desired outcome**
An indicative improvement in the actual number of compensable injuries suffered and reported by occupational category and split by stress vs non-stress injuries.

**Primary point of collection**
iCare self insurance Treasury Managed Fund data warehouse

**Data Collection Source/System**
iCare self insurance Treasury Managed Fund data warehouse

**Primary data source for analysis**
iCare self insurance Treasury Managed Fund data warehouse

**Indicator definition**
Number of NSW Health employees who have lodged a claim as a result of a workplace injury, split by occupational category and then by stress vs non-stress claims

**Numerator**

**Numerator definition**
The number of claims reported monthly split by occupational category and then by stress vs non-stress claims within each category:

- General Administration
- Hotel & Linen Services
- Maintenance
- Medical Support
- Ambulance (emergency)
- Nurses
Strategy 4 IMs: Develop and Support our People & Culture

Note: does not include, within a reporting period, NSW Health staff who are booked to attend but have not completed the program at the time of reporting.

**Numerator source**: iCare self insurance Treasury Managed Fund data warehouse

**Numerator availability**: Available Monthly

**Denominator**
- **Denominator definition**: N/A
- **Denominator source**: N/A
- **Denominator availability**: N/A

**Inclusions**: The number of compensable claims reported each month.

**Exclusions**: Claims reported excludes null claims

**Targets**
- **Target**: A target of 10% below the actual number of compensable claims lodged results for the previous financial year for each occupational category.

**Comments**

**Context**: To monitor whether overall levels of active claims are changing over time. Isolating the relative movement in one claim type and/or one occupation type highlights specific trends for the various categories and allows identification of successful safety awareness strategies.

**Related Policies/ Programs**: Injury Management and Return To Work Policy PD2013_006

**Useable data available from**: Baseline data for the previous financial year by month, quarter and annual.

**Frequency of Reporting**: Monthly, Quarterly and Annual.

**Time lag to available data**: Reporting available 1 week after the conclusion of the month.

**Business owners**
- **Contact - Policy**: Executive Director, Workplace Relations
- **Contact - Data**: Manager Insurance & Risk, Financial Services & Asset Management Division

**Representation**
- **Data type**: Numeric
- **Form**: Number
- **Representational layout**: NNN,NNN
- **Minimum size**: 3
- **Maximum size**: 6
- **Date Effective**: 1 July 2016
Related National Indicator
INDICATOR SPC105
PREVIOUS ID: 0095

**Leave Liability**: Reduction in the total number of staff who have accrued leave balances of more than 30 days (Number)

**Shortened Title**
Leave Liability

**Service Agreement Type**
Improvement Measure

**Framework Strategy**
Strategy 4: Develop and Support our People and Culture

**Framework Objective**
4.5 (Improve health, safety and wellbeing at work)

**Status**
Final

**Version number**
1.4

**Scope**

**Goal**
Effective management of annual (recreation) leave in NSW Health

**Desired outcome**
To reduce leave liability for staff to 30 days per employee.

**Primary point of collection**
StaffLink

**Data Collection Source/System**
Public Service Commission Workforce Profile via the State Management Reporting Service (SMRS)

**Primary data source for analysis**
Public Service Commission Workforce Profile via the State Management Reporting Service (SMRS)

**Indicator definition**
A count of the number of employees with annual leave balances over a defined number of days at a single point of time, to a maximum of 30 days per employee.

**Numerator**

**Numerator definition**
A count of the number employees with annual leave over a defined number of days at a single point of time. Count is reported in cohort groups of 5 days i.e. <30 days, 30-35 days, 35-40 days and greater than 40 days.

**Numerator source**
State Management Reporting Service (SMRS)

**Numerator availability**
Fortnightly

**Denominator**

**Denominator definition**
No denominator

**Denominator source**

**Denominator availability**

**Inclusions**
All non-casual staff

**Exclusions**
Excludes casual employees, sessional, seasonal and retained staff

**Targets**

**Target**
A reduction of the number of staff with excessive leave balance to a maximum of 30 days per employee.
Comments

Interpretation

- The reduction of the number of staff with excessive leave balance indicates that employees are receiving their entitlements, a reduction in cost on termination to Local Health Districts,
- opportunities for other staff to act in higher positions to cover periods of annual leave and the
- requirement to fill large blocks of excessive leave which may have negative impact on the service.
- reduces need to provision more resources to annual leave budget

Context

As such the Annual Holidays Act (1944) and most Health Awards provide that annual leave accrued is to be taken within six months of its falling due and that annual leave accruals beyond this date are considered “excessive”. NSW Government has committed to “A managed reduction in public sector annual leave balances to a maximum of 40 days per employee by 30 June 2013, 35 days per employee by 30 June 2014, and 30 days per employee by 30 June 2015” (NSW Government Budget Statement 2013, p 4 – 6, http://www.treasury.nsw.gov.au/__data/assets/pdf_file/0020/24590/bp2_Ch4.pdf)

Related Policies/Programs

- Annual Holidays Act (1944)
- The Government Sector Employment Act 2013
- Policy Directive PD2014_029 Leave Matters for the NSW Health Service
- Relevant Industrial instruments, Awards and Determinations

Useable data available from

2004/05

Frequency of Reporting

Quarterly and Annually

Time lag to available data

3 months from end of quarter

Business owners

Contact - Policy
Executive Director, Workforce Planning and Development Branch

Contact - Data
Director, Workforce Planning and Performance Unit, Workforce Planning and Development Branch

Representation

Data type
Numeric

Form
Number

Representational layout
NNNNNN

Minimum size
3

Maximum size
6

Data domain

Related National Indicator
Public Service Commission, Workforce Profile
2018-19 Service Performance Agreements
Strategy 4 IMs: Develop and Support our People & Culture

INDICATOR: MS4401

Hand Hygiene Compliance (%)

Previous IDs:

Shortened Title
Hand Hygiene Compliance

Service Agreement Type
Improvement Measure

Framework Strategy
Strategy 4: Develop and Support our People and Culture

Framework Objective
4.5 (Improve health, safety and wellbeing at work)

Status
Draft

Version number
1.01

Scope
All NSW Health facilities

Goal

Desired outcome
Reducing healthcare associated infections through auditing of their colleagues hand hygiene practices.

Primary point of collection
TBA

Data Collection Source/System
National Hand Hygiene Initiative

Primary data source for analysis
TBA

Indicator definition
The rate of hygiene hand compliance within the reporting period.

Hand Hygiene Compliance % = \frac{\text{Total compliant moments}}{\text{Total moments observed}} \times 100

Numerator

Numerator definition
Total compliant moments observed within the reporting period.

Numerator source
National Hand Hygiene Initiative

Numerator availability
Quarterly

Denominator

Denominator definition
Total moments observed within the reporting period.

Denominator source
National Hand Hygiene Initiative

Denominator availability
Quarterly

Inclusions

Exclusions

Targets

Target
N/A

Context

Related Policies/ Programs
### Useable data available from

TBA

### Frequency of Reporting

Quarterly

### Time lag to available data

Business owners
- Clinical Excellence Commission
- Director, Clinical Excellence Commission
- Director, Clinical Excellence Commission

### Representation

- Data type: Numeric
- Form: Number, presented as a percentage
- Representational layout: NNN.N
- Minimum size: 3
- Maximum size: 5
- Data domain
- Date effective: 1st July 2017

### Related National Indicator

Page 466
INDICATOR: DHMR_5301

Previous ID: Clinical Trials: Persons recruited to cancer clinical trials (Number)

Shortened Title
Persons recruited to cancer clinical trials

Service Agreement Type
Improvement Measure

Framework Strategy
Strategy 5: Support and Harness Health and Medical Research and Innovation

Framework Objective
5.3 (Make NSW a global leader in clinical trials)

Status
Final

Version number
1.01

Scope
Since 1 July 2016, the Cancer Institute NSW Clinical Trials Program allocates funding to NSW Local Health Districts (LHDs) and NSW Specialty Networks based on;

a) enrolment into 'Portfolio' cancer clinical trials that are independent of, but complement, industry clinical trials, to support the rapid translation of new and innovative therapies into practice for the benefit of people with cancer.

b) core funding based on the number of incident cases within the LHD or specialty network.

Clinical Trial Units (CTUs) that are participating in the program are requested to provide activity data for both Industry and non-industry funded prospective interventional cancer clinical trials via the Cancer Institute NSW Clinical Trials Portal.

Goal
Make NSW a destination of choice for cancer clinical trials.

Desired outcome
Increased enrolments into cancer clinical trials.

Primary point of collection
Clinical Trial enrolment logs at Clinical Trial Units (CTUs), data are entered quarterly into Cancer Institute NSW Clinical Trials Portal by all cancer CTUs across NSW.

Data Collection Source/System
Cancer Institute NSW Clinical Trials Portal.

Primary data source for analysis
Participating CTUs within an LHD are required to report quarterly on enrolments into all prospective interventional cancer clinical trials via the Cancer Institute NSW Clinical Trials Portal as part of the LHDs block funding for cancer services. Historical numbers can change over time as CTUs can submit adjustments for previous report periods.

Indicator definition
The number of enrolments into cancer clinical trials in the Cancer Institute NSW Clinical Trials Portal during a financial year.

Numerator
Total number of enrolments into cancer clinical trials that were enrolled in the financial year to date.

Note: Far West LHD has not been conducting interventional cancer clinical trials,
2018-19 Service Performance Agreements
Strategy 5 IMs: Support and Harness Health & Medical Research and Innovation

there will be no enrolments.

**Numerator source**
Cancer Institute’s Clinical Trials Portal

**Numerator availability**
Available Quarterly

**Denominator**

<table>
<thead>
<tr>
<th>Denominator definition</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator source</td>
<td>N/A</td>
</tr>
<tr>
<td>Denominator availability</td>
<td>N/A</td>
</tr>
</tbody>
</table>

**Inclusions**
N/A

**Exclusions**
N/A

**Targets**
N/A

**Context**

<table>
<thead>
<tr>
<th>Cancer Clinical Trial Units participating in the program</th>
</tr>
</thead>
<tbody>
<tr>
<td>LHD</td>
</tr>
<tr>
<td>-----</td>
</tr>
<tr>
<td><strong>Central Coast</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Hunter New England</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Illawarra Shoalhaven</strong></td>
</tr>
<tr>
<td><strong>Mid North Coast</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Murrumbidgee</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Nepean Blue Mountains</strong></td>
</tr>
<tr>
<td><strong>Northern NSW</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Northern Sydney</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>South Eastern Sydney</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>
South Western Sydney
- Bankstown Hospital
- Bankstown RadOnc
- Braeside Hospital - Palliative Care
- Campbelltown - Macarthur Cancer Therapy Centre
- Campbelltown RadOnc
- Liverpool - Cancer Therapy Centre
- Liverpool Haematology
- Liverpool Palliative Care
- Liverpool Psycho-oncology
- Liverpool RadOnc
- Southern Highlands Cancer Therapy Centre

Southern NSW
- Canberra Hospital

St Vincent's Health
- Sacred Heart Supportive and Palliative Care Service
- The Kinghorn Cancer Centre- Haematology
- The Kinghorn Cancer Centre- Oncology

Sydney
- Chris O'Brien Lifehouse MedOnc
- Chris O'Brien Lifehouse RadOnc
- Concord - Haematology
- Concord - Medical Oncology
- Concord Palliative Care
- RPAH - Haematology
- RPAH – SOURCE

Sydney Children's Hospital Network
- Children's Cancer & Haematology Service
- Children's Hospital at Westmead
- Sydney Children's Hospital

Western NSW
- Orange - Central West Cancer Care Centre

Western Sydney
- Blacktown Cancer & Haematology Centre
- Westmead - Breast Cancer Institute
- Westmead - Endoscopy Unit
- Westmead - Gynaecological Oncology
- Westmead Collaborative Cancer Trials Unit
- Westmead Hospital - Haematology & Bone Marrow Transplantation
- Westmead Hospital - Medical Oncology
- Westmead Hospital - Radiation Oncology

Melanoma Institute Australia, San Clinical Trial Unit, Northern Cancer Institute, and Mater Hospital are included in the NSW total only.

The Clinical Trials Program is aiming to increase access to cancer clinical trials in NSW. Improved access to cancer clinical trials in NSW should be reflected by this indicator showing an increasing trend in the number of enrolments into cancer clinical trials.
Related Policies/ Programs

Useable data available from 1 July 2016

Frequency of Reporting Quarterly

Time lag to available data CTU report quarterly data at end of report period, data available for previous quarter 1 month after submission.

Business owners

Contact - Policy Director, Strategic Research Investment Division, Cancer Institute NSW
Contact - Data Manager, Data Intelligence, Strategic Research Investment Division, Cancer Institute NSW

Representation

Data type Numeric
Form Number
Representational layout NNN
Minimum size 1
Maximum size 3
Data domain N/A
Date effective

Related National Indicators

Indicator

Source
<table>
<thead>
<tr>
<th>INDICATOR:</th>
<th>MS5301, MS5302</th>
<th><strong>Participants enrolled to commercial clinical trial projects:</strong></th>
</tr>
</thead>
</table>
| **Previous ID:** | | - As a proportion of those initially agreed to be enrolled per the Clinical Trial Research Agreement minimum target (%) *(MS5301)*  
- First participant enrolled by the site within 40 calendar days of site authorisation (%) *(MS5302)* |
| **Shortened Title(s):** | Participants enrolled clinical trial – agreed enrollment  
Participants enrolled clinical trial – within 40 days |
| **Service Agreement Type:** | Improvement Measure |
| **Framework Strategy:** | Strategy 5: Support and Harness Health & Medical Research and Innovation |
| **Framework Objective:** | 5.4 (Enable the research environment) |
| **Status** | Final draft |
| **Version number** | 1.1 |
| **Scope** | To increase the number of commercial trials that achieve or surpass their enrolment target.  
To reduce the time taken to enroll the first participant into commercial trials conducted in NSW. |
| **Goal** | | |
| **Desired outcome** | | |
| **Primary point of collection** | | |
| **Data Collection Source/System** | AU RED; then REGIS when implemented |
| **Primary data source for analysis** | AU RED; then REGIS when implemented |
| **Indicator definition** | MS5301: The proportion of commercial clinical trials (excluding LNR) closed to enrolment at the site within the reporting period, that reached or surpassed their minimum enrolment target at study closure.  
MS5302: The proportion of commercial clinical trials (excluding LNR) authorised within the reporting period with at least one participant enrolled by Day 40 post Site Specific Authorisation. |
| **Numerator** | | |
| **Numerator definition** | MS5301: Total number of commercial clinical trials (excluding LNR) that closed to enrolment at the site within the reporting period, that reached or surpassed their enrolment target at study closure.  
MS5302: Total number of commercial clinical trials (excluding LNR) authorised within the reporting period with at least one participant enrolled by Day 40 post Site Specific Authorisation. |
| **Numerator source** | AU RED; then REGIS when implemented |
| **Numerator availability** | | |
| **Denominator** | | |
| **Denominator definition** | MS5301: Total number of commercial clinical trials (excluding LNR) closed to enrolment at the site within the reporting period. |
MS5302: Total number of commercial clinical trials (excluding LNR) authorised within the reporting period.

Denominator source: AU RED; then REGIS when implemented

Denominator availability:

**Inclusions**

- Study Type = Clinical trial (other); Clinical trial of a drug; Clinical trial of a device; Clinical trial of a drug and device; First Time In Human (FTIH) or First Time In Patients (FTIP) Clinical trial – drug; First Time In Human (FTIH) or First Time In Patients (FTIP) Clinical trial – device; First Time In Human (FTIH) or First Time In Patients (FTIP) Clinical trial – drug and device.
- LNR = No
- Major Sponsor Type = Commercially Sponsored
- Application Type = Site Specific Assessment
- Current Decision = Authorised; authorised with conditions; further information response authorised.
- Study State = Closed to enrolment at site

**Exclusions**

- Study Type = Clinical research; Health Research/ Social Science; Other (please state)
- LNR = Yes
- Major Sponsor Type = Collaborative Group; Investigator Initiated Group; Institution; Other
- Application Type = Application – Single Site; Application – Multi Site
- Current Decision = Invalid application; not authorised; Request for further information/ modification; not requiring review by Research Organisation; further information response not authorised; further information response not complete
- Study State = all except “closed to enrolment at site.” (Study state may have been subsequently changed since it was set to “closed to enrolment at site”. Data will be culled for all studies wherein Study State was designated “closed to enrolment at site” within the reporting period.)

MS5302:

- Study Type = Clinical research; Health Research/ Social Science; Other (please state)
- LNR = Yes
- Major Sponsor Type = Collaborative Group; Investigator Initiated Group; Institution; Other
2018-19 Service Performance Agreements
Strategy 5 IMs: Support and Harness Health & Medical Research and Innovation

- Application Type = Application – Single Site; Application – Multi Site
- Current Decision = Invalid application; not authorised; Request for further information/ modification; not requiring review by Research Organisation; further information response not authorised; further information response not complete

Targets
N/A

Context
Related Policies/ Programs

Useable data available from

Frequency of Reporting
- Annually

Time lag to available data

Business owners
Contact - Policy
Executive Director, Office for Health and Medical Research
Contact - Data
Executive Director, Office for Health and Medical Research

Representation
Data type
Numeric
Form
Number, presented as a percentage (%)
Representational layout
NNN.N
Minimum size
3
Maximum size
5
Data domain
N/A
Date effective
N/A

Related National Indicators
Indicator

Source
**INDICATOR:** DHMR_5403  
**Previous ID:**  

<table>
<thead>
<tr>
<th>Shortened Title</th>
<th>Client Data Linkage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Service Agreement Type</strong></td>
<td>Improvement Measure</td>
</tr>
<tr>
<td>Framework Strategy</td>
<td>Strategy 5: Support and Harness Health and Medical Research and Innovation</td>
</tr>
<tr>
<td>Framework Objective</td>
<td>5.4 (Enable the research environment)</td>
</tr>
<tr>
<td><strong>Status</strong></td>
<td>Final</td>
</tr>
<tr>
<td><strong>Version number</strong></td>
<td>1.01</td>
</tr>
</tbody>
</table>

**Scope**  
All records included in the Centre for Health Record Linkage routine linkage system and accessible for secondary purposes.

**Goal**  
To increase the number and scope of records that are routinely sourced and linked for secondary purposes.

**Desired outcome**  
To increase the volume and timeliness of linked data that is accessible for secondary purposes.

**Primary point of collection**  
Centre for Health Record Linkage Data Linkage Unit

**Data Collection Source/System**  
Master Linkage Key history spreadsheet

**Primary data source for analysis**  
Master Linkage Key history spreadsheet

**Indicator definition**  
The total number of records linked in the Centre for Health Record Linkage Master Linkage Key.

**Numerator**  
Numerator definition: The total number of records linked in the Centre for Health Record Linkage Master Linkage Key.

**Note:** Includes records from ACT and Commonwealth collections, which are also accessible for research.

**Numerator availability**  
Available Quarterly

**Denominator**  
Denominator definition: N/A

**Denominator source**  
N/A

**Denominator availability**  
N/A

**Inclusions**  
N/A

**Exclusions**  
N/A

**Targets**  
TBA
### Context
Routine linkage systems within jurisdictions provide well documented scientific and economic advantages and the CHeReL linkage system that is considered an internationally recognised state-wide research asset.

### Related Policies/ Programs
- **Useable data available from**: July 2007
- **Frequency of Reporting**: Annual or Quarterly
- **Time lag to available data**: Reporting available by the 1st day of each quarter, data is available for previous quarter

### Business owners
- **Contact - Policy**: Executive Director, Centre for Epidemiology and Evidence
- **Contact - Data**: Director, Centre for Health Record Linkage

### Representation
- **Data type**: Numeric
- **Form**: Number, presented as a number
- **Representational layout**: N{14}
- **Minimum size**: 10
- **Maximum size**: 14
- **Data domain**: N/A

### Related National Indicators
## STRATEGY 6 IMs: Enable eHealth, Health Information and Data Analytics

<table>
<thead>
<tr>
<th>INDICATOR: DeH_6101</th>
<th>eMR2 Implementation Progress: Hospitals where the eMR2 has been implemented (%)</th>
</tr>
</thead>
</table>

**Previous IDs:**
- eMR2 Implementation Progress
- Hospitals where the eMR2 has been implemented (%)

**Shortened Title**
eMR2 Implementation Progress

**Service Agreement Type**
Improvement Measure

**Framework Strategy**
Strategy 6: Enable eHealth, Health Information and Data Analytics

**Framework Objective**
6.1 (Implement integrated paper-lite clinical information systems)

**Status**
Draft

**Version number**
1.0

**Scope**
To support acute, integrated and comprehensive care, active patient involvement and timely decision-making integrated medical records.

**Goal**
To reduce of the hybrid medical record (use of paper and electronic records simultaneously) through expansion of the digital patient record across care settings.

**Desired outcome**
Better management of patient medical records

**Primary point of collection**
eHealth NSW Program Delivery

**Data Collection Source/System**
eHealth PCMO Integrated Progress Update

**Primary data source for analysis**
eHealth PCMO Integrated Progress Update

**Indicator definition**
The percentage (%) of hospitals with eMR2 implemented.

**Numerator**
- **Numerator definition**
  Total number of hospitals where the eMR2 has been implemented.
- **Numerator source**
eHealth PCMO Integrated Progress Update
- **Numerator availability**
  Available Monthly

**Denominator**
- **Denominator definition**
  Total number of targeted / in scope hospitals. As of March 2017, the number is 179.
- **Denominator source**
eHealth PCMO Integrated Progress Update
- **Denominator availability**
  Available

**Inclusions**

**Exclusions**

**Targets**
- **Target**
  N/A
2018-19 Service Performance Agreements
Strategy 6 IMs: Enable eHealth, Health Information and Data Analytics

Context

Related Policies/ Programs eHealth Strategy 2016-2026

Useable data available from September 2016
Frequency of Reporting Monthly / Quarterly
Time lag to available data The 10th day of each month, data available for previous month

Business owners
  Contact - Policy Executive Director, eHealth
  Program Delivery Director, eHealth
  Contact - Data Program Delivery Director, eHealth

Representation
  Data type Numeric
  Form Number, expressed as a percentage
  Representational layout NNN.N%
  Minimum size 3
  Maximum size 5
  Data domain
  Date effective 1 July 2017

Related National Indicator
**INDICATOR: DeH_6102**

**eMeds Implementation Progress:** Hospitals where eMeds has been implemented (%)

**Previous IDs:**
- eMeds Implementation Progress
- Hospitals where eMeds has been implemented (%)

**Shortened Title:** eMeds Implementation Progress

**Service Agreement Type:** Improvement Measure

**Framework Strategy:** Strategy 6: Enable eHealth, Health Information and Data Analytics

**Framework Objective:** 6.1 (Implement integrated paper-lite clinical information systems)

**Status:** Draft

**Version number:** 1.0

**Scope:**
To provide a complete picture of a patient’s medicines as they are prescribed, reviewed, dispensed and administered in hospitals.

**Goal:**
To provide doctors, pharmacists, nurses and other users with access to patient information and evidence-based clinical decision supports in ‘real time’ and from anywhere in the hospital.

**Desired outcome:**
Better management of patient medicines lifecycle within hospitals

**Primary point of collection:** eHealth NSW Program Delivery

**Data Collection Source/System:** eHealth PCMO Integrated Progress Update

**Primary data source for analysis:** eHealth PCMO Integrated Progress Update

**Indicator definition:** The percentage (%) of hospitals with eMeds implemented.

### Numerator
- **Numerator definition:** Total number of hospitals where eMeds has been implemented.
- **Numerator source:** eHealth PCMO Integrated Progress Update
- **Numerator availability:** Available Monthly

### Denominator
- **Denominator definition:** Total number of targeted / in scope hospitals. As of March 2017, the number is 58.
- **Denominator source:** eHealth PCMO Integrated Progress Update
- **Denominator availability:** Available

### Inclusions

### Exclusions

**Targets**
- **Target:** N/A

**Context**

**Related Policies/ Programs:** eHealth Strategy 2016-2026
Useable data available from  
September 2016

Frequency of Reporting  
Monthly / Quarterly

Time lag to available data  
The 10th day of each month, data available for previous month

Business owners
Contact - Policy  
Executive Director, eHealth
Program Delivery Director, eHealth

Contact - Data  
Program Delivery Director, eHealth

Representation
Data type  
Numeric

Form  
Number, expressed as a percentage

Representational layout  
NNN.%

Minimum size  
3

Maximum size  
5

Data domain

Date effective  
1 July 2017

Related National Indicator
**INDICATOR:** DeH_6103

**eRIC Implementation Progress:** Hospitals where eRIC has been implemented (%)

**Previous IDs:**

- eRIC Implementation Progress
- Hospitals where eRIC has been implemented (%)

**Shortened Title**

- eRIC Implementation Progress

**Service Agreement Type**

- Improvement Measure

**Framework Strategy**

- Strategy 6: Enable eHealth, Health Information and Data Analytics

**Framework Objective**

- 6.1 (Implement integrated paper-lite clinical information systems)

**Status**

- Draft

**Version number**

- 1.0

**Scope**

To integrate data every minute from bedside monitors, ventilators and specialised equipment in one configuration for Adult, Paediatric and Neonatal ICUs using evidence based best clinical practice.

**Goal**

To provide the complex, minute-by-minute patient monitoring and analysis necessary to safely manage the critically ill.

**Desired outcome**

Better management of patient with critical ill in hospitals and contribute to reduction of mortality rate across the state.

**Primary point of collection**

- eHealth NSW Program Delivery

**Data Collection Source/System**

- eHealth PCMO Integrated Progress Update

**Primary data source for analysis**

- eHealth PCMO Integrated Progress Update

**Indicator definition**

The percentage (%) of hospital beds with eRIC implemented.

**Numerator**

- Numerator definition: Total number of hospital beds where eRIC has been implemented.
- Numerator source: eHealth PCMO Integrated Progress Update
- Numerator availability: Available Monthly

**Denominator**

- Denominator definition: Total number of targeted / in scope hospital beds. As of March 2017, the number is 861.
- Denominator source: eHealth PCMO Integrated Progress Update
- Denominator availability: Available

**Inclusions**

- 

**Exclusions**

- 

**Targets**

- Target: N/A

**Context**

- 

---

2018-19 Service Performance Agreements

Strategy 6 IMs: Enable eHealth, Health Information and Data Analytics

Page 480
2018-19 Service Performance Agreements
Strategy 6 IMs: Enable eHealth, Health Information and Data Analytics

Related Policies/ Programs eHealth Strategy 2016-2026

Useable data available from February 2017

Frequency of Reporting Monthly / Quarterly

Time lag to available data The 10th day of each month, data available for previous month

Business owners
  Contact - Policy Executive Director, eHealth
  Program Delivery Director, eHealth
  Contact - Data Program Delivery Director, eHealth

Representation
  Data type Numeric
  Form Number, expressed as a percentage
  Representational layout NNN.N%
  Minimum size 3
  Maximum size 5
  Data domain
  Date effective 1 July 2017

Related National Indicator
### Electronic Discharge Summaries

**INDICATOR:** SIC108

**Previous IDs:** Electronic Discharge Summaries: sent electronically and accepted by a GP Broker system (%)

<table>
<thead>
<tr>
<th>Shortened Title</th>
<th>Electronic Discharge Summaries – GP Broker</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Service Agreement Type</strong></td>
<td>Improvement Measure</td>
</tr>
<tr>
<td><strong>Framework Strategy</strong></td>
<td>Strategy 6: Enable eHealth, Health Information and Data Analytics</td>
</tr>
<tr>
<td><strong>Framework Objective</strong></td>
<td>6.2 (Foster eHealth solutions that support integrated health)</td>
</tr>
<tr>
<td><strong>Status</strong></td>
<td>Final</td>
</tr>
<tr>
<td><strong>Version number</strong></td>
<td>2.1</td>
</tr>
</tbody>
</table>

**Scope**

All admitted inpatient stays

**Goal**

All general practitioners to receive an electronic discharge summary after their patient has received care as a hospital inpatient.

**Desired outcome**

- To improve care coordination between hospitals and general practitioners
- To improve patient health outcomes

**Primary point of collection**

Patient Administration Systems

**Data Collection Source/System**

Cerner, iPM, CorePAS

**Primary data source for analysis**

HiE, Enterprise Service Bus, HealtheNet Clinical Repository

**Indicator definition**

The percentage of unique discharge summaries sent electronically to a GP Messaging Broker and accepted by a GP’s software during a financial year by LHD/SHN, versus total discharged inpatient episodes submitted to the HealtheNet Clinical Repository.

**Numerator**

**Numerator definition**

Total number of discharged inpatient episodes within a financial year where an electronic discharge summary has been accepted by a GP Broker System.

This is indicated by an Electronic Discharge Summary Broker Deliver Status of ‘acceptedByBroker’.

**Numerator source**

HealtheNet Statewide Infrastructure: Rhapsody, Enterprise Service Bus and Clinical Repository Databases

**Numerator availability**

Monthly

**Denominator**

**Denominator definition**

Total number of admitted inpatient stays within a financial year.

**Denominator source**

HealtheNet Clinical Repository/HIE

**Denominator availability**

Monthly
**Inclusions**

**Exclusions**

**Targets**

Target: N/A

**Context**

**Related Policies/ Programs**

Useable data available from: 1 July 2015

**Frequency of Reporting**

Monthly

**Time lag to available data**

**Business owners**

Integrated Care Branch

Contact - Policy: Director, Integrated Care Branch

Contact - Data: Executive Director, Health System Information and Performance Reporting

**Representation**

Data type: Numeric

Form: Number, expressed as a percentage

Representational layout: NNN.N

Minimum size: 3

Maximum size: 5

**Date effective**

1 July 2016

**Related National Indicator**
### HealthRoster Implementation Progress

#### Health Employees Rostered Within HealthRoster (%)

<table>
<thead>
<tr>
<th>Shortened Title</th>
<th>HealthRoster Implementation Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Agreement Type</td>
<td>Improvement Measure</td>
</tr>
<tr>
<td>Framework Strategy</td>
<td>Strategy 6: Enable eHealth, Health Information and Data Analytics</td>
</tr>
<tr>
<td>Framework Objective</td>
<td>6.3 (Systemise improved access to data through improved platforms)</td>
</tr>
<tr>
<td>Status</td>
<td>Draft</td>
</tr>
<tr>
<td>Version number</td>
<td>1.0</td>
</tr>
</tbody>
</table>

#### Scope
To implement a modern, fit for purpose rostering system and reduce IT legacy risks around unsupported systems.

#### Goal
To effectively roster staffing needs by time of day, day of week and by skill level. Managers to receive dynamic feedback and alerts on roster to staffing needs including over or under staffing, potential violations of award conditions, among others.

#### Desired outcome
To improve rostering processes and practices and realise improvements in organisational efficiency, shift patterns for staff and contribute to delivering better patient care.

#### Primary point of collection
eHealth NSW Program Delivery

#### Data Collection Source/System
eHealth PCMO Integrated Progress Update

#### Primary data source for analysis
eHealth PCMO Integrated Progress Update

#### Indicator definition
The percentage (%) of in scope employees rostered.

##### Numerator
- **Numerator definition**: Total number of employees rostered.
- **Numerator source**: eHealth PCMO Integrated Progress Update
- **Numerator availability**: Available Monthly

##### Denominator
- **Denominator definition**: Total number of targeted / in scope employees. As of March 2017, the number is +136,000
- **Denominator source**: eHealth PCMO Integrated Progress Update
- **Denominator availability**: Available

#### Inclusions

#### Exclusions

#### Targets
Target: N/A

Context:

Related Policies/Programs: eHealth Strategy 2016-2026
Useable data available from: February 2017
Frequency of Reporting: Monthly / Quarterly
Time lag to available data: The 10th day of each month, data available for previous month

Business owners:
- Contact - Policy: Executive Director, eHealth
- Program Delivery Director, eHealth
- Contact - Data: Program Delivery Director, eHealth

Representation:
- Data type: Numeric
- Form: Number, expressed as a percentage
- Representational layout: NNN.N%
- Minimum size: 3
- Maximum size: 5
- Date effective: 1 July 2017

Related National Indicator
<table>
<thead>
<tr>
<th><strong>INDICATOR:</strong> DSR_7305</th>
<th><strong>HWAN Implementation Progress:</strong> Facilities connected to the Health Wide Area Network (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Previous IDs:</strong></td>
<td></td>
</tr>
</tbody>
</table>

**Shortened Title**: HWAN Implementation Progress

**Service Agreement Type**: Improvement Measure

**Framework Strategy**: Strategy 6: Enable eHealth, Health Information and Data Analytics

**Framework Objective**: 6.3 (Systemise improved access to data through improved platforms)

**Status**: Draft

**Version number**: 1.0

**Scope**: To provide a dedicated network which will support statewide services and applications.

**Goal**: To facilitate communications between Health locations statewide in a secure and reliable way, providing remote access, multimedia applications and services, data exchange, voice and video services as well as wireless access.

**Desired outcome**: To lay the foundation for the successful delivery of clinical programs such as Electronic Medications Management and overall communications.

**Primary point of collection**: eHealth NSW Program Delivery

**Data Collection Source/System**: eHealth PCMO Integrated Progress Update

**Primary data source for analysis**: eHealth PCMO Integrated Progress Update

**Indicator definition**: The percentage (%) of facilities connected to the HWAN.

**Numerator**

- **Numerator definition**: Total number of facilities connected to the HWAN.
- **Numerator source**: eHealth PCMO Integrated Progress Update
- **Numerator availability**: Available Monthly

**Denominator**

- **Denominator definition**: Total number of targeted / in scope facilities. As of March 2017, the number is 750.
- **Denominator source**: eHealth PCMO Integrated Progress Update
- **Denominator availability**: Available

**Inclusions**

**Exclusions**

**Targets**

- **Target**: N/A
Context

Related Policies/ Programs  eHealth Strategy 2016-2026

Useable data available from  February 2017

Frequency of Reporting  Monthly / Quarterly

Time lag to available data  The 10th day of each month, data available for previous month

Business owners

Contact - Policy  Executive Director, eHealth
                Program Delivery Director, eHealth

Contact - Data  Program Delivery Director, eHealth

Representation

Data type  Numeric

Form  Number, expressed as a percentage

Representational layout  NNN.N%

Minimum size  3

Maximum size  5

Data domain

Date effective  1 July 2017

Related National Indicator
INDICATOR: DSR_7306

Previous IDs:

**SWIS Implementation (Identity Management)**

**Progress**: Facilities Standardised under the Statewide Infrastructure as a Service Program (%)

**Shortened Title**: SWIS Implementation Progress

**Service Agreement Type**: Improvement Measure

**Framework Strategy**: Strategy 6: Enable eHealth, Health Information and Data Analytics

**Framework Objective**: 6.3 (Systemise improved access to data through improved platforms)

**Status**: Draft

**Version number**: 1.0

**Scope**: To establish a single statewide user identity (ID) for all NSW Health employees. This means that regardless of which Local Health District (LHD) or health agency you work for, you will be able to log onto any NSW Health approved computer or mobile device using a single email and user ID.

**Goal**: To reduce the number of accounts / password required to access clinical and corporate applications

**Desired outcome**: To increase productivity of clinicians and corporate staff, increase efficiencies in support and application delivery and enhance the delivery of NSW Health services across the state.

**Primary point of collection**: eHealth NSW Program Delivery

**Data Collection Source/System**: eHealth PCMO Integrated Progress Update

**Primary data source for analysis**: eHealth PCMO Integrated Progress Update

**Indicator definition**: The percentage (%) of facilities standardised under SWIS program.

**Numerator**

Numerator definition: Total number of facilities standardised under SWIS program.

Numerator source: eHealth PCMO Integrated Progress Update

Numerator availability: Available Monthly

**Denominator**

Denominator definition: Total number of targeted / in scope facilities.

Denominator source: eHealth PCMO Integrated Progress Update

Denominator availability: Available

**Inclusions**

**Exclusions**

**Targets**
### 2018-19 Service Performance Agreements

**Strategy 6 IMs: Enable eHealth, Health Information and Data Analytics**

<table>
<thead>
<tr>
<th><strong>Target</strong></th>
<th>N/A</th>
</tr>
</thead>
</table>

**Context**

**Related Policies/ Programs**
- eHealth Strategy 2016-2026

**Useable data available from**
- February 2017

**Frequency of Reporting**
- Monthly / Quarterly

**Time lag to available data**
- The 10th day of each month, data available for previous month

**Business owners**

- **Contact - Policy**
  - Executive Director, eHealth
  - Program Delivery Director, eHealth

- **Contact - Data**
  - Program Delivery Director, eHealth

**Representation**

- **Data type**
  - Numeric

- **Form**
  - Number, expressed as a percentage

- **Representational layout**
  - NNN.N%

- **Minimum size**
  - 3

- **Maximum size**
  - 5

- **Data domain**

- **Date effective**
  - 1 July 2017

**Related National Indicator**
<table>
<thead>
<tr>
<th><strong>INDICATOR:</strong> DSR_7307</th>
<th><strong>Data Centre Reform Server Migration</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Progress:</strong></td>
<td><strong>Servers Migrated to Government Data Centres (GovDC) (%)</strong></td>
</tr>
</tbody>
</table>

**Previous IDs:**
- Data Centre Reform Server Migration

**Shortened Title**
- Servers Migrated to GovDC

**Service Agreement Type**
- Improvement Measure

**Framework Strategy**
- Strategy 6: Enable eHealth, Health Information and Data Analytics

**Framework Objective**
- 6.3 (Systemise improved access to data through improved platforms)

**Status**
- Draft

**Version number**
- 1.0

**Scope**
- To migrate current servers in NSW health data centres to GovDC

**Goal**
- To increase reliability and security for NSW Health’s computer systems, minimise the ongoing environmental impact of NSW Health’s data centre operations and improve technical and operational services.

**Desired outcome**
- To establish a future-proof, resilient technology environment to support the delivery of high performance applications for clinicians and corporate applications as part of the NSW government wide Data Centre reform.

**Primary point of collection**
- eHealth NSW Program Delivery

**Data Collection Source/System**
- eHealth PCMO Integrated Progress Update

**Primary data source for analysis**
- eHealth PCMO Integrated Progress Update

**Indicator definition**
- The percentage (%) of servers migrated to GovDC.

**Numerator**
- **Numerator definition**
  - Total number of servers migrated to GovDC.
- **Numerator source**
  - eHealth PCMO Integrated Progress Update
- **Numerator availability**
  - Available Monthly

**Denominator**
- **Denominator definition**
  - Total number of targeted / in scope servers. As of March 2017, the number is 1352.
- **Denominator source**
  - eHealth PCMO Integrated Progress Update
- **Denominator availability**
  - Available

**Inclusions**
- Servers migrated or identified for decommissioning

**Exclusions**

**Targets**
- **Target**
  - N/A
### Context
Program end date is 30/06/2018

### Related Policies/ Programs
- eHealth Strategy 2016-2026
- NSW Data Centre Reform (DFSI)

### Useable data available from
February 2017

### Frequency of Reporting
Monthly / Quarterly

### Time lag to available data
The 10th day of each month, data available for previous month

### Business owners
- **Contact - Policy**: Executive Director, eHealth
  Program Delivery Director, eHealth
- **Contact - Data**: Program Delivery Director, eHealth

### Representation
- **Data type**: Numeric
- **Form**: Number, expressed as a percentage
- **Representational layout**: NNN.N%
- **Minimum size**: 3
- **Maximum size**: 5
- **Data domain**
- **Date effective**: 1 July 2017

### Related National Indicator

---
<table>
<thead>
<tr>
<th>INDICATOR: DSR_7308</th>
<th>Data Centre Reform Application Migration Progress: Health Applications Migrated to Government Data Centres (GovDC) (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous IDs:</td>
<td></td>
</tr>
<tr>
<td>Shortened Title</td>
<td>Health Applications Migrated to GovDC</td>
</tr>
<tr>
<td>Service Agreement Type</td>
<td>Improvement Measure</td>
</tr>
<tr>
<td>Framework Strategy</td>
<td>Strategy 6: Enable eHealth, Health Information and Data Analytics</td>
</tr>
<tr>
<td>Framework Objective</td>
<td>6.3 (Systemise improved access to data through improved platforms)</td>
</tr>
<tr>
<td>Status</td>
<td>Draft</td>
</tr>
<tr>
<td>Version number</td>
<td>1.0</td>
</tr>
<tr>
<td>Scope</td>
<td>To migrate current applications (clinical and corporate) in NSW Health data centres to GovDC.</td>
</tr>
<tr>
<td>Goal</td>
<td>To increase reliability and security for NSW Health's computer systems, minimise the ongoing environmental impact of NSW Health's data centre operations and improve technical and operational services.</td>
</tr>
<tr>
<td>Desired outcome</td>
<td>To establish a future-proof, resilient technology environment to support the delivery of high performance applications for clinicians and corporate applications as part of the NSW government wide Data Centre reform.</td>
</tr>
<tr>
<td>Primary point of collection</td>
<td>eHealth NSW Program Delivery</td>
</tr>
<tr>
<td>Data Collection Source/System</td>
<td>eHealth PCMO Integrated Progress Update</td>
</tr>
<tr>
<td>Primary data source for analysis</td>
<td>eHealth PCMO Integrated Progress Update</td>
</tr>
<tr>
<td>Indicator definition</td>
<td>The percentage (%) of applications migrated to GovDC.</td>
</tr>
<tr>
<td><strong>Numerator</strong></td>
<td></td>
</tr>
<tr>
<td>Numerator definition</td>
<td>Total number of applications migrated to GovDC.</td>
</tr>
<tr>
<td>Numerator source</td>
<td>eHealth PCMO Integrated Progress Update</td>
</tr>
<tr>
<td>Numerator availability</td>
<td>Available Monthly</td>
</tr>
<tr>
<td><strong>Denominator</strong></td>
<td></td>
</tr>
<tr>
<td>Denominator definition</td>
<td>Total number of targeted / in scope applications. As of March 2017, the number is 260.</td>
</tr>
<tr>
<td>Denominator source</td>
<td>eHealth PCMO Integrated Progress Update</td>
</tr>
<tr>
<td>Denominator availability</td>
<td>Available</td>
</tr>
<tr>
<td><strong>Inclusions</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Exclusions</strong></td>
<td></td>
</tr>
<tr>
<td>Targets</td>
<td></td>
</tr>
<tr>
<td>Target</td>
<td>N/A</td>
</tr>
</tbody>
</table>
### Context
Program end date is 30/06/2018

### Related Policies/ Programs
- eHealth Strategy 2016-2026
- NSW Data Centre Reform (DFSI)

### Useable data available from
February 2017

### Frequency of Reporting
Monthly / Quarterly

### Time lag to available data
The 10th day of each month, data available for previous month

### Business owners
- **Contact - Policy**: Executive Director, eHealth
- **Contact - Data**: Program Delivery Director, eHealth

### Representation
<table>
<thead>
<tr>
<th>Data type</th>
<th>Numeric</th>
</tr>
</thead>
<tbody>
<tr>
<td>Form</td>
<td>Number, expressed as a percentage</td>
</tr>
<tr>
<td>Representational layout</td>
<td>NNN.N%</td>
</tr>
<tr>
<td>Minimum size</td>
<td>3</td>
</tr>
<tr>
<td>Maximum size</td>
<td>5</td>
</tr>
<tr>
<td>Data domain</td>
<td></td>
</tr>
<tr>
<td>Date effective</td>
<td>1 July 2017</td>
</tr>
</tbody>
</table>

### Related National Indicator
<table>
<thead>
<tr>
<th>Shortened Title</th>
<th>Deliver Infrastructure: Business Cases Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Agreement Type</td>
<td>Improvement Measure</td>
</tr>
<tr>
<td>Framework Strategy</td>
<td>Strategy 7: Deliver Infrastructure &amp; System Capability</td>
</tr>
<tr>
<td>Framework Objective</td>
<td>7.1 (Deliver agreed infrastructure on time and budget)</td>
</tr>
<tr>
<td>Status</td>
<td>Final</td>
</tr>
<tr>
<td>Version number</td>
<td>1.0</td>
</tr>
</tbody>
</table>

**Scope**
Health capital works projects for which Health Infrastructure has responsibility (major projects generally valued at >$10 million).

**Goal**
Deliver agreed infrastructure on time and on budget.

**Desired outcome**
Major health capital works projects achieving key planning phase milestones on time.

**Primary point of collection**
HI Milestone Report.

**Data Collection Source/System**
HI Portal.

**Primary data source for analysis**
Achievement of project milestones reported by HI Project Directors on the HI Portal.

**Indicator definition**
The number of business cases completed in the relevant quarter.

**Numerator**
- **Numerator definition**
  Total number of business cases, for projects which Health Infrastructure has responsibility (generally valued at >$10 million), that are completed in the relevant quarter.
- **Numerator source**
  HI Portal
- **Numerator availability**
  Available Quarterly

**Inclusions**
Health Infrastructure managed projects

**Exclusions**
LHD-managed projects (<$10 million)

**Targets**
- **Target**
  N/A

**Context**

**Related Policies/ Programs**

**Useable data available from**
### Frequency of Reporting
Quarterly

### Time lag to available data
Reporting required by the 10th day of January, April, July, October; data available for previous quarter.

### Business owners
- **Contact - Policy**: Executive Director, Planning & Solutions, Health Infrastructure
- **Contact - Data**: Executive Officer, Health Infrastructure

### Representation

<table>
<thead>
<tr>
<th>Data type</th>
<th>Numeric</th>
</tr>
</thead>
<tbody>
<tr>
<td>Form</td>
<td>Number</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Representational layout</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum size</td>
</tr>
<tr>
<td>Maximum size</td>
</tr>
<tr>
<td>Data domain</td>
</tr>
<tr>
<td>Date effective</td>
</tr>
</tbody>
</table>

### Related National Indicator
## Deliver Infrastructure: Construction Commenced (%)

### Shortened Title
Deliver Infrastructure: Construction Commenced

### Service Agreement Type
Improvement Measure

### Framework Strategy
Strategy 7: Deliver Infrastructure & System Capability

### Framework Objective
7.1 (Deliver agreed infrastructure on time and budget)

### Status
Final

### Version number
1.1

### Scope
Health capital works projects for which Health Infrastructure has responsibility (major projects generally valued at >$10 million).

### Goal
Deliver agreed infrastructure on time and on budget.

### Desired outcome
Major health capital works projects achieving key construction phase milestones on time.

### Primary point of collection
Health Infrastructure Milestone Report.

### Data Collection Source/System
Health Infrastructure Portal.

### Primary data source for analysis
Achievement of project milestones reported by Health Infrastructure Project Directors on the Health Infrastructure Portal.

### Indicator definition
The percentage (%) of major health capital projects forecast to have commenced Main Works construction that have actually commenced Main Works construction.

### Numerator

<table>
<thead>
<tr>
<th>Numerator definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of health capital works projects, for which Health Infrastructure has responsibility (generally valued at &gt;$10 million), that: are forecast to have commenced Main Works construction in the relevant quarter AND have commenced Main Works construction in or before that quarter.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Numerator source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Infrastructure Portal</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Numerator availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Available Quarterly</td>
</tr>
</tbody>
</table>

### Denominator

<table>
<thead>
<tr>
<th>Denominator definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of health capital works projects, for which Health Infrastructure has responsibility (generally valued at &gt;$10 million), that are forecast (in the Business Case) to have commenced Main Works construction in the relevant quarter.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Denominator source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Infrastructure Portal</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Denominator availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Available Quarterly</td>
</tr>
</tbody>
</table>

### Inclusions
Major Health Infrastructure managed projects

### Exclusions
LHD-managed projects (<$10 million);
Health Infrastructure projects within the:
2018-19 Service Performance Agreements
Strategy 7 IMs: Deliver Infrastructure & System Capability

- Rural Ambulance Infrastructure Reconfiguration (RAIR),
- Sydney Ambulance Metropolitan Infrastructure Strategy (SAMIS), and
- Multipurpose Service (MPS) programs.

**Targets**

| Target | N/A |

**Context**

While the forecast construction commencement date for an individual project won't change, the number of projects forecast to commence construction in a given future quarter may increase as more Business Cases are completed.

**Related Policies/ Programs**

Useable data available from

**Frequency of Reporting**
Quarterly

**Time lag to available data**
Reporting required by the 10th day of January, April, July, October; data available for previous quarter.

**Business owners**

Contact - Policy
Executive Director, Delivery, Health Infrastructure

Contact - Data
Executive Officer, Health Infrastructure

**Representation**

| Data type | Numeric |
| Form | Number, expressed as a percentage |
| Representational layout | NNN.N% |
| Minimum size | 3 |
| Maximum size | 5 |
| Data domain |
| Date effective | 1 July 2017 |

**Related National Indicator**
<table>
<thead>
<tr>
<th>INDICATOR: DSR_7303</th>
<th>Deliver Infrastructure: Construction Completed (%)</th>
</tr>
</thead>
</table>

**Previous IDs:**
- Deliver Infrastructure: Construction Completed

**Shortened Title**
Deliver Infrastructure: Construction Completed

**Service Agreement Type**
Improvement Measure

**Framework Strategy**
Strategy 7: Deliver Infrastructure & System Capability

**Framework Objective**
7.1 ( Deliver agreed infrastructure on time and budget)

**Status**
Final

**Version number**
1.1

**Scope**
Health capital works projects for which Health Infrastructure has responsibility (major projects generally valued at >$10 million).

**Goal**
Deliver agreed infrastructure on time and on budget.

**Desired outcome**
Major health capital works projects delivered on time.

**Primary point of collection**
Health Infrastructure Milestone Report.

**Data Collection Source/System**
Health Infrastructure Portal

**Primary data source for analysis**
Achievement of project milestones reported by Health Infrastructure Project Directors on the Health Infrastructure Portal.

**Indicator definition**
The percentage (%) of major health capital projects forecast in the business case to have completed Main Works construction, that have actually completed Main Works construction

**Numerator**
Numerator definition:
Total number of health capital works projects, for which Health Infrastructure has responsibility (generally valued at >$10 million), that are forecast to have completed Main Works construction in the relevant quarter AND have completed Main Works construction in or before that quarter.

Numerator source:
Health Infrastructure Portal

Numerator availability:
Available Quarterly

**Denominator**
Denominator definition:
Total number of health capital works projects, for which Health Infrastructure has responsibility (generally valued at >$10 million), that are forecast (in the Business Case) to have completed Main Works construction in the relevant quarter.

Denominator source:
Health Infrastructure Portal

Denominator availability:
Available Quarterly

**Inclusions**
Major Health Infrastructure managed projects

**Exclusions**
LHD-managed projects (<$10 million);
Health Infrastructure projects within the:
- Rural Ambulance Infrastructure Reconfiguration (RAIR),
- Sydney Ambulance Metropolitan Infrastructure Strategy (SAMIS), and
- Multipurpose Service (MPS) programs.

**Targets**

| Target | N/A |

**Context**

While the forecast construction commencement date for an individual project won’t change, the number of projects forecast to commence construction in a given future quarter may increase as more Business Cases are completed.

**Related Policies/Programs**

**Useable data available from**

**Frequency of Reporting**

Quarterly

**Time lag to available data**

Reporting required by the 10th day of January, April, July, October; data available for previous quarter.

**Business owners**

Contact - Policy: Executive Director, Delivery, Health Infrastructure

Contact - Data: Executive Officer, Health Infrastructure

**Representation**

<table>
<thead>
<tr>
<th>Data type</th>
<th>Numeric</th>
</tr>
</thead>
<tbody>
<tr>
<td>Form</td>
<td>Number, expressed as a percentage</td>
</tr>
<tr>
<td>Representational layout</td>
<td>NNN.N%</td>
</tr>
<tr>
<td>Minimum size</td>
<td>3</td>
</tr>
<tr>
<td>Maximum size</td>
<td>5</td>
</tr>
<tr>
<td>Data domain</td>
<td></td>
</tr>
<tr>
<td>Date effective</td>
<td>1 July 2017</td>
</tr>
</tbody>
</table>

**Related National Indicator**
**2018-19 Service Performance Agreements**

**Strategy 7 IMs: Deliver Infrastructure & System Capability**

<table>
<thead>
<tr>
<th>INDICATOR: DSR_7402</th>
<th>Whole of Lifecycle Asset Management: Asset and Facilities Management (AFM) Online Take-up (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous IDs:</td>
<td>Whole of Lifecycle Asset Management: Asset and Facilities Management (AFM) Online Take-up (%)</td>
</tr>
</tbody>
</table>

**Shortened Title**  
AFM Take-up

**Service Agreement Type**  
Improvement Measure

**Framework Strategy**  
Strategy 7: Deliver Infrastructure & System Capability

**Framework Objective**  
7.3 (Build asset management capability)

**Status**  
Draft

**Version number**  
1.0

**Scope**  
The AFM Online Take-up (%) metric is a summation of four underlying measures that fall into three asset management related categories of space, assets and business process.

The measure is extent of Preventative Maintenance data

The data will be measured State-wide and broken down to Public Health Organisations (PHOs).

**Goal**  
To provide improved transparency on Asset Management decision making and support the identification and management of asset related risks and service levels.

Implementation of the AFM Online system will provide Public Health Organisations with an enabling tool.

**Desired outcome**  
Improved line of sight on asset related risks and improved service levels to ensure safe and fit for purpose assets.

**Primary point of collection**  
AFM Online

**Data Collection Source/System**  
AFM Online meta data fields to be confirmed.

The underlying measures provide an indication of AFM Online system configuration activity related to achieving centralised reporting of AFM equipment

**Primary data source for analysis**  

**Indicator definition**  
The percentage of AFM take-up:

\[ \text{AFM Take-up} \% = \left( \frac{\text{PM}}{\text{TA}} \right) \times 100 \]

where

- PM - Preventative maintenance assigned to an asset
- TA – Count of t assigned to an asset

**Note:** Could be raw integer month-on-month though percentage may help normalize data between district to show % change month-on-month
## Numerator

<table>
<thead>
<tr>
<th>Numerator definition</th>
<th>See Indicator definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator source</td>
<td>AFM Online IS</td>
</tr>
<tr>
<td>Numerator availability</td>
<td>TBA</td>
</tr>
</tbody>
</table>

## Denominator

<table>
<thead>
<tr>
<th>Denominator definition</th>
<th>See Indicator definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator source</td>
<td>AFM Online IS</td>
</tr>
<tr>
<td>Denominator availability</td>
<td>TBA</td>
</tr>
</tbody>
</table>

## Inclusions

Job plans with associated building, major medical and biomedical equipment assets.

PHOs:
- All Local Health Districts
- Sydney Children’s Hospital Network
- Ambulance Service of NSW

## Exclusions

Exclude all other asset data

## Targets

Target: TBD – targeting take-up of system over 24 months with priority deliverable statutory compliance reporting in 12-month timeframe.

## Context

AFM Online is the enabling tool for Health Asset and facilities Management

## Related Policies/ Programs

Health Asset Management reform program
Property Asset Utilisation Taskforce (PAUT) Phase II reforms

## Useable data available from

July 2017
(to be confirmed if July 2016 to June 2017 data may be available)

## Frequency of Reporting

Quarterly

## Time lag to available data

Reporting required by the 10th day of each quarter, data available for previous quarter

## Business owners

Contact - Policy: Director Asset Management, Finance and Asset Management Division
Contact - Data: Director Asset Management, Finance and Asset Management Division

## Representation

<table>
<thead>
<tr>
<th>Data type</th>
<th>Numeric</th>
</tr>
</thead>
<tbody>
<tr>
<td>Form</td>
<td>Number, presented as a percentage (%)</td>
</tr>
<tr>
<td>Representational layout</td>
<td>NN.N</td>
</tr>
<tr>
<td>Minimum size</td>
<td>3</td>
</tr>
<tr>
<td>Maximum size</td>
<td>4</td>
</tr>
<tr>
<td>Data domain</td>
<td></td>
</tr>
<tr>
<td>-----------------------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td>Date effective</td>
<td>30 June 2017</td>
</tr>
<tr>
<td>Related National Indicator</td>
<td>N/A</td>
</tr>
<tr>
<td>INDICATOR:</td>
<td>MS7401, MS7402</td>
</tr>
<tr>
<td>-----------</td>
<td>----------------</td>
</tr>
</tbody>
</table>
| Previous IDs: | • Buildings with asbestos registers and management plans (%) (MS7401)  
| | • Buildings with risk rating assigned (%) (MS7402) |
| Shortened Title(s) | Asbestos Documentation: Buildings With Registers/Plans  
| | Asbestos Documentation: Buildings With Risk Rating |
| Service Agreement Type | Improvement Measure |
| Framework Strategy | Strategy 7: Deliver Infrastructure & System Capability |
| Framework Objective | 7.3 (Build asset management capability) |
| Status | Final |
| Version number | 1.0 |
| Scope | All Local Health Districts to have current asbestos registers and asbestos management plans for all buildings in their portfolios uploaded to AFM Online |
| Goal | To ensure Local Health Districts meet statutory obligations and AFM Online implementation timeframes |
| Desired outcome | Quarter on quarter improvement in AFM Online implementation of key deliverables |
| Primary point of collection | AFM Online. |
| Data Collection Source/System | • AFM Online:  
| | Number of buildings in each Local Health District \(T\)  
| | Asbestos registers and management plans in respect of each building \(B\)  
| | Buildings assigned risk rating \(C\) |
| Primary data source for analysis | AFM Online |
| Indicator definition | MS7401 - Number of buildings with asbestos registers and management plans divided by total number of buildings at the quarter end compared with number of buildings with asbestos registers and management plans divided by total number of buildings at beginning of quarter expressed as a percentage  
| | MS7402 - Number of buildings with risk rating assigned divided by number of buildings at the quarter end compared with number of buildings with risk rating assigned at beginning of the quarter expressed as a percentage  
| | or in mathematical terms  
| | MS7401 - ((B_{t2}/T_{t2}) - (B_{t1}/T_{t1}))/((B_{t1}/T_{t1}))\cdot100  
| | MS7402 - (C_{t2} - C_{t1})/C_{t1}\cdot100 |
| Numerator definition | MS7401 - Difference between number of buildings with asbestos registers and management plans at the end of the quarter and number of buildings |
with asbestos registers and management plans at the beginning of the quarter.

**MS7402** - Difference between number of buildings with risk assigned at end of quarter and number of buildings with risk assigned at end of quarter

<table>
<thead>
<tr>
<th>Numerator source</th>
<th>AFM Online</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator availability</td>
<td>Available monthly</td>
</tr>
</tbody>
</table>

**Denominator**

<table>
<thead>
<tr>
<th>Denominator definition</th>
<th>MS7401 - Number of buildings with asbestos registers and management plans divided by total number of buildings at beginning of quarter MS7402 - Number of buildings with risk rating assigned at beginning of quarter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator source</td>
<td>AFM Online</td>
</tr>
<tr>
<td>Denominator availability</td>
<td>Monthly</td>
</tr>
</tbody>
</table>

**Inclusions**

Included PHOs:
- All Local Health Districts
- HealthShare
- Ambulance Service of NSW
- Sydney Children's Hospital Network
- Justice Health & Forensic Mental Health Network
- NSW Pathology
- Plus: ‘Total of included entities’

**Exclusions**

Buildings where asbestos registers are not required.

**Targets**

- Target
  - 10% quarter on quarter improvement until 100% achieved
  - Not Performing: <10% quarter on quarter improvement
  - Under Performing: >=5% and <7.5%
  - Performing: >=7.5%

**Context**

The indicator allows comparisons of the degree to which AFM Online implementation is occurring across LHDs and identify where LHDs are meeting/not meeting statutory requirements with regards to asbestos management.

This indicator will also be used as an indicator under Property NSW’s Property Asset Utilisation Taskforce (PAUT) Phase II reforms.

**Related Policies/ Programs**

- Health Asset Management reform program
- Property Asset Utilisation Taskforce (PAUT) Phase II reforms

**Useable data available from**

FY 2017 – 18

**Frequency of Reporting**

Quarterly

**Time lag to available data**

LHDs are required to maintain current registers therefore uploads should
occur at intervals aligned with updating reports.

**Business owners**  
**MOH Financial Services and Asset Management Division**

- **Contact - Policy**  
  Jan Schmidt, Director Asset Management, Financial Services and Asset Management Division

- **Contact - Data**  
  Chris O’Neil, AFM Online Program Director, Financial Services and Asset Management Division

**Representation**

<table>
<thead>
<tr>
<th>Data type</th>
<th>Numeric</th>
</tr>
</thead>
<tbody>
<tr>
<td>Form</td>
<td>Number, presented as a percentage (%)</td>
</tr>
<tr>
<td>Representational layout</td>
<td>N.NN</td>
</tr>
<tr>
<td>Minimum size</td>
<td>4</td>
</tr>
<tr>
<td>Maximum size</td>
<td>4</td>
</tr>
<tr>
<td>Date effective</td>
<td>30 June 2018</td>
</tr>
</tbody>
</table>

**Related National Indicator**  
N/A
INDICATOR: MS7403

Previous IDs:

Shortened Title: AFM Online – Data Description Completion

Service Agreement Type: Improvement Measure
Framework Strategy: Strategy 7: Deliver Infrastructure & System Capability
Framework Objective: 7.3 (Build asset management capability)

Status: Final
Version number: 1.0

Scope: All Local Health Districts to meet AFM Online asset data description metrics as follows:
- Building & Facility Categories:
  - Peer Group [A]
  - Building Class [B]
- Building & Facility Categories:
  - BCA Classification [C]
  - BCA Construction Type [D]

Goal: To understand the degree to which LHDs are uploading relevant data and artifacts to AFM Online.

Desired outcome: Improved information detailing the degree to which AFM Online implementation has progressed.

Primary point of collection: AFM Online.

Data Collection Source/System: AFM Online
Primary data source for analysis: AFM Online

Indicator definition: Quarter-on-quarter improvement in the number of buildings and facilities where category data has been uploaded, measured as a percentage

\[ \text{Numerator} = (A_2+B_2+C_2+D_2) - (A_1+B_1+C_1+D_1) \]
\[ \text{Denominator} = (A_1+B_1+C_1+D_1) \]
\[ \text{Indicator} = \left( \frac{\text{Numerator}}{\text{Denominator}} \right) * 100 \]

Where \( 1 \) = value at beginning of quarter and \( 2 \) = value at end of quarter

Numerator:
- Numerator definition: Sum of buildings with required data elements at end of quarter being measured minus sum of buildings with required data elements at beginning of quarter being measured
- Numerator source: AFM Online
- Numerator availability: Available monthly, reported quarterly

Denominator:
- Denominator definition: Sum of buildings at beginning of quarter being measured
Denominator source: AFM Online
Denominator availability: Monthly, reported quarterly

**Inclusions**
- All Local Health Districts
- HealthShare
- Ambulance Service of NSW
- Sydney Children’s Hospital Network
- Justice Health & Forensic Mental Health Network
- NSW Pathology
- Plus: ‘Total of included entities’

**Exclusions**
Enteries not adopting AFM Online.

**Targets**
- **Target**: 10% improvements q-on-q until all buildings meet data requirements
  - Not Performing: <5% q-on-q improvement
  - Under Performing: >=5% and <7.5% q-on-q improvement
  - Performing: >=7.5% q on q improvement

**Context**
The indicator enables the degree to which AFM Online implementation is occurring to be compared across LHDs, and to identify where LHDs are meeting/not meeting implementation requirements.

**Related Policies/ Programs**
- Health Asset Management reform program
- Property Asset Utilisation Taskforce (PAUT) Phase II reforms

**Useable data available from**
FY 2017 – 18

**Frequency of Reporting**
Quarterly

**Time lag to available data**
Nil

**Business owners**
**MOH Financial Services and Asset Management Division**
- Contact - Policy: Jan Schmidt, Director Asset Management, Financial Services and Asset Management Division
- Contact - Data: Chris O’Neil, AFM Online Program Director, Financial Services and Asset Management Division

**Representation**
- Data type: Numeric
- Form: Number, presented as a percentage (%)
- Representational layout: N.NN
- Minimum size: 3
- Maximum size: 3
- Data domain:
- Date effective: 30 June 2018
2018-19 Service Performance Agreements
Strategy 7 IMs: Deliver Infrastructure & System Capability

Related National Indicator  N/A
<table>
<thead>
<tr>
<th>INDICATOR:</th>
<th>MS7404</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AFM Online – GBA Survey Measure (%)</strong></td>
<td></td>
</tr>
<tr>
<td>Previous IDs:</td>
<td>AFM Online – GBA Survey Measure</td>
</tr>
<tr>
<td><strong>Shortened Title</strong></td>
<td>AFM Online – GBA Survey Measure</td>
</tr>
<tr>
<td><strong>Service Agreement Type</strong></td>
<td>Improvement Measure</td>
</tr>
<tr>
<td><strong>Framework Strategy</strong></td>
<td>Strategy 7: Deliver Infrastructure &amp; System Capability</td>
</tr>
<tr>
<td><strong>Framework Objective</strong></td>
<td>7.3 (Build asset management capability)</td>
</tr>
<tr>
<td><strong>Status</strong></td>
<td>Final</td>
</tr>
<tr>
<td><strong>Version number</strong></td>
<td>1.0</td>
</tr>
<tr>
<td><strong>Scope</strong></td>
<td>All Local Health Districts to meet AFM Online asset data description metrics as follows:</td>
</tr>
<tr>
<td></td>
<td>• Verified GBA</td>
</tr>
<tr>
<td><strong>Goal</strong></td>
<td>To understand the degree to which LHDs are uploading relevant, high quality data and artifacts to AFM</td>
</tr>
<tr>
<td><strong>Desired outcome</strong></td>
<td>Improved descriptive metrics and portfolio reporting</td>
</tr>
<tr>
<td><strong>Primary point of collection</strong></td>
<td>AFM Online</td>
</tr>
<tr>
<td><strong>Data Collection Source/System</strong></td>
<td>AFM Online</td>
</tr>
<tr>
<td><strong>Primary data source for analysis</strong></td>
<td>AFM Online</td>
</tr>
<tr>
<td><strong>Indicator definition</strong></td>
<td>Verify data and indicate source:</td>
</tr>
<tr>
<td></td>
<td>1. Verified by Survey (score =10) [A]</td>
</tr>
<tr>
<td></td>
<td>2. Estimated via Six Maps or similar application (score =2) [B]</td>
</tr>
<tr>
<td></td>
<td>3. Estimated with no supporting documentation/Not entered (score = 1) [C]</td>
</tr>
<tr>
<td></td>
<td>Total score divided by number of buildings in LHD [T] x 10 expressed as percentage.</td>
</tr>
<tr>
<td></td>
<td>or in mathematical terms</td>
</tr>
</tbody>
</table>
| | \[
| \left( \frac{(A\times10)+(B\times2)+(C)}{T} \right) \times 100
| \]
| Numerator | Numerator definition |
| | Sum of scores attributable to each building |
| | Numerator source |
| | AFM Online |
| | Numerator availability |
| | Available monthly, reported quarterly |
| Denominator | Denominator definition |
| | Total number of buildings in LHD [T] x maximum possible score (10) |
### 2018-19 Service Performance Agreements

**Strategy 7 IMs: Deliver Infrastructure & System Capability**

<table>
<thead>
<tr>
<th>Denominator source</th>
<th>AFM Online</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator availability</td>
<td>Monthly</td>
</tr>
</tbody>
</table>

**Inclusions**

- Included PHOs:
  - All Local Health Districts
  - HealthShare
  - Ambulance Service of NSW
  - Sydney Children’s Hospital Network
  - Justice Health & Forensic Mental Health Network
  - NSW Pathology
  - Plus: ‘Total of included entities’

**Exclusions**

- Entities not adopting AFM Online.

**Targets**

- **Target**
  - 10% improvement in the number of buildings with verified data quarter on quarter, until 100% achieved
  - Not Performing: <5% improvement in number of buildings with verified data q-on-q
  - Under Performing: >=5% and <7.5% q-on-q
  - Performing: >=7.5% q-on-q

**Context**

The indicator allows comparisons of the degree to which AFM Online implementation is occurring across LHDs and identify the degree to which data quality is improving.

**Related Policies/ Programs**

- Health Asset Management reform program
- Property Asset Utilisation Taskforce (PAUT) Phase II reforms

**Useable data available from**

- FY 2017 – 18

**Frequency of Reporting**

- Quarterly

**Time lag to available data**

- Nil

**Business owners**

**MOH Financial Services and Asset Management Division**

- **Contact - Policy**
  - Jan Schmidt, Director Asset Management, Financial Services and Asset Management Division

- **Contact - Data**
  - Chris O’Neil, AFM Online Program Director, Financial Services and Asset Management Division

**Representation**

- **Data type**
  - Numeric

- **Form**
  - Number, presented as a percentage (%)

- **Representational layout**
  - N.NN

- **Minimum size**
  - 3

- **Maximum size**
  - 3

- **Data domain**
  -
Date effective 30 June 2018
Related National Indicator N/A
<table>
<thead>
<tr>
<th>INDICATOR:</th>
<th>MS7405</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AFM Online – Building Age Recorded (%)</strong></td>
<td></td>
</tr>
</tbody>
</table>

**Previous IDs:**
- AFM Online – Building Age Recorded

<table>
<thead>
<tr>
<th>Shortened Title</th>
<th>AFM Online – Building Age Recorded</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Agreement Type</td>
<td>Improvement Measure</td>
</tr>
<tr>
<td>Framework Strategy</td>
<td>Strategy 7: Deliver Infrastructure &amp; System Capability</td>
</tr>
<tr>
<td>Framework Objective</td>
<td>7.3 (Build asset management capability)</td>
</tr>
<tr>
<td>Status</td>
<td>Final</td>
</tr>
<tr>
<td>Version number</td>
<td>1.0</td>
</tr>
</tbody>
</table>

**Scope**
All Local Health Districts to meet AFM Online asset data description metrics as follows:
- Building Age

**Goal**
To understand the degree to which LHDs are uploading relevant and accurate data and artifacts to AFM Online.

**Desired outcome**
Improved transparency of degree to which AFM Online implementation has progressed and data integrity is optimised

**Primary point of collection**
AFM Online.

**Data Collection Source/System**
AFM Online

**Primary data source for analysis**
AFM Online

**Indicator definition**
The number of buildings where a verified building commissioning date is entered (A) divided by total number of buildings in LHD (T) expressed as a percentage

\[
\text{or in mathematical terms} \quad (A/T) \times 100
\]

**Numerator**
- **Numerator definition**
  Number of buildings in LHD where verified commissioning date is entered (A)
- **Numerator source**
  AFM Online
- **Numerator availability**
  Available monthly, reported quarterly

**Denominator**
- **Denominator definition**
  Total number of buildings in LHD (T)
- **Denominator source**
  AFM Online
- **Denominator availability**
  Available monthly, reported quarterly

**Inclusions**
- Included PHOs:
  - All Local Health Districts
  - HealthShare
2018-19 Service Performance Agreements
Strategy 7 IMs: Deliver Infrastructure & System Capability

- Ambulance Service of NSW
- Sydney Children’s Hospital Network
- Justice Health & Forensic Mental Health Network
- NSW Pathology
- Plus: ‘Total of included entities’

**Exclusions**
Entities not adopting AFM Online.

**Targets**

**Target**
10% quarter on quarter improvement until 100% achieved
Not Performing: <5% q-on-q improvement
Under Performing: >=5% and <7.5% q-on-q improvement
Performing: >=7.5% q-on-q improvement

**Context**
The indicator allows comparisons of the degree to which AFM Online implementation is occurring across LHDs and identify where LHDs are meeting/not meeting implementation requirements.

**Related Policies/ Programs**
- Health Asset Management reform program
- Property Asset Utilisation Taskforce (PAUT) Phase II reforms

**Useable data available from**
FY 2017 – 18

**Frequency of Reporting**
Quarterly

**Time lag to available data**
Nil

**Business owners**

**MOH Financial Services and Asset Management Division**

**Contact - Policy**
Jan Schmidt, Director Asset Management, Financial Services and Asset Management Division

**Contact - Data**
Chris O’Neil, AFM Online Program Director, Financial Services and Asset Management Division

**Representation**

**Data type**
Numeric

**Form**
Number, presented as a percentage (%)

**Representational layout**
N.NN

**Minimum size**
3

**Maximum size**
3

**Data domain**

**Date effective**
30 June 2018
Related National Indicator  N/A
## STRATEGY 8 IMs: Build Financial Sustainability and Robust Governance

<table>
<thead>
<tr>
<th>INDICATOR:</th>
<th>SFA113</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Previous IDs:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Shortened Title</strong></td>
<td>Grouped AN-SNAP Class Episodes</td>
</tr>
<tr>
<td><strong>Service Agreement Type</strong></td>
<td>Improvement Measure</td>
</tr>
<tr>
<td><strong>Framework Strategy</strong></td>
<td>Strategy 8: Build Financial Sustainability and Robust Governance</td>
</tr>
<tr>
<td><strong>Framework Objective</strong></td>
<td>8.1 (Secure a long term sustainable financial position)</td>
</tr>
<tr>
<td><strong>Status</strong></td>
<td>Final</td>
</tr>
<tr>
<td><strong>Version number</strong></td>
<td>1.31</td>
</tr>
<tr>
<td><strong>Scope</strong></td>
<td>Sub and non acute admitted patient episodes completed in 2018-19 in ABF in-scope facilities, excluding mental health services provided in designated mental health units and children &lt;18 years of age.</td>
</tr>
<tr>
<td><strong>Goal</strong></td>
<td>Ensure all sub and non acute admitted patients receive appropriate clinical assessments that are required for effective treatment</td>
</tr>
</tbody>
</table>
| **Desired outcome** | • Greater accountability for providing the appropriate care to all sub and non acute admitted patients.  
• To ensure IHPA's intention to remove care type per diem weights for sub and non acute admitted patient episodes not assigned to an AN-SNAP classes from 1st July 2015 does not adversely impact NSW services. |
| **Primary point of collection** | Patient Medical Record, Synaptix |
| **Data Collection Source/System** | Synaptix, Hospital PAS, Admitted Patient Data Collection, LHD Activity Targets |
| **Primary data source for analysis** | HIE, Synaptix |
| **Indicator definition** | Percentage of sub and non acute admitted patient episodes grouped to an AN-SNAP Class |
| **Numerator** |  |
| Numerator definition | Number of sub and non acute admitted patient episodes with an available AN-SNAP Class |
| Numerator source | Synaptix |
| Numerator availability | Available |
| **Denominator** |  |
| Denominator definition | All sub and non acute admitted patient episodes |
| Denominator source | HIE |
| Denominator availability | Dependent upon local arrangements for loading of admitted patient data to the HIE. May be daily or weekly |
| **Inclusions** | All overnight admitted patient episodes with care types 2 (Rehabilitation), 3 (Palliative care), 4 (Geriatric Evaluation and Management), 7 (Maintenance care) and 8 (Psychogeriatrics) |
2018-19 Service Performance Agreements
Strategy 8 IMs: Build Financial Sustainability and Robust Governance

**Exclusions**
- Same day episodes
- Sub Acute Mental health episodes occurring in designated Mental Health Units
- Sub and Non Acute Episodes of care provided to children (i.e. <18 years of age)
- Incomplete cases

**Targets**
- Individual targets have been established for LHDs

**Context**
From 1st July 2015 IHPA will no longer price sub and non acute episodes of care that have not been assigned to an AN_SNAP class. Reduction in and monitoring of the level of activity that this applies to is essential in reducing the risk to NSW.

**Related Policies/ Programs**
- NSW care type Policy
- IHPA pricing framework
- IHPA national Efficient Price Determination

**Useable data available from**
2010-11 financial year

**Frequency of Reporting**
Monthly

**Time lag to available data**
15 days

**Business owners**
**Health Activity Based Management**
- Contact - Policy
  Director, Activity Based Management
- Contact - Data
  Director, Activity Based Management

**Representation**
- Data type: Numeric
- Form: Number, presented as a percentage (%)
- Representational layout: NNN.N
- Minimum size: 3
- Maximum size: 4
- Data domain
- Date effective: 1 July 2014

**Related National Indicator**
**INDICATORS:** SFA106, SFA107, SFA108, SFA109

**ED Records unable to be grouped:**

(i) to URG with a breakdown for error codes: E1, E2, E3, E6, E7 and E8

- Number of records for each URG error code (number) (SFA106)
- Percentage of records for each URG error code (%) (SFA107)

(ii) to UDG with a breakdown for error codes E1 and E2

- Number of records for each UDG error code (number) (SFA108)
- Percentage of records for each UDG error code (%) (SFA109)

**Shortened Title**

ED Records Unable to Group – URG
ED Records Unable to Group – UDG

**Service Agreement Type**

Improvement Measure

**Framework Strategy**

Strategy 8: Build Financial Sustainability and Robust Governance

**Framework Objective**

8.1 (Secure a long term sustainable financial position)

**Status**

Final

**Version number**

2.21

**Scope**

All Emergency Department presentations in ABF in-scope and NEC hospitals.

**Goal**

- To highlight URG and UDG grouping problems.
- To highlight data issues that are preventing the generation of an NWAU for ED visits.

**Desired outcome**

Reduce the number of ED records that cannot generate an NWAU.

**Primary point of collection**

Emergency Department staff

**Data Collection Source/System**

Emergency Department Data Collection - Emergency Department Information System (EDIS)/Cerner First Net/other electronic Emergency Department Information Systems & iPM ED (for all HNE LHDs).

**Primary data source for analysis**

HIE

**Indicator definition**

For each reported URG or UDG error code, report (i) the number of ED visits and (ii) the percentage of ED visits that generated the URG or UDG error code.

**Numerator**

**Numerator definition**

The total number of ED presentation records which generated a URG error code of E1, E2, E3, E6, E7 or E8, or UDG error code of E1 or E2, disaggregated by each URG or UDG error code.

NWAU version for 2018-19 is URG 1.4 or UDG 1.3

**Numerator source**

HIE

**Numerator availability**

Available from 1 July 2012

**Denominator**
Denominator definition: Total number of ED presentations (for percentage of records measure only).

Denominator source: HIE

Denominator availability: Available from 1 July 2012

**Inclusions**

All patients presenting to emergency department at ABF in scope and NEC facilities.

The following are the relevant error codes and their meaning:

- E1 Error – Episode End Status not (1, 2, 3, 4, 5, 6 or 7) *(for NSW, this is equivalent to ED Mode of Separation values not 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12 or 13)*
- E2 Error – Triage not (1, 2, 3, 4 or 5)
- E3 Error – Blank diagnosis code
- E6 Error – Type of visit not (1, 2, 3, 4 or 5) *(for NSW this is equivalent to ED Type of Visit not values 1, 2, 3, 4, 5, 6, 8, 9, 10, 11)*
- E7 Error – Sex code not consistent with diagnosis code
- E8 Error – Diagnosis code not recognised

**Exclusions**

- Visit type in (‘12’, ‘13’) i.e. Telehealth presentation, current admitted patient presentation
- Separation mode = ‘99’ i.e. Registered in error
- URG Error codes E4 and E5
- Duplicate records, having same facility, MRN, arrival date/time and date of birth

**Targets**

| Target | N/A |

**Context**

**Related Policies/ Programs** Activity Based Funding

**Useable data available from** 1 July 2012

**Frequency of Reporting** Monthly

**Time lag to available data** Reporting required by the 10th day of each month, data available for previous month.

**Business owners** ABF Taskforce

| Contact - Policy | Director, ABF Taskforce |
| Contact - Data   | Executive Director, System Information & Analytics |

**Representation**

| Data type       | Numeric |
| Form            | Quantitative value |
| Representational layout | Numeric: N{NNNNNN} Percentage: N{NN.NN} |
| Minimum size    | 1       |
| Maximum size    | 6       |
Data domain
Date effective 1 July 2014

Related National Indicator
### Coding Timeliness: Uncoded Acute Separations (%)

**INDICATOR:** SFA105  
**Previous IDs:** 9C10, 0109

<table>
<thead>
<tr>
<th>Shortened Title</th>
<th>Coding Timeliness</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Service Agreement Type:</strong></td>
<td>Improvement Measure</td>
</tr>
<tr>
<td><strong>Framework Strategy:</strong></td>
<td>Strategy 8: Build Financial Sustainability and Robust Governance</td>
</tr>
<tr>
<td><strong>Framework Objective:</strong></td>
<td>8.1 (Secure a long term sustainable financial position)</td>
</tr>
</tbody>
</table>

| Status | Final |
| Version number | 2.4 |

| Scope | Acute episodes in 2018-19 ABF in scope hospitals |
| Goal | Records to be coded promptly to aid in the management of health services. |
| Desired outcome | Improved timeliness of clinical coding. |

| Primary point of collection | Patient Medical Record |
| Data Collection Source/System | Hospital PAS systems, Admitted Patient Data Collection |
| Primary data source for analysis | HIE |

**Indicator definition**  
The percentage of uncoded completed acute episodes in the reporting period.

**Numerator**

<table>
<thead>
<tr>
<th>Numerator definition</th>
<th>(i) Number of uncoded completed acute episodes for the reported calendar month as at the reporting date.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(ii) Number of uncoded completed acute episodes YTD (to the end of the reported calendar month) as at the reporting date.</td>
</tr>
</tbody>
</table>

The numerator identifies the number of uncoded episodes for a given month as at the date of reporting (or YTD as at the end of the month). As the Ministry’s reporting date shifts from month to month, it is not possible to specify a particular number of days since separation, for this improvement measure.

For example, the January 2017 report (generated on 18/01/2017), will report percentage of uncoded acute episodes for November 2016 (month and YTD) as at 18/01/2017 – this date is the reporting date. YTD means Year to Date as at 30/11/2016, and is the number of uncoded acute separations for the financial year ending 30/11/2016 as at 18/01/2017.

The combination of the month being reported and the date which the report is run will result in a different number of days post separation being reported in any given reporting period. In the above example, as the reporting date is the 18th, this is reporting uncoded acute episodes > 49 days following separation (the difference between 30/11/2016 and 18/01/2017). If however it was run on the 23rd, then this would be uncoded acute episodes > 54 days following separation.

Number of uncoded episodes is calculated by comparing the number of
episodes in EPISODE_DRG with an_drg_return_cd = “00” against the episodes in EPISODE_SRG. (Note: A coded episode is where an_drg_return_cd = “00”. All other episodes are considered uncoded)

Numerator source  HIE  
Numerator availability  Available

Denominator
Denominator definition
(i) Number of completed acute episodes for the reported calendar month.
(ii) Number of completed acute episodes YTD as at the end of the reported month

Denominator source  HIE  
Denominator availability  Available

Inclusions
• Acute episodes (care type = 1)
• Episode end date within the period
• Facilities in 2018-19 ABF in scope hospitals
• Episodes for dialysis or same day chemotherapy
• ICU only episodes

Exclusions
N/A

Targets  
Target  <=5% (uncoded YTD)

Note: in reporting, the target is assessed as <=5% uncoded at the second reporting period after the end of month. That is, for a July 2017 discharge date, 95% of records are meant to be coded by the time the September 2017 reporting occurs.

Context  
Clinical coding episodes to DRGs is required for episode funding and other purposes where it is vital to know what conditions the patient had and what procedures they received.

Related Policies/ Programs  
Useable data available from  1990
Frequency of Reporting  Monthly
Time lag to available data  Admitted Patient Data Collection data for all admitted patients must be coded and queued for processing on the Ministry's HIE by the 28th calendar day after the end of the week of separation (week ending each Friday)

Business owners  
Contact - Policy  Executive Director, System Purchasing Branch
Contact - Data  Executive Director, System Information and Analytics

Representation  
Data type  Numeric
Form  Number, presented as a percentage
### 2018-19 Service Performance Agreements

**Strategy 8 IMs: Build Financial Sustainability and Robust Governance**

<table>
<thead>
<tr>
<th>Representational layout</th>
<th>NNN.N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum size</td>
<td>3</td>
</tr>
<tr>
<td>Maximum size</td>
<td>5</td>
</tr>
<tr>
<td>Date effective</td>
<td>July 2010</td>
</tr>
</tbody>
</table>

**Related National Indicator**
2018-19 Service Performance Agreements
Strategy 8 IMs: Build Financial Sustainability and Robust Governance

INDICATOR: MS8101

<table>
<thead>
<tr>
<th>Shortened Title</th>
<th>Total Activity Delivered (NWAU)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous IDs:</td>
<td>Total Activity Delivered (NWAU)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service Agreement Type</th>
<th>Improvement Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Framework Strategy</td>
<td>Strategy 8: Build Financial Sustainability and Robust Governance</td>
</tr>
<tr>
<td>Framework Objective</td>
<td>8.1 (Secure a long term sustainable financial position)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Status</th>
<th>Final</th>
</tr>
</thead>
<tbody>
<tr>
<td>Version number</td>
<td>1.1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Scope</th>
<th>All facilities in scope of ABF in 2018-19.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goal</td>
<td>Greater certainty concerning the amount of activity to be performed in a year.</td>
</tr>
<tr>
<td>Desired outcome</td>
<td></td>
</tr>
<tr>
<td>To improve operating efficiency by enhancing the capacity to manage costs and monitor performance by creating an explicit relationship between funds allocated and services provided</td>
<td></td>
</tr>
<tr>
<td>To achieve greater accountability for management of resources and performance</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Primary point of collection</th>
<th>Patient Medical Record</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data Collection Source/System</td>
<td>Hospital PAS, Admitted Patient Data Collection, LHD Activity Targets</td>
</tr>
<tr>
<td>Primary data source for analysis</td>
<td>HIE, EDWARD, Non Admitted Mental Health Service Event (NAMHSE) derived from CHAMB, ABM Portal</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Indicator definition</th>
<th>The total amount of activity delivered in the reporting period, reported in NWAU18.</th>
</tr>
</thead>
</table>

**Numerator**

<table>
<thead>
<tr>
<th>Numerator definition</th>
<th>The total sum of NWAU18 for all ABF Streams:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Acute Admitted</td>
</tr>
<tr>
<td></td>
<td>Emergency Department</td>
</tr>
<tr>
<td></td>
<td>Mental Health-Acute</td>
</tr>
<tr>
<td></td>
<td>Sub-Acute Admitted</td>
</tr>
<tr>
<td></td>
<td>Non-Admitted</td>
</tr>
<tr>
<td></td>
<td>Non-Admitted - Dental</td>
</tr>
<tr>
<td></td>
<td>Non-Admitted - Mental Health</td>
</tr>
</tbody>
</table>

**NOTE:** Uncoded episodes are estimated at average NWAU17 from last year's activity, with a 10% NWAU loading for current month uncoded episodes.

<table>
<thead>
<tr>
<th>Numerator source</th>
<th>HIE, EDWARD, Non Admitted Mental Health Service Event (NAMHSE) derived from CHAMB, ABM Portal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator availability</td>
<td>Available 2 months after the end of the period of measurement.</td>
</tr>
</tbody>
</table>
### Denominator

<table>
<thead>
<tr>
<th>Denominator definition</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator source</td>
<td></td>
</tr>
<tr>
<td>Denominator availability</td>
<td></td>
</tr>
</tbody>
</table>

### Inclusions

- Episode end date within the period
- Facilities in scope of ABF in 2018-19
- For Non-Admitted, only the following FUNDING_SOURCE_NHDD_CODES: (‘01’ ‘02’ ‘03’ ‘04’ ‘06’ ‘08’ ‘10’ ‘11’ ‘12’ ‘99’)

### Exclusions

- For Acute Admitted: (i) ED only episodes; (ii) Mental Health episodes
- For Emergency Department: (i) visit type 12, 13; (ii) separation mode 99; (iii) Duplicate with same facility, MRN, arrival date, arrival time and birth date
- For Non-Admitted: the following Tier2 clinics: (10.19, 30.01, 30.02, 30.03, 30.04, 30.05, 30.06, 30.07, 30.08, 40.01, 40.34, 99.94, 99.95, 99.96, 99.97, 99.98)

### Targets

<table>
<thead>
<tr>
<th>Target</th>
<th>Context</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Related Policies/ Programs</td>
</tr>
<tr>
<td></td>
<td>Activity Based Funding</td>
</tr>
<tr>
<td></td>
<td>Useable data available from</td>
</tr>
<tr>
<td></td>
<td>2009/10</td>
</tr>
<tr>
<td></td>
<td>Frequency of Reporting</td>
</tr>
<tr>
<td></td>
<td>Monthly</td>
</tr>
<tr>
<td></td>
<td>Time lag to available data</td>
</tr>
<tr>
<td></td>
<td>6 – 7 weeks</td>
</tr>
<tr>
<td></td>
<td>Business owners</td>
</tr>
<tr>
<td></td>
<td>Contact - Policy</td>
</tr>
<tr>
<td></td>
<td>Executive Director, Finance Branch</td>
</tr>
<tr>
<td></td>
<td>Contact - Data</td>
</tr>
<tr>
<td></td>
<td>Executive Director, Activity Based Management</td>
</tr>
<tr>
<td></td>
<td>Representation</td>
</tr>
<tr>
<td></td>
<td>Data type</td>
</tr>
<tr>
<td></td>
<td>Numeric</td>
</tr>
<tr>
<td></td>
<td>Form</td>
</tr>
<tr>
<td></td>
<td>Decimal</td>
</tr>
<tr>
<td></td>
<td>Representational layout</td>
</tr>
<tr>
<td></td>
<td>{NNNNNN{NNN.N}</td>
</tr>
<tr>
<td></td>
<td>Minimum size</td>
</tr>
<tr>
<td></td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Maximum size</td>
</tr>
<tr>
<td></td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>Data domain</td>
</tr>
<tr>
<td>Related National Indicator</td>
<td>National Efficient Price Determination 2018-19</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>INDICATOR: KFA102</td>
<td><strong>Expenditure Matched to Budget</strong>: June projection</td>
</tr>
<tr>
<td>-------------------</td>
<td>---------------------------------------------</td>
</tr>
<tr>
<td>Previous IDs:</td>
<td>Variance – General Fund (%)</td>
</tr>
</tbody>
</table>

**Expenditure Matched to Budget**

<table>
<thead>
<tr>
<th>Shortened Title</th>
<th>Expenditure Matched to Budget Projection</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Service Agreement Type</strong></td>
<td>Improvement Measure</td>
</tr>
<tr>
<td><strong>Framework Strategy</strong></td>
<td>Strategy 8: Build Financial Sustainability and Robust Governance</td>
</tr>
<tr>
<td><strong>Framework Objective</strong></td>
<td>8.1 (Secure a long term sustainable financial position)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Status</th>
<th>Final</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Version number</strong></td>
<td>1.21</td>
</tr>
<tr>
<td><strong>Scope</strong></td>
<td>Financial Management</td>
</tr>
<tr>
<td><strong>Goal</strong></td>
<td>Health Entities to operate within approved allocation</td>
</tr>
<tr>
<td><strong>Desired outcome</strong></td>
<td>Health Entities achieve an on budget or favorable result</td>
</tr>
<tr>
<td><strong>Primary point of collection</strong></td>
<td>Health Entities</td>
</tr>
<tr>
<td><strong>Data Collection Source/System</strong></td>
<td>Oracle Accounting System</td>
</tr>
<tr>
<td><strong>Primary data source for analysis</strong></td>
<td>Health Entity monthly financial narrative/SMRS</td>
</tr>
<tr>
<td><strong>Indicator definition</strong></td>
<td>General Fund expenditure is the LHD forecast of FY expenditure to budget.</td>
</tr>
</tbody>
</table>

**Numerator**

- **Numerator definition**: Full 12 months estimated General Fund expenditure
- **Numerator source**: SMRS
- **Numerator availability**: Available

**Denominator**

- **Denominator definition**: Full 12 months Budget General Fund expenditure
- **Denominator source**: SMRS
- **Denominator availability**: Available

**Inclusions**

**Exclusions**

The General Fund Measure excludes Special Purpose & Trust Funds

**Targets**

- **Target**: On budget or favorable to budget

**Context**

Health Entities are expected to operate within approved budget

**Related Policies/ Programs**

**Useable data available from**

Annual - Financial year (available from Finance on a monthly basis)

**Frequency of Reporting**

Monthly

**Time lag to available data**

Available at month end

**Business owners**

Finance
Contact - Policy  Chief Financial Officer
Contact - Data  Director, Financial Performance & Reporting (Jen Smithwick)

Representation
Data type  Numeric
Form  Number, presented as a percentage (%)
Representational layout  NNN.NN
Minimum size  1
Maximum size  6
Data domain  

Related National Indicator
<table>
<thead>
<tr>
<th>Shortened Title</th>
<th>Revenue Matched to Budget Projection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Agreement Type</td>
<td>Improvement Measure</td>
</tr>
<tr>
<td>Framework Strategy</td>
<td>Strategy 8: Build Financial Sustainability and Robust Governance</td>
</tr>
<tr>
<td>Framework Objective</td>
<td>8.1 (Secure a long term sustainable financial position)</td>
</tr>
<tr>
<td>Status</td>
<td>Final</td>
</tr>
<tr>
<td>Version number</td>
<td>1.11</td>
</tr>
<tr>
<td>Scope</td>
<td>Financial Management</td>
</tr>
<tr>
<td>Goal</td>
<td>Health Entities achieve approved own source revenue budget</td>
</tr>
<tr>
<td>Desired outcome</td>
<td>Health Entities achieve an on budget or favourable result</td>
</tr>
<tr>
<td>Primary point of collection</td>
<td>Health Entities</td>
</tr>
<tr>
<td>Data Collection Source/System</td>
<td>Oracle</td>
</tr>
<tr>
<td>Primary data source for analysis</td>
<td>Health Entity Monthly Financial Narrative/SMRS</td>
</tr>
<tr>
<td>Indicator definition</td>
<td>General Fund own source revenue is the LHD forecast of FY own source revenue anticipated.</td>
</tr>
</tbody>
</table>

**Numerator**
- Numerator definition: Full 12 months estimated General Fund own source revenue
- Numerator source: SMRS
- Numerator availability: Available

**Denominator**
- Denominator definition: Full 12 months Budget General Fund own source revenue.
- Denominator source: SMRS
- Denominator availability: Available

**Inclusions**

**Exclusions**
The General Fund Measure excludes Special Purpose & Trust Funds. The Own Source revenue excludes Government grant contributions (subsidy)

**Targets**
- Target: On budget or favourable to budget

**Context**
Health Entities are expected to achieve approved budget

**Related Policies/ Programs**

**Useable data available from**
Annual - Financial year (available from Finance on a monthly basis)

**Time lag to available data**
Available at month end
<table>
<thead>
<tr>
<th><strong>Business owners</strong></th>
<th>Finance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact - Policy</td>
<td>Chief Financial Officer</td>
</tr>
<tr>
<td>Contact - Data</td>
<td>Director, Financial Performance &amp; Reporting (Jen Smithwick)</td>
</tr>
</tbody>
</table>

**Representation**

- **Data type**: Numeric
- **Form**: Number, presented as a percentage (%)
- **Representational layout**: XXX.XX
- **Minimum size**: 1
- **Maximum size**: 6

**Related National Indicator**
**INDICATOR: MS8102**

**Variation Against Reported Expenditure:** Small Rural Hospitals & Specialist Hospitals (%)

**Previous IDs:**

**Shortened Title**

Purchased Activity Variance: Small Rural & Specialist Hosp

**Service Agreement Type**

Improvement Measure

**Framework Strategy**

Strategy 8: Build Financial Sustainability and Robust Governance

**Framework Objective**

8.1 (Secure a long term sustainable financial position)

**Status**

Final

**Version number**

1.1

**Scope**

All expenditure reported in 2018-19 block funded hospitals – Small Rural hospitals & Specialist Hospitals which are non in-scope for ABF funding in NSW.

**Goal**

Greater certainty concerning the cost of providing services from Small Rural Hospitals & Specialist Services in a year.

**Desired outcome**

- To improve operating efficiency by enhancing the capacity to manage costs and monitor performance by creating an explicit relationship between funds allocated and services provided
- To achieve greater accountability for management of resources and performance

**Primary point of collection**

District and Network Return

**Data Collection Source/System**

District and Network Return

**Primary data source for analysis**

District and Network Return and ABM Portal

**Indicator definition**

Variation of year to date expenditure from the year to date budget for Small Rural Hospitals & Specialist Hospitals.

**Numerator**

Numerator definition

Total year to date expenditure for Small Rural Hospitals & Specialist Hospitals.

Numerator source

ABM Portal

Numerator availability

6 monthly

**Denominator**

Denominator definition

Total year to date budget for non-ABF hospitals.

Denominator source

ABM Portal

Denominator availability

6 monthly

**Inclusions**

- Small Rural Hospitals & Specialist Hospitals Facilities out of scope of ABF in 2018-19

**Exclusions**

- All ABF hospitals expenses

**Targets**
<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Target</strong></td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Context</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Related Policies/ Programs</strong></td>
<td>Activity Based Funding</td>
</tr>
<tr>
<td><strong>Useable data available from</strong></td>
<td>2012/13</td>
</tr>
<tr>
<td><strong>Frequency of Reporting</strong></td>
<td>6 monthly</td>
</tr>
<tr>
<td><strong>Time lag to available data</strong></td>
<td>6 – 7 weeks</td>
</tr>
<tr>
<td><strong>Business owners</strong></td>
<td></td>
</tr>
<tr>
<td>Contact - Policy</td>
<td>Director, Activity Based Management</td>
</tr>
<tr>
<td>Contact - Data</td>
<td>Director, Activity Based Management</td>
</tr>
<tr>
<td><strong>Representation</strong></td>
<td></td>
</tr>
<tr>
<td>Data type</td>
<td>Numeric</td>
</tr>
<tr>
<td>Form</td>
<td>Number, presented as a percentage (%)</td>
</tr>
<tr>
<td>Representational layout</td>
<td>NNN.N</td>
</tr>
<tr>
<td>Minimum size</td>
<td>3</td>
</tr>
<tr>
<td>Maximum size</td>
<td>5</td>
</tr>
<tr>
<td>Data domain</td>
<td></td>
</tr>
<tr>
<td>Date effective</td>
<td>July 2009</td>
</tr>
<tr>
<td><strong>Related National Indicator</strong></td>
<td></td>
</tr>
</tbody>
</table>
## 2018-19 Service Performance Agreements
### Strategy 8 IMs: Build Financial Sustainability and Robust Governance

<table>
<thead>
<tr>
<th>INDICATOR: SFA103</th>
<th>Patient Fee Debtors &gt; 45 days as a percentage of rolling prior 12 months patient fee revenues (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous IDs: 9C6, 0036</td>
<td></td>
</tr>
</tbody>
</table>

### Shortened Title
Patient Fee Debtors > 45 days

### Service Agreement Type
Improvement Measure

### Framework Strategy
Strategy 8: Build Financial Sustainability and Robust Governance

### Framework Objective
8.3 (Drive improved financial capability)

### Status
Final

### Version number
1.21

### Scope
Liquidity Management

### Goal
To minimise the level of outstanding patient fees debtors

### Desired outcome
A reduction in the level of debtors

### Primary point of collection
Health Entities

### Data Collection Source/System
Oracle

### Primary data source for analysis
Health Entity Monthly Financial Narrative/SMRS

### Indicator definition
Patient fees unpaid over 45 days from date of invoice (or in the case of compensable & ineligible patients > 150 days)

#### Numerator
- **Numerator definition**: Balance of debtors at month end
- **Numerator source**: SMRS
- **Numerator availability**: Available

#### Denominator
- **Denominator definition**: Total patient fees raised in the immediately preceding 12 month period
- **Denominator source**: SMRS
- **Denominator availability**: Available

### Inclusions
Patient fees unpaid over 45 days from date of invoice or in the case of compensable & ineligible patient fees, debtors over 150 days only

### Exclusions
N.A

### Targets
- **Target**: <5%

### Context
Health entities are expected to minimise the level of outstanding patient fees debtors. This improves the liquidity position of Health Entities

### Related Policies/ Programs
Useable data available from
Annual – financial year

### Frequency of Reporting
Monthly

### Time lag to available data
Available at month end
Business owners: Finance

Contact - Policy: Chief Financial Officer
Contact - Data: Associate Director, Finance Performance & Reporting

Representation

- Data type: Numeric
- Form: Number, presented as a percentage (%)
- Representational layout: N(NN.NN)
- Minimum size: 1
- Maximum size: 6

Related National Indicator
INDICATOR: KFA106
Previous ID: 9C5

Small Business Creditors - Paid within 30 days from receipt of a correctly rendered invoice (%)

Shortened Title
Small Business Creditors Paid within 30 days

Service Agreement Type
Improvement Measure

Framework Strategy
Strategy 8: Build Financial Sustainability and Robust Governance

Framework Objective
8.3 (Drive improved financial capability)

Status
Final

Version number
1.31

Scope
Liquidity Management

Goal
Compliance with Treasury Circular 11/12 Payment of Accounts

Desired outcome
Payment of small business creditors within 30 days

Primary point of collection
Health Entities

Data Collection Source/System
Oracle

Primary data source for analysis
Health Entity monthly financial narrative report.

Indicator definition
Outstanding number of correctly rendered invoices received from registered small business suppliers that were paid in excess of the defined benchmark of 30 days from date of receipt of invoice compared to the total number of correctly rendered invoices received from registered small business suppliers, and expressed as a percentage.

Numerator

Numerator definition
Outstanding number of correctly rendered invoices received from registered small business suppliers that were paid in excess of the defined benchmark of 30 days from date of receipt of invoice.

Numerator source
Health Entity monthly financial narrative report

Numerator availability
Available

Denominator

Denominator definition
Total number of correctly rendered invoices received from registered small business suppliers

Denominator source
Health Entity monthly financial narrative report

Denominator availability
Available

Inclusions

Exclusions
Disputed payments/ late entry payments

Targets
100%

Context
NSW Treasury Circular 11/12 Payment of Accounts sets out the Government’s commitment to pay small business suppliers in 30 days or pay penalty interest. Late payment of small business suppliers affects the standing of NSW Health in the general community, and is of continuing interest to Government and central agencies.
<table>
<thead>
<tr>
<th>Related Policies/ Programs</th>
<th>NSW Ministry of Health Financial Requirements and Conditions of Subsidy (Government Grants) Public Health Organisations, 2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Useable data available from</td>
<td>1 January 2012</td>
</tr>
<tr>
<td>Frequency of Reporting</td>
<td>Monthly internal reporting to Ministry</td>
</tr>
<tr>
<td></td>
<td>Quarterly external reporting by Ministry to Dept Finance and Services</td>
</tr>
<tr>
<td></td>
<td>Annual external reporting in Annual Report</td>
</tr>
<tr>
<td>Time lag to available data</td>
<td>Available at month end</td>
</tr>
<tr>
<td>Business owners</td>
<td>Finance</td>
</tr>
<tr>
<td>Contact - Policy</td>
<td>Chief Financial Officer</td>
</tr>
<tr>
<td>Contact - Data</td>
<td>Associate Director, Financial Performance &amp; Reporting (Jen Smithwick)</td>
</tr>
<tr>
<td>Representation</td>
<td></td>
</tr>
<tr>
<td>Data type</td>
<td>Numeric</td>
</tr>
<tr>
<td>Form</td>
<td>Number, presented as a percentage (%)</td>
</tr>
<tr>
<td>Representational layout</td>
<td>N{NN}</td>
</tr>
<tr>
<td>Minimum size</td>
<td>1</td>
</tr>
<tr>
<td>Maximum size</td>
<td>3</td>
</tr>
<tr>
<td>Related National Indicator</td>
<td></td>
</tr>
</tbody>
</table>
INDICATOR: KFA105
Previous ID: 9C5

Recurrent Trade Creditors > 45 days correct and ready for payment (Number)

Shortened Title: Recurrent Trade Creditors > 45 days

Service Agreement Type: Improvement Measure
Framework Strategy: Strategy 8: Build Financial Sustainability and Robust Governance
Framework Objective: 8.3 (Drive improved financial capability)

Status: Final
Version number: 1.41

Scope: Liquidity Management
Goal: Improved liquidity management by Health Entities
Desired outcome: Payment of creditors within benchmark
Primary point of collection: Health Entities

Data Collection Source/System: Oracle
Primary data source for analysis: Health Entity monthly financial narrative report / SMRS

Indicator definition: Outstanding amount in ($'000) of invoices that are correct and ready for payment at the end of the reporting period that remain unpaid in excess of the defined benchmark of 45 days from date of receipt of invoice.

Inclusions

Exclusions
• Credit notes are excluded from this measure.
• Disputed payments/ late entry payments

Targets

Target: $0 (Nil / zero)

Context: Creditor management is an ongoing performance issue that affects the standing of NSW Health in the general community and is of continuing interest to central agencies. Creditor management is an indicator of a Health Entity's performance in managing its liquidity. The Ministry's preferred position is to have all ready for payment invoices paid within the benchmark of 45 days. All creditors are to be paid within contract or agreed terms based on valid invoices supported by approved purchase orders.

Related Policies/ Programs: NSW Ministry of Health Financial Requirements and Conditions of Subsidy (Government Grants) Public Health Organisations, 2014/15

Useable data available from: 1 January 2011
Frequency of Reporting: Monthly internal reporting to Ministry
Annual external reporting in Annual Report
Time lag to available data: Available from Finance at month end

Business owners:
Contact - Policy: Chief Financial Officer
Contact - Data: Associate Director, Financial Performance & Reporting

Representation
<table>
<thead>
<tr>
<th>Data type</th>
<th>Numeric</th>
</tr>
</thead>
<tbody>
<tr>
<td>Form</td>
<td>Number, presented as an amount ($'000)</td>
</tr>
<tr>
<td>Representational layout</td>
<td>N{N,NNN}</td>
</tr>
<tr>
<td>Minimum size</td>
<td>1</td>
</tr>
<tr>
<td>Maximum size</td>
<td>5</td>
</tr>
</tbody>
</table>

**Related National Indicator**
## Strategy 2: Provide World-Class Clinical Care Where Patient Safety is First

<table>
<thead>
<tr>
<th>Strategic Priority</th>
<th>Performance Domain</th>
<th>Measure</th>
<th>Target</th>
<th>Not Performing</th>
<th>Under Performing</th>
<th>Performing</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Timeliness and accessibility</td>
<td>All cases where STEM is confirmed and patient meets Pre-hospital Assessment for Primary Angioplasty (PAPA) criteria and who arrive at the designated cardiac catheterisation laboratory facility within 60 minutes (%)</td>
<td>95</td>
<td>&lt; 85</td>
<td>≥ 85 and &lt; 95</td>
<td>≥ 95</td>
</tr>
<tr>
<td></td>
<td>Timeliness and accessibility</td>
<td>Major trauma patients managed as per protocol T1 by either direct transport to a Trauma Service OR with Aeromedical Retrieval Service notification (%)</td>
<td>95</td>
<td>&lt; 85</td>
<td>≥ 85 and &lt; 95</td>
<td>≥ 95</td>
</tr>
<tr>
<td></td>
<td>Timeliness and accessibility</td>
<td>Eligible Stroke FAST positive patients transported to a 24/7 acute thrombolytic centre within the 4.5 hour clinical window from time of onset for Metropolitan Sydney (%)</td>
<td>90</td>
<td>&lt; 80</td>
<td>≥ 80 and &lt; 90</td>
<td>≥ 90</td>
</tr>
<tr>
<td></td>
<td>Timeliness and accessibility</td>
<td>Eligible Stroke FAST positive patients transported to a 24/7 acute thrombolytic centre or Acute Stroke Unit within the 4.5 hour clinical window from time of onset for Regional NSW (%)</td>
<td>70</td>
<td>&lt; 60</td>
<td>≥ 60 and &lt; 70</td>
<td>≥ 70</td>
</tr>
<tr>
<td></td>
<td>Appropriateness</td>
<td>Mental Health patients who have a mental health assessment completed (%)</td>
<td>50</td>
<td>&lt; 40</td>
<td>≥ 40 and &lt; 50</td>
<td>≥ 50</td>
</tr>
<tr>
<td></td>
<td>Safety</td>
<td>Complaints Management: acknowledged within 5 days (%)</td>
<td>100</td>
<td>&lt; 90</td>
<td>≥ 90 and &lt; 100</td>
<td>100</td>
</tr>
<tr>
<td></td>
<td>Safety</td>
<td>Complaints Management: Complaints resolved within 35 days (%)</td>
<td>80</td>
<td>&lt; 70</td>
<td>≥ 70 and &lt; 80</td>
<td>≥ 80</td>
</tr>
<tr>
<td></td>
<td>Safety</td>
<td>Death Review: Witnessed deaths reviewed within 45 days (%)</td>
<td>100</td>
<td>&lt; 90</td>
<td>≥ 90 and &lt; 100</td>
<td>100</td>
</tr>
<tr>
<td></td>
<td>Safety</td>
<td>Root cause analysis: NSW Ambulance Internal RCAs completed in 70 days (%)</td>
<td>100</td>
<td>&lt; 90</td>
<td>≥ 90 and &lt; 100</td>
<td>100</td>
</tr>
<tr>
<td></td>
<td>Safety</td>
<td>Clinical Incidents Management: Clinical incidents completed within 28 days (%)</td>
<td>85</td>
<td>&lt; 75</td>
<td>≥ 75 and &lt; 85</td>
<td>≥ 85</td>
</tr>
<tr>
<td></td>
<td>Timeliness and accessibility</td>
<td>Triple Zero call answer time – calls answered within 10 seconds (%)</td>
<td>90</td>
<td>&lt; 85</td>
<td>≥ 85 and &lt; 90</td>
<td>≥ 90</td>
</tr>
<tr>
<td></td>
<td>Timeliness and accessibility</td>
<td>Transfer of Care: patients transferred from Ambulance to ED ≤ 30 minutes (%)</td>
<td>90</td>
<td>&lt; 80</td>
<td>≥ 80 and &lt; 90</td>
<td>≥ 90</td>
</tr>
<tr>
<td></td>
<td>Timeliness and accessibility</td>
<td>Make Ready Time ≤ 20 minutes (%)</td>
<td>90</td>
<td>&lt; 80</td>
<td>≥ 80 and &lt; 90</td>
<td>≥ 90</td>
</tr>
<tr>
<td></td>
<td>Timeliness and accessibility</td>
<td>Response Time – time of ambulance arrival to 1A incidents at the 50th percentile (minutes)</td>
<td>10</td>
<td>&gt; 12</td>
<td>&gt; 10 and ≤ 12</td>
<td>≤ 10</td>
</tr>
<tr>
<td></td>
<td>Effectiveness</td>
<td>Frequent User Management Program Monitoring - reduction in the number of 000 calls from the Top 20 callers currently enrolled (%)</td>
<td>50% change from 15/16 baseline</td>
<td>&lt; 25%</td>
<td>≥ 25% and &lt; 50%</td>
<td>≥ 50%</td>
</tr>
</tbody>
</table>
## Strategy 4: Develop and Support our People and Culture

| 4.1 Patient Centred Culture | **Staff Engagement** - People Matter Survey  
Engagement Index - Variation from previous year (%) | Increase <= -5 <0 to -5 Increase, or no change from previous survey |
|-----------------------------|--------------------------------------------------|------------------------------------------|
| Efficiency                  | **Recruitment** - Improvement on baseline  
Average time from request to recruit to decision to approve/decline/defer recruitment (business days) | 10 Increase from previous year. No change Decrease from previous Year |
| Efficiency                  | **Staff Performance Reviews** - Within the last 12 months (%) | 100 <85 >=85 and <90 >=90 |
| 4.3 Equity                  | **Aboriginal Workforce Participation** - Aboriginal Workforce as a proportion of total workforce (%) | 1.9% Decrease from previous Year No change Increase on previous Year |
| 4.5 Safety                  | **Compensable Workplace Injury - Claims**  
(Number) 10% Decrease Increase >=0 and <10% Decrease >= 10% Decrease |

## Strategy 5: Support and Harness Health and Medical Research and Innovation

| 5.4 Research | **Ethics Application Approvals** - By the Human Research Ethics Committee within 45 calendar days  
Involved more than low risk to participants (%) | 95 <75 >=75 and <95 >=95 |
| Research | **Research Governance Application Authorisations** - Site specific within 15 calendar days - Involved more than low risk to participants - (%) | 95 <75 >=75 and <95 >=95 |

## Strategy 7: Deliver Future Focused Infrastructure and Strategic Commissioning

| 7.1 Finance | **Capital Variation** - Against Approved Budget (%) | On budget > +/- 10 of budget NA < +/- 10 of budget |
| Finance | **Asset Maintenance Expenditure** – As a proportion of asset replacement value (% change) | >=10 < 5 >= 5 and < 10 >=10 |

## Strategy 8: Build Financial Sustainability and Robust Governance

| 8.1 Finance | **Expenditure Matched to Budget** - General Fund - Variance (%) | On budget or Favourable >0.5 Unfavourable >0 but <=0.5 Unfavourable On budget or Favourable |
| Finance | **Own Sourced Revenue Matched to Budget** - General Fund - Variance (%) | On budget or Favourable >0.5 Unfavourable >0 but <=0.5 Unfavourable On budget or Favourable |

**Note:** Only NSW Ambulance specific indicators are listed below. Common indicators and measures are referenced in the main body of this data supplement. Each indicator title above has been hyperlinked to the definition for ease of use.
## INDICATOR: AMB-001

### STEMI Pre Hospital Management (%)

- All cases where STEMI is confirmed and patient meets Pre-hospital Assessment for Primary Angioplasty (PAPA) criteria and who arrive at the designated cardiac catheterisation laboratory facility within 60 minutes

### Shortened Title
STEMI Pre Hospital Management

### Service Agreement Type
Key Performance Indicator

### Framework Strategy
Strategy 2: Provide World-Class Clinical Care Where Patient Safety is First

### Framework Objective
2.1 (Embed quality improvement to ensure safer patient care)

### Status
Final

### Version number
1.0

### Scope
All STEMI patients

### Goal
STEMI (ST Elevation myocardial infarction) is a time critical condition with STEMI guidelines suggesting the occluded artery is opened in 90 minutes from first medical contact.

### Desired outcome
To meet the STEMI guidelines to ensure the best possible outcome for the patient.

### Primary point of collection
Data Analytics and Clinical Performance

### Data Collection Source/System
eMR

### Primary data source for analysis
Raw data is provided to the specialty team for auditing, Cardiac Team. Cleansed and accurate data is then returned to the Manager Clinical Performance for resubmission to Data Analytics for input into the state dashboard.

### Indicator definition
The percentage of cases where STEMI is confirmed (Confirmed STEMI = at patient + 20 minutes) and patient meets the PAPA (Cardiac Reperfusion – Primary Angioplasty) criteria and who arrive at the designated CCL (Cardiac Catheter Laboratory) facility within 60 minutes.

### Numerator

<table>
<thead>
<tr>
<th>Numerator definition</th>
<th>The number of patients under the C12 protocol, transported to a CCL, where the destination time minus at patient time &lt;= 80 minutes.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator source</td>
<td>eMR</td>
</tr>
<tr>
<td>Numerator availability</td>
<td>Monthly</td>
</tr>
</tbody>
</table>

### Denominator

<table>
<thead>
<tr>
<th>Denominator definition</th>
<th>The number of patients under the C12 protocol, transported to a CCL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator source</td>
<td>eMR</td>
</tr>
<tr>
<td>Denominator availability</td>
<td>Monthly</td>
</tr>
</tbody>
</table>

### Inclusions
N/A

### Exclusions
Excluding cases recorded as assist loads (Numerator and Denominator)
Targets

Target 95%

- Not performing < 85
- Under performing ≥ 85 and < 95
- Performing > 95

Context

Treatment of STEMI is time-critical and guidelines recommend that the artery is opened within 90 minutes of first medical contact. Patients who are diagnosed with STEMI, transported to a PCI-capable hospital and achieve reperfusion within guideline-directed timeframes achieve better outcomes.

Related Policies/ Programs

NSW Cardiac Reperfusion Strategy – ACI

Clinical Guidelines for Management of Acute Coronary Syndromes – 2016

Heart Maps – National Heart Foundation
https://www.heartfoundation.org.au/for-professionals/heart-maps

Useable data available from

July 2017. Previous measures for STEMI used a slightly different criteria and timeframe.

Frequency of Reporting

Monthly

Time lag to available data

2 months.

Business owners

NSW Ambulance

Contact - Policy Manager Clinical Performance, Clinical Systems Integration

Contact - Data Data Analyst, Data Analytics, Finance, Performance & Assets

Representation

Data type Numeric

Form Number, presented as a percentage (%)

Representational layout NNN

Minimum size 1

Maximum size 3.

Data domain Refer to above numerator and denominator for calculations.

Date effective July 2018

Related National Indicator
INDICATOR: AMB-002

Major Trauma Management (%)

- Major trauma patients managed as per protocol T1 by either direct transport to a Trauma Service OR with Aeromedical Retrieval Service (AMRS) notification (%)

Shortened Title
Major Trauma Management

Service Agreement Type
Key Performance Indicator

Framework Strategy
Strategy 2: Provide World-Class Clinical Care Where Patient Safety is First

Framework Objective
2.1 (Embed quality improvement to ensure safer patient care)

Status
Final

Version number
1.0

Scope
All patients managed under the protocol T1 Major Trauma

Goal
Timely access to definitive specialist trauma care is linked to increased survival and improved outcomes for major trauma patients. Paramedics provide their patients with the opportunity for better outcomes when they either directly transported to a Trauma Service OR provide early notification to Aeromedical Retrieval Service (AMRS).

Desired outcome
Timely access to definitive specialist trauma care to ensure the best possible outcome for the patient.

Primary point of collection
Data Analyst, Informatics and Information Unit and Clinical Performance

Data Collection Source/System
eMR

Primary data source for analysis
Raw data is provided to the specialty team for auditing. Trauma Team. Cleansed and accurate data is then returned to the Manager Clinical Performance for resubmission to the Informatics and Information Unit for input into the state dashboard.

Indicator definition
The percentage of major trauma patients managed as per protocol T1 by either direct transport to a Trauma Service OR with Aeromedical Retrieval Service (AMRS) notification.

Numerator
Numerator definition
The number of major trauma T1 Protocol patients who were transported to a Trauma Service or AMRS notification

Numerator source
eMR

Numerator availability
Monthly

Denominator
Denominator definition
The number of major trauma T1 Protocol patients who were transported
cases

Denominator source
eMR

Denominator availability
Monthly
Inclusions | N/A
---|---
Exclusions | N/A

Targets
- Target 95%
  - Not performing < 85
  - Under performing > 85 and <95
  - Performing ≥ 95

Context
Trauma systems are an integrated and systematic structure designed to facilitate and coordinate a multidisciplinary system response to provide optimal care to injured patients from onset of injury through rehabilitation and return of ideal functioning.\(^1\,\(^2\)

Care of seriously injured patients starts at the scene of injury, continues through the emergency department, and is expanded in the hospital, often in the radiology department, operating theatres, intensive care unit and the wards. Optimal care of injured patients is dependant on teamwork, smooth transitions, and the correct sequence of appropriate interventions. In the care of injured patients, the good will, capability and knowledge of experts is not enough; clinicians require a system of supporting equipment, resources, and personnel.\(^3\)

Mortality has been shown to be reduced by 9% with the establishment of a well organised state trauma system.\(^4\)

The main objective of an established trauma system is to get the right patient at the right hospital in the right time receiving the right care.

References

Related Policies/ Programs
- NSW Health Selected Specialty and Statewide Services Plan.
- NSW Trauma Service Plan 2009.
- Critical Care Tertiary Referral Networks (Paediatrics) Policy Directive 2010-030

Useable data available from
- July 2009

Frequency of Reporting
- Monthly

Time lag to available data
- 2 months.


**Business owners**
NSW Ambulance

**Contact - Policy**
Manager Clinical Performance, Clinical Services

**Contact - Data**
Data Analyst, Informatics and Information Unit, Business Innovation & Planning

**Representation**

- **Data type**: Numeric
- **Form**: Number, presented as a percentage (%)
- **Representational layout**: NNN
- **Minimum size**: 1
- **Maximum size**: 3.
- **Data domain**: Refer to above numerator and denominator for calculations.

**Date effective**: July 2017

**Related National Indicator**
INDICATOR: AMB-003a, AMB-003b

Stroke Fast Positive Pre Hospital Management (%)

- Eligible Stroke FAST positive patients transported to a 24/7 Acute Thrombolytic Centre within the 4.5 hour clinical window from time of onset (%), disaggregated by:
  - Metropolitan Sydney (AMB-003a)
  - Regional NSW (AMB-003b)

Previous IDs:
- Stroke Fast Positive Pre Hospital Management (%)

Shortened Title
Stroke Fast Positive Pre Hospital Management

Service Agreement Type
Key Performance Indicator

Framework Strategy
Strategy 2: Provide World-Class Clinical Care Where Patient Safety is First

Framework Objective
2.1 (Embed quality improvement to ensure safer patient care)

Status
Final

Version number
1.0

Scope
All Stroke FAST positive patients

Goal
To meet the pre-hospital clinical window for hyper acute care, defined as 4.5 hours from symptom onset to arrival at hospital.

Desired outcome
The most common cause of stroke is an ischaemic cerebral event following thrombus lodgement in a narrowed cerebral artery. Stroke patients that receive thrombolysis and/or endovascular clot retrieval (ECR) are more likely to have improved outcomes.

Primary point of collection
Data Analyst, Informatics and Information Unit and Clinical Performance

Data Collection Source/System
eMR

Primary data source for analysis
Raw data is provided to the specialty Stroke team for auditing. Cleansed and accurate data is then returned to the Manager Clinical Performance for resubmission to the Informatics and Information Unit for input into the state dashboard.

Indicator definition
The percentage of eligible Stroke FAST positive patients transported to a 24/7 acute thrombolytic centre within the 4.5 hour clinical window from time of onset for, disaggregated by (i) Metropolitan Sydney and (ii) Regional NSW

Numerator

Numerator definition
The number of eligible C11P Protocol patients transported to an Acute Thrombolytic Centre, where the destination time minus the time of onset is <= 4.5 hours.

Numerator source
eMR

Numerator availability
Monthly

Denominator

Denominator definition
The number of eligible C11P Protocol patients

Denominator source
eMR

Denominator availability
Monthly

Inclusions
N/A
**Exclusions**

Exclude cases where stroke onset >6 hours, wake up stroke, unknown onset is recorded and assist loads. Exclude cases where time of onset and call received are equal to or greater than 3.5 hours (Numerator and Denominator).

**Targets**

**Target**

AMB-003a: 90%
- Not performing < 80
- Under performing ≥ 80 and <90
- Performing ≥ 90

AMB-003b: 70%
- Not performing < 60
- Under performing ≥ 60 and <70
- Performing ≥ 70

**Context**

Patients who present with an ischaemic stroke may be eligible for thrombolysis and/or endovascular clot retrieval. Transporting these patients directly to an ATC minimises time to treatment leading to improved outcomes.

**Related Policies/ Programs**

NSW Stroke Reperfusion Service – ACI

No Postcode untouched – Stroke Foundation

Clinical Guidelines for Stroke Management 2017

**Useable data available from**

July 2017. Previous measures for Stroke used different criteria and timeframes.

**Frequency of Reporting**

Monthly

**Time lag to available data**

2 months.

**Business owners**

NSW Ambulance

Contact - Policy: Manager Clinical Performance, Clinical Services
Contact - Data: Data Analyst, Informatics and Information Unit, Business Innovation & Planning

**Representation**

**Data type** Numeric

**Form** Number, presented as a percentage (%)

**Representational layout** NNN

**Minimum size** 1

**Maximum size** 3

**Data domain** Refer to above numerator and denominator for calculations.
Date effective: July 2017

Related National Indicator
INDICATOR: AMB-004

Mental Health Assessments (%)

- Mental Health patients who have a mental health assessment completed (%)

Shortened Title
Mental Health Assessments

Service Agreement Type
Key Performance Indicator

Framework Strategy
Strategy 2: Provide World-Class Clinical Care Where Patient Safety is First

Framework Objective
2.1 (Embed quality improvement to ensure safer patient care)

Status
Final

Scope
All identified Mental Health patients

Goal
Conducting a mental health assessment enables Paramedics to make informed clinical decisions regarding how to address the needs of mental health patients and to identify risk factors that may present such as the safety and well-being of the patient and staff, including risk of suicide.

Desired outcome
To provide appropriate care for mental health patients by identifying risk factors as per above. This will assist in ensuring the best possible outcome for the patient.

Primary point of collection
Data Analyst, Informatics and Information Unit and Clinical Performance Data Collection

Source/System
eMR

Primary data source for analysis
Raw data is provided Manager Clinical Performance for resubmission to the Informatics and Information Unit for input into the state dashboard.

Indicator definition
The percentage of identified Mental Health patients that have a mental health assessment completed by paramedics.

Numerator
Numerator definition
The number of eligible patients for the S3 Chief Protocol – Mental Health and have:

- Mental Health Procedure AND/OR
- Mental Health Procedure:Mental Health Assessment AND/OR
- Mental Health Procedure:Search Section 81 (NSW) AND/OR
- Mental Health Procedure:Section 20 (NSW)

Numerator source
eMR

Numerator availability
Monthly

Denominator
Denominator definition
The number of eligible patients for the S3 Chief Protocol – Mental Health

Denominator source
eMR

Denominator availability
Monthly

Inclusions
N/A
Exclusions

N/A

Targets

Target 50%

• Not performing < 40
• Under performing ≥ 40 and <50
• Performing ≥ 50

Context

A trend in non-performance will initiate a review of training needs in relation to mental health assessment skills.

Related Policies/ Programs

- Protocol MH1 – Mental Health Emergency (formerly S3)
- Protocol MH2 – Suicide Risk Assessment and Mgmt (formerly S6)
- Protocol MH3 – Enacting s20 and s81 of the MH Act 2007
- Protocol MH4 – Mental Health – Mechanical Restraint
- Protocol MH5 – Mental Health – Search Protocol
- Protocol MH6 – Mgmt Acute Severe Behavioural Disturbance – Mental Health (formerly A7)

Useable data available from

July 2017. Previous measures for Mental Health used different criteria which related to data capture on the eMR.

Frequency of Reporting

Monthly

Time lag to available data

2 months.

Business owners

NSW Ambulance

Contact - Policy
Manager Clinical Performance, Clinical Services

Contact - Data
Data Analyst, Informatics and Information Unit, Business Innovation & Planning

Representation

Data type
Numeric

Form
Number, presented as a percentage (%)

Representational layout
NNN

Minimum size
1

Maximum size
3.

Data domain
Refer to above numerator and denominator for calculations.

Date effective
July 2017

Related National Indicator
**Complaints Management Acknowledgement (%)**

- Complaints received by NSW Ambulance which are acknowledged within 5 days (%)

<table>
<thead>
<tr>
<th>Shortened Title</th>
<th>Complaints Management Acknowledgement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Agreement Type</td>
<td>Key Performance Indicator</td>
</tr>
<tr>
<td>Framework Strategy</td>
<td>Strategy 2: Provide World-Class Clinical Care Where Patient Safety is First</td>
</tr>
<tr>
<td>Framework Objective</td>
<td>2.1 (Embed quality improvement to ensure safer patient care)</td>
</tr>
<tr>
<td>Status</td>
<td>Final</td>
</tr>
<tr>
<td>Version number</td>
<td>1.0</td>
</tr>
</tbody>
</table>

**Scope**

All complaints received by NSW Ambulance

**Goal**

Management of a complaint provides the opportunity for complainants to have their issues resolved effectively, ensuring that any identified risks are managed appropriately and that action is taken to minimise or eliminate those risks.

**Desired outcome**

Complaints provide unique information about the quality of health care from the perspective of consumers and their carers.

**Primary point of collection**

Information Support Officer, Clinical Services

**Data Collection Source/System**

IIMS

**Primary data source for analysis**

Information Support Officer, Patient Safety and Clinical Quality.

**Indicator definition**

The percentage of complaints received by NSW Ambulance that are acknowledged within 5 days.[PD2006_073]

**Numerator**

The number of complaints received by NSW Ambulance recorded in IIMS where the difference between the Acknowledgement date and the Date complaint received is <= 5 days

Sourced from:

The data field within IIMS called [Date complaint received]
The data field within IIMS called [Acknowledgement date - 5 days]

**Numerator source**

IIMS

**Numerator availability**

Six days after the incident has been notified.

**Denominator**

The number of complaints received by NSW Ambulance recorded in IIMS

**Denominator source**

IIMS

**Denominator availability**

Six days after the incident has been notified.

**Inclusions**

N/A

**Exclusions**

Complaints received by the Health Care Complaints Commission, Ministry of Health, Members of Parliament (Numerator and Denominator)
2018-19 Service Performance Agreements  
NSW Ambulance Services Supplement

Targets

Target  100%
- Not performing < 90
- Under performing ≥ 90 and <100
- Performing 100

Context
Mandatory reporting by the Ministry of Health

Related Policies/ Programs
PD2014-004 Incident Management Policy. Complaint Management Operating Procedure which has been reviewed updated and approved by the Senior Leadership Team in September 2017 and is currently awaiting a document number.

Useable data available from
IIMS went live at NSW Ambulance in December 2004.

Frequency of Reporting
Monthly

Time lag to available data
Six days after the incident has been notified

Business owners
NSW Ambulance

Contact - Policy
Director Patient Safety and Clinical Quality

Contact - Data
Information Support Officer, Patient Safety and Clinical Quality.

Representation

Data type
Numeric

Form
Number, presented as a percentage (%)

Representational layout
NNN

Minimum size
1

Maximum size
3

Data domain
The two fields [Date complaint received] and [Acknowledgement date - 5 days] are part of a data download from IIMS with both fields expressed in a dd/mm/yyyy date format.

The downloaded data is processed in Access where a new field [Complaints Completion Test - 5 Days] is created by applying the following query calculation [Acknowledgement date - 5 days] - [Date complaint received] = [Complaints Completion Test - 5 Days]. This new calculated field is exported to an Excel spreadsheet with the calculation being represented as an Integer, eg: 1 = 1 Day, 2 = 2 Days, etc.

Date effective
December 2004

Related National Indicator
### Complaints Management Resolution (%)

**Previous IDs:**
- Complaints Management Resolution (%)
- Complaints received by NSW Ambulance which are resolved within 35 days (%)

<table>
<thead>
<tr>
<th>Shortened Title</th>
<th>Complaints Management Resolution</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Service Agreement Type</strong></td>
<td>Key Performance Indicator</td>
</tr>
<tr>
<td><strong>Framework Strategy</strong></td>
<td>Strategy 2: Provide World-Class Clinical Care Where Patient Safety is First</td>
</tr>
<tr>
<td><strong>Framework Objective</strong></td>
<td>2.1 (Embed quality improvement to ensure safer patient care)</td>
</tr>
<tr>
<td><strong>Status</strong></td>
<td>Final</td>
</tr>
<tr>
<td><strong>Version number</strong></td>
<td>1.0</td>
</tr>
</tbody>
</table>

**Scope**
- All complaints received by NSW Ambulance

**Goal**
- Management of a complaint provides the opportunity for complainants to have their issues resolved effectively, ensuring that any identified risks are managed appropriately and that action is taken to minimise or eliminate those risks.

**Desired outcome**
- Complaints provide unique information about the quality of health care from the perspective of consumers and their carers.

**Primary point of collection**
- Information Support Officer, Clinical Services

**Data Collection Source/System**
- IIMS

**Primary data source for analysis**
- Information Support Officer, Patient Safety and Clinical Quality.

**Indicator definition**
- The percentage of complaints received by NSW Ambulance that are resolved within 35 days.

**Numerator**
- **Numerator definition**
  - The number of complaints received by NSW Ambulance recorded in IIMS where the difference between the Complaint resolution date and the Date complaint received is \( \leq 35 \) days

  **Sourced from:**
  - The data field within IIMS called [Date complaint received]
  - The data field within IIMS called [Complaint resolution date]

- **Numerator source**
  - IIMS

- **Numerator availability**
  - 36 days after the incident has been notified

**Denominator**
- **Denominator definition**
  - The number of complaints received by NSW Ambulance recorded in IIMS

- **Denominator source**
  - IIMS

- **Denominator availability**
  - 36 days after the incident has been notified

**Inclusions**
- N/A

**Exclusions**
- Complaints received by the Health Care Complaints Commission, Ministry of
Targets

Target

80%

- Not performing < 70
- Under performing ≥ 70 and < 80
- Performing ≥ 80

Context

Mandatory reporting by the Ministry of Health

Related Policies/ Programs

PD2014-004 Incident Management Policy. Complaint Management Operating Procedure which has been reviewed updated and approved by the Senior Leadership Team in September 2017 and is currently awaiting a document number.

Useable data available from

IIMS went live at NSW Ambulance in December 2004

Frequency of Reporting

Monthly

Time lag to available data

36 days after the incident has been notified

Business owners

NSW Ambulance

Contact - Policy

Director Patient Safety and Clinical Quality

Contact - Data

Information Support Officer, Patient Safety and Clinical Quality.

Representation

Data type

Numeric

Form

Number, presented as a percentage (%)

Representational layout

NNN

Minimum size

1

Maximum size

3.

Data domain

The two fields [Date complaint received] and [Complaint resolution date] are part of a data download from IIMS with both fields expressed in a dd/mm/yyyy date format.

The downloaded data is processed in Access where a new field [Complaints Completion Test - Final] is created by applying the following query calculation [Acknowledgement date - 5 days] - [Date complaint received] = [Complaints Completion Test - Final].

This new calculated field is exported to an Excel spreadsheet with the calculation being represented as an Integer, eg: 1 = 1 Day, 2 = 2 Days, etc

Date effective

December 2004

Related National Indicator

No national indicator found on the AIHW website
Deaths Review Performance (%)

- Witnessed deaths reviewed within 45 days (%)

Shortened Title: Deaths Review Performance

Service Agreement Type: Key Performance Indicator

Framework Strategy: Strategy 2: Provide World-Class Clinical Care Where Patient Safety is First

Framework Objective: 2.1 (Embed quality improvement to ensure safer patient care)

Status: Final

Version number: 1.0

Scope: All deaths in Ambulance care

Goal: That the Clinical Review Group conducts a review of all cardiac arrest cases marked witnessed by Ambulance Officer within 45 days. This ensures that the treatment given complies with Ambulance protocols and procedures.

Desired outcome: To learn from these cases and drive improvement in patient safety outcomes.

Primary point of collection: Data Analyst, Informatics and Information Unit and Clinical Performance Data Collection

Source/System: eMR

Primary data source for analysis: Raw data is provided to the Patient Safety Officer for review by the Clinical Review Group. The results of the review are provided back to the Manager Clinical Performance for input into the state dashboard.

Indicator definition: The percentage of witnessed deaths that were reviewed by the Clinical Review Group within 45 days.

Numerator:

Numerator definition: The number of witnessed deaths that were reviewed by the Clinical Review Group within 45 days

Death Review Criteria:
Initial Assessment: Cardiac Arrest witnessed by Ambulance Officer
DWMGR_FCT_CASE_NATURES.DISPLAY_SEQUENCE 1
CDWMGR_FCT_ASSESSMENTS.CLINICAL_CODE_PATH Like "WITNESSED:WITNSAMBO"
CDWMGR_FCT_CASE_REPORTS.OBSERVED_PATIENT_OUTCOME Died En Route

Numerator source: eMR

Numerator availability: Monthly

Denominator:

Denominator definition: The number of witnessed deaths that were reviewed by the Clinical Review Group

Denominator source: eMR
Denominator availability Monthly

**Inclusions**
N/A

**Exclusions**
N/A

**Targets**
Target 100%
- Not performing < 90
- Under performing > 90 and <100
- Performing 100

**Context**
Mandatory reporting by the Ministry of Health

**Related Policies/ Programs**
Clinical Excellence Commission, Mortality Review in NSW: A Way Forward

**Useable data available from**
Last 5 years

**Frequency of Reporting**
Monthly

**Time lag to available data**
2 months.

**Business owners**
NSW Ambulance
- Contact - Policy Manager Clinical Performance, Clinical Services
- Contact - Data Data Analyst, Informatics and Information Unit, Business Innovation & Planning

**Representation**
- Data type Numeric
- Form Number, presented as a percentage (%)
- Representational layout NNN
- Minimum size 1
- Maximum size 3
- Data domain Refer to above numerator and denominator for calculations.

**Date effective**
July 2017

**Related National Indicator**
No national indicator found on the AIHW website
### Clinical Incidents Management Completion (%)

- Clinical incidents completed within 28 days (%)

<table>
<thead>
<tr>
<th>Shortened Title</th>
<th>Clinical Incident Management Completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Agreement Type</td>
<td>Key Performance Indicator</td>
</tr>
<tr>
<td>Framework Strategy</td>
<td>Strategy 2: Provide World-Class Clinical Care Where Patient Safety is First</td>
</tr>
<tr>
<td>Framework Objective</td>
<td>2.1 (Embed quality improvement to ensure safer patient care)</td>
</tr>
<tr>
<td>Status</td>
<td>Final</td>
</tr>
<tr>
<td>Version number</td>
<td>1.0</td>
</tr>
</tbody>
</table>

#### Scope
Clinical incidents entered in IIMS

#### Goal
To complete all NSW Ambulance clinical incidents within 28 days.

#### Desired outcome
To monitor and manage these incidents to improve patient safety and clinical quality.

#### Primary point of collection
Information Support Officer, Patient Safety and Clinical Quality.

#### Data Collection Source/System
IIMS

#### Primary data source for analysis
Information Support Officer, Patient Safety and Clinical Quality.

#### Indicator definition
The percentage of clinical incidents completed within 28 days.

#### Numerator
- Numerator definition: The total number of clinical incidents reported in IIMS within the reporting period where the Date Incident Completed date is <=28 days after the Date Incident Notified date.
  - Numerator source: IIMS
  - Numerator availability: 29 days after incident notification.

#### Denominator
- Denominator definition: The total number of clinical incidents reported in IIMS within the reporting period.
  - Denominator source: IIMS
  - Denominator availability: 29 days after incident notification

#### Inclusions
All IIMS incidents

#### Exclusions
N/A

#### Targets
- Target: 85%
  - Not performing < 75
  - Under performing ≥ 75 and < 85
  - Performing ≥ 85
Context: Mandatory reporting by the Ministry of Health


Useable data available from: December 2004

Frequency of Reporting: Monthly

Time lag to available data: 29 days after incident notification.

Business owners: NSW Ambulance

Contact - Policy: Director Patient Safety and Clinical Quality

Contact - Data: Information Support Officer, Patient Safety and Clinical Quality

Representation:

Data type: Numeric

Form: Number, presented as a percentage (%)

Representational layout: NNN

Minimum size: 1

Maximum size: 3

Data domain: The 28 day KPI is generated by a query within the IIMS program called the Run Audit Report.

Date effective: December 2004

Related National Indicator
<table>
<thead>
<tr>
<th><strong>INDICATOR:</strong> AMB-007</th>
<th><strong>Triple Zero Call Answer Time Performance (%)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Previous IDs:</strong></td>
<td>Triple Zero (000) call answer time within 10 seconds (%)</td>
</tr>
</tbody>
</table>

**Shortened Title**
Triple Zero Call Answer Time Performance

**Service Agreement Type**
Key Performance Indicator

**Framework Strategy**
Strategy 2: Provide World-Class Clinical Care Where Patient Safety is First

**Framework Objective**
2.4 (Ensure timely access to care)

**Status**
Final

**Version number**
1.0

**Scope**
All Triple Zero (000) calls

**Goal**
Answer 90% of Triple Zero (000) calls in 10 seconds,

**Desired outcome**
Minimal wait time for patients and their families to be connected with a Communications Assistance who will triage the call and provide medical assistance

**Primary point of collection**
Genesys Interactive Insights

**Data Collection Source/System**
Genesys Interactive insights

**Primary data source for analysis**
Genesys Interactive insights

**Indicator definition**
The percentage of initial Triple Zero (000) calls answered within 10 seconds.

**Numerator**

<table>
<thead>
<tr>
<th><strong>Numerator definition</strong></th>
<th>The number of initial Triple Zero calls answered within 10 seconds</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Numerator source</strong></td>
<td>Genesys Interactive Insights</td>
</tr>
<tr>
<td><strong>Numerator availability</strong></td>
<td>Available</td>
</tr>
</tbody>
</table>

**Denominator**

<table>
<thead>
<tr>
<th><strong>Denominator definition</strong></th>
<th>The number of initial Triple Zero calls <strong>Denominator = the number of first presentation calls – short abandoned</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Denominator source</strong></td>
<td>Genesys interactive insights</td>
</tr>
<tr>
<td><strong>Denominator availability</strong></td>
<td>Available</td>
</tr>
</tbody>
</table>

**Inclusions**
All first presentation Triple Zero (000) calls that are presented to NSW Ambulance.

- This includes calls that are unanswered after 75 seconds and represented on a higher priority line.**

**Exclusions**
Second and subsequent presentations of triple zero (000) calls
Targets

Target: Answer 90% of Triple Zero (000) calls in 10 seconds.

Under performing ≥ 85 and < 90

Not performing < 85

Context

Answering Triple Zero (000) calls in 10 seconds promotes optimum patient outcomes through the timely processing of requests for assistance. This leads to early intervention with pre arrival medical instructions as required.

Related Policies/ Programs

NSW State Health Plan; 2017-2018 Service Agreement

Useable data available from

Genesys Interactive Insights

Frequency of Reporting

Monthly

Time lag to available data

Immediate

Business owners

NSW Ambulance Service Delivery

Contact - Policy

Executive Director Service Delivery.

Contact - Data

Executive Director, Business Innovation and Planning

Representation

Data type

Numeric

Form

Number, presented as a percentage (%)

Representational layout

NNN

Minimum size

1

Maximum size

3

Data domain

Related National Indicator

http://meteor.aihw.gov.au/content/index.phtml/itemId/401254
### INDICATOR: AMB-008

#### Make Ready Time Performance (\%)  
- Ambulance preparation time the following recording of Delayed Available status (\%)

<table>
<thead>
<tr>
<th>Shortened Title</th>
<th>Make Ready Time (MRT) Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Agreement Type</td>
<td>Key Performance Indicator</td>
</tr>
<tr>
<td>Framework Strategy</td>
<td>Strategy 2: Provide World-Class Clinical Care Where Patient Safety is First</td>
</tr>
<tr>
<td>Framework Objective</td>
<td>2.4 (Ensure timely access to care)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Status</th>
<th>Final</th>
</tr>
</thead>
<tbody>
<tr>
<td>Version number</td>
<td>1.0</td>
</tr>
</tbody>
</table>

| Scope | All NSW Ambulances cases (P1 – P3). |
| Goal | Timely movement from ‘Delayed Available’ status to an ‘Available’ status, resulting in timely returned operational availability. |
| Desired outcome | Greater resource capacity and availability through improved total turnaround time. |

| Primary point of collection | Operator, Computer Aided Dispatch (CAD) system |
| Primary data source for analysis | Ambulance Service, NSW (ASNSW) Operator, Computer Aided Dispatch (CAD) system, Ambulance Intelligence System (AIS) – Qlikview Dashboard. |

**Indicator definition**
The percentage of NSW Ambulance cases (P1-P3) where the time between activation of Delayed Available (either verbally noted or through activation via the Mobile Data Terminal (MDT) is less than or equal to 20 minutes. This period is known as ‘Make Ready Time’ or MRT.

‘Make Ready Time’ is the time interval measured in minutes between:
- Start time: Recording of ‘Delayed Available’ (DA) and
- End time: Recording of ‘Available’.

\[
\text{MRT (mins) = Available (mins) – Delayed Available (mins)}
\]

**Numerator**
- **Numerator definition**: The total number of NSW Ambulances P1 – P3 cases that had a MRT of ≤ 20mins.
- **Numerator source**: Computer Aided Dispatch (CAD) system, Ambulance Intelligence System (AIS) – Qlikview Dashboard.
- **Numerator availability**: Available.
Denominator

Denominator definition: The total number of NSW Ambulances P1 – P3 cases


Denominator availability: Available.

Inclusions: NSW Ambulance cases where the Ambulance Priority is rated P1 – P3

Exclusions: Patients where the Ambulance Priority is rated P4 – P9

Priority Error assigned or Missing ambulance data due to CAD outage Make Ready Second is null.

P1 cases when MRT Seconds less than 1 and greater than 2850;
P2 cases when MRT less than 1 and greater than 2320;
P3 cases when MRT Seconds less than 1 and greater than 2075;

Targets

Target: Target: >= 90%

Not performing: <80%

Under performing: ≥80 and <90

Context

Improved ambulance turnaround time through an improved make ready time, can lead to improved response capacity and availability

Related Policies/ Programs


Useable data available from

2012/13 (Note: Major MPDS Grid change)

Frequency of Reporting

Monthly

Time lag to available data

Immediate

Business owners

NSW Ambulance Service Delivery

Contact - Policy

Executive Director, Service Delivery
Contact - Data
Executive Director, Business Innovation and Planning

Representation
Data type
Numeric
Form
Number, presented as a percentage (%)
Representational layout
NN.N
Minimum size
3
Maximum size
4
Data domain

Date effective
2016/17

Related National Indicator
### Median Ambulance Response Time (Minutes)

- Ambulance response times to Priority 1A Incidents (50th Percentile – minutes)

<table>
<thead>
<tr>
<th>Shortened Title</th>
<th>Median Ambulance Response Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Agreement Type</td>
<td>Key Performance Indicator</td>
</tr>
<tr>
<td>Framework Strategy</td>
<td>Strategy 2: Provide World-Class Clinical Care Where Patient Safety is First</td>
</tr>
<tr>
<td>Framework Objective</td>
<td>2.4 (Ensure timely access to care)</td>
</tr>
<tr>
<td>Status</td>
<td>Final</td>
</tr>
<tr>
<td>Version number</td>
<td>1.0</td>
</tr>
</tbody>
</table>

#### Scope
All Priority 1A Incidents.

#### Goal
Timely arrival of ambulance response to 1A Incidents

#### Desired outcome
- Ensure timely arrival to patients with life threatening conditions
- Improved survival rate for patients in cardiac arrest

#### Primary point of collection
Operator, Computer Aided Dispatch (CAD) system

#### Data Collection Source/System
Ambulance Service, NSW (ASNSW) Operator, Computer Aided Dispatch (CAD) system.

#### Primary data source for analysis
Ambulance Service, NSW (ASNSW) Operator, Computer Aided Dispatch (CAD) system, Ambulance Intelligence System (AIS) – Qlikview Dashboard.

#### Indicator definition
The time (minutes) of ambulance arrival to 1A incidents at the 50\(^{th}\) percentile.

#### Numerator
- **Numerator definition**
  - The median value (in minutes) of all ambulance arrival to 1A incidents within the reporting period.
  - The time (in minutes) of ambulance arrival to 1A incidents at the 50\(^{th}\) percentile.
- **Numerator source**
  - NSW Ambulance Computer Aided Dispatch System
- **Numerator availability**
  - Available

#### Denominator
- **Denominator definition**
- **Denominator source**
- **Denominator availability**

#### Inclusions
1A incidents where the 1st ambulance arrived at scene.

#### Exclusions
Subsequent ambulance arrival at scene to 1A incidents
All other ambulance priority codes

#### Targets
- **Target**
  - Target: <=10 minutes at 50\(^{th}\) percentile
Not Performing: >12 minutes

Under Performing: >10 minutes and ≤ 12 minutes

**Context**
Ensure timely arrival to patients with life threatening conditions to improve survival rate for patients in cardiac arrest.

**Related Policies/ Programs**

Useable data available from 2012/13 (Note: Major MPDS Grid change)

**Frequency of Reporting**
Monthly

**Time lag to available data**
Immediate.

**Business owners**
NSW Ambulance Service Delivery.

- Contact - Policy: Executive Director, Service Delivery
- Contact - Data: Executive Director, Business Innovation and Planning

**Representation**

- Data type: Numeric
- Form: Number presented in decimal minutes.
- Representational layout: NN.N
- Minimum size: 3
- Maximum size: 4
- Data domain
- Date effective: 2012/2013

**Related National Indicator**
Report on Government Services

http://meteor.aihw.gov.au/content/index.phtml/itemId/401254
**Frequent User Management Program Monitoring** (%)

- Triple zero (000) calls made by the top 20 patients enrolled in the frequent user management program compared to a baseline (% change)

**Shortened Title**: Frequent User Management Program Monitoring

**Service Agreement Type**: Key Performance Indicator

**Framework Strategy**: Strategy 2: Provide World-Class Clinical Care Where Patient Safety is First

**Framework Objective**: 2.5 (Use system performance information to drive reform)

**Status**: Final

**Version number**: 1.0

**Scope**: Top 20 patients enrolled in the Frequent User Management program at June 2016.

**Goal**: To determine whether the interventions delivered as part of the program have been successful in reducing the patients’ calls to 000.

**Desired outcome**: Better clinical outcomes for patients

**Primary point of collection**: eMR billing engine

**Data Collection Source/System**: eMR

**Primary data source for analysis**: NSW Ambulance Finance Directorate

**Indicator definition**: This KPI records the reduction in the number of 000 calls from the Top 20 callers enrolled in the frequent user management program. The actual calls per month are compared to a baseline with the difference being expressed as a percentage and reported monthly.

**Numerator**

- **Numerator definition**: The numerator is the average number of calls for the 20 patients during the 2016/2017 year minus the number of calls each month

- **Numerator source**: eMR billing engine

- **Numerator availability**: Data will be three months in arrears

**Denominator**

- **Denominator definition**: The denominator is the average number of calls for the 20 patients during the 2017/2018 year.

- **Denominator source**: eMR billing engine

- **Denominator availability**: The denominator remains the same throughout the year

**Inclusions**: Patients who meet the NSW Ambulance definition of ‘frequent’ i.e. 10 or more calls in a six month period
**Exclusions**

As per inclusions above

**Targets**

**Target**

50% reduction in calls from the 2015/2016 baseline

- `< 25% = not performing`
- `> 25% and < 50% = underperforming`
- `≥ 50% = performing`

**Context**

Nil

**Related Policies/ Programs**

Nil

**Useable data available from**

July 2017

**Frequency of Reporting**

Monthly

**Time lag to available data**

There will be a three month lag for data to be available for reporting

**Business owners**

NSW Ambulance

Contact - Policy: Manager Clinical Performance, Clinical Services

Contact - Data: Director Mental Health, Clinical Services; Frequent User Management Program Manager, Clinical Services

**Representation**

**Data type**

Numeric

**Form**

Number, presented as a percentage (%)

**Representational layout**

NNN

**Minimum size**

1

**Maximum size**

3

**Data domain**

Refer to above numerator and denominator for calculations.

**Date effective**

July 2016

**Related National Indicator**