2024-25 KPI AND IMPROVEMENT MEASURES DATA SUPPLEMENT PART 1 OF 2

KEY PERFORMANCE INDICATORS

NSW GOVERNMENT | Health

Version – 1.2

July 2024

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

MOH-SystemInformationAndAnalytics@health.nsw.gov.au.

VERSION CONTROL

Date	Indicator No.	Measure	Version Control Change
Health Outcome 1: **Patients and carers have positive experiences and outcomes that matter**			
17/04/2024	KS2301	Overall Patient Experience Index – adult admitted patients (Number)	Change in scope, number of languages, inclusions, exclusions and availability of data date, Data business owner contact and Related National Indicator. Version 1.3
02/11/2023	KS2302	Patient Engagement Index – adult admitted patients (Number)	Change in scope, number of languages, inclusions, exclusions and availability of data date, Data business owner contact and Related National Indicator. Version 1.3
17/04/2024	KS2303	Overall Patient Experience Index – ED patients (Number)	Change in scope, number of languages, inclusions, exclusions and availability of data date, Data business owner contact and Related National Indicator. Version 1.3
02/11/2023	KS2304	Patient Engagement Index – ED patients not admitted to hospital (Number)	Change in scope, number of languages, inclusions, exclusions and availability of data date, Data business owner contact and Related National Indicator. Version 1.3
15/05/2024	KPI2413	Communication and Engagement Index - Aboriginal admitted patient	New KPI
Health Outcome 2: **Safe care is delivered across all settings**			
17/04/2024	KPI2401	Hospital Access Target – Discharged from ED within 4 hours	New KPI
17/04/2024	KPI2402	Hospital Access Target – Admitted to ED Short Stay Unit within 4 Hours	New KPI
17/04/2024	KPI2403	Hospital Access Target – Admitted/Transferred from ED within 6 hours	New KPI
17/04/2024	KPI2404	Hospital Admission Target – ED Extended Stay of No Greater Than 12 hours	New KPI
17/04/2024	KPI2405	Hospital Access Target – Admitted to a Psychiatric Emergency Care Centre (PECC) within 4 hours	New KPI
17/04/2024	KPI2407	Hospital Access Target – ED Extended Stay of No Greater Than 12 hours - Mental Health or Self-harm Related Presentations	New KPI
17/04/2024	KPI2406	Mental Health Inpatient Discharge Performance: Inpatient Discharges from Mental Health Inpatient Care by Midday (%)	New KPI

Date	Indicator No.	Measure	Version Control Change
01/05/2024	KSA202	Emergency Department Extended Stays: Mental Health Presentations staying in ED > 24 hours (number)	KPI removed. Now Improvement Measure.
01/05/2024	KPI22-03	Renal Supportive Care Enrolment: End-Stage Kidney Disease Patient (Number)	KPI removed. Now Improvement Measure.
01/05/2024	SSA105 SSA105a	Emergency department presentations treated within benchmark times (%) - Triage 1: seen within 2 minutes	KPI removed. Renumbered to SSA105a Now Improvement Measure. Continue to be reported in HSP Report
27/05/2024	SSA105b SSA105c	Emergency department presentations treated within benchmark times (%) - Triage 2 & 3	All reference to triage 1 removed.
01/05/2024	SSA101	Emergency Treatment Performance – Admitted (% of patients treated in ≤ 4 hours)	KPI removed. Now Improvement Measure. Continue to be reported in HSP Report
01/05/2024	KSA103a	Elective Surgery Access Performance - Patients treated on time (%): Category 1	KPI removed. Now Improvement Measure. Continue to be reported in HSP Report
01/05/2024	KSA103b	Elective Surgery Access Performance - Patients treated on time (%): Category 2	KPI removed. Now Improvement Measure. Continue to be reported in HSP Report
01/05/2024	KSA103c	Elective Surgery Access Performance - Patients treated on time (%): Category 3	KPI removed. Now Improvement Measure. Continue to be reported in HSP Report
17/05/2024	PI-03	Hospital in the Home: Admitted Activity (%)	Term "Overnight separations" changed to "acute overnight episodes of care" Changes to • Numerator definition. • Denominator definition. • Inclusions. • Context.
01/05/2024	MS2213	Virtual Care Access: Non-admitted services provided through Virtual Care (%)	Revised KPI. Indicator definition updated to include remote client monitoring modality. Addition of service contact code 'X'. Updates to Exclusions, addition of establishment type codes 13.05, 13.06, 13.07, 13.08, 15.03, 16.05, 20.02, 20.03, 20.04, 20.05, 21.04, 21.05, 28.02, 28.03, 28.04, 32.32, 32.42, 32.59, 34.03, 34.04, 34.09, 34.10, 35.02, 36.23, 37.04, 38.07, 39.02, 39.12 and 39.26 Removed 35.01 Revised wording of target. Revision 5.0
29/05/2024	IM22-004b	Incomplete Emergency Department Attendances: Aboriginal Patients who departed	IM22-004b split by "Did not wait" and "Left at own risk" and removed.

Date	Indicator No.	Measure	Version Control Change
	KPI2411 KPI2412	from an ED with a "Did not wait" or "Left at own risk" status (%)	KPI renumbered KPI2411 & KPI2412
11/06/2024 11/07/2024	KQS204 KQS204a	Mental Health Acute Post – Discharge Community Care – Follow up within seven days (%) All persons (KQS204) Aboriginal persons (KQS204a)	Change of title to: Mental Health Acute Post-Discharge: Follow up by Community Care within seven days of discharge ~~from custody~~ Update to title to remove "from custody" KPI Data supplement V1.2 KPI Version 3.1
12/06/2024	KS2140	Third or Fourth Degree Perineal Lacerations (Rate per 10,000 admitted patient service events)	Removal of reference to SE_ADM_MODE_NHDD_CD Targets updated. Version 2.0
12/06/2024	KS2141	Hospital Acquired Neonatal Birth Trauma (Rate per 10,000 admitted patient service events)	Removal of reference to SE_ADM_MODE_NHDD_CD Targets updated. Version 2.0
27/06/2024	KS2128 to KS2141	All HAC KPIs. KS2128, KS2129, KS2130. KS2131, KS2132, KS2133, KS2134, KS2135, KS2136, KS2137, KS2138, KS2139, KS2140 and KS2141	Targets updated. Version 2.0 Target file also available in HIRD at Data Resource ID=49174
12/06/2024	SSQ106, SSQ107	Unplanned Hospital Readmissions; all unplanned admissions within 28 days of separation (%)	Removal of reference to SE_ADM_MODE_NHDD_CD
Health Outcome 3: **People are healthy and well**			
17/04/2024	KS2410	Aboriginal paediatric patients undergoing Otitis Media procedures (number)	KPI removed. Now Improvement Measure.
17/04/2024	PH-015A	Hospital Drug and Alcohol Consultation Liaison - number of consultations (% increase)	KPI removed. Now Improvement Measure. Continue to be reported in HSP Report New target for LHD targets.
17/04/2022	KPI23-001	Children fully immunised at five years of age (%) - Aboriginal children - Non-Aboriginal children	KPI removed. Now Improvement Measure.
17/04/2022	PH-013A	Smoking during pregnancy - At any time (number):Aboriginal women	KPI removed. Now Improvement Measure.
17/04/2022	SPH007	Smoking during pregnancy - At any time (number):Non-Aboriginal women	KPI removed. Now Improvement Measure.
01/05/2024	KPI2414, KPI2415	Pregnant Women Quitting Smoking - by second half of pregnancy (%) – All women giving birth (removed) – Aboriginal women giving birth (new) – Non-Aboriginal women giving birth (new)	KPI DPH_1201 removed (All women giving birth) New KPI2414 Aboriginal women giving birth New KPI2415 Non-Aboriginal women giving birth

Date	Indicator No.	Measure	Version Control Change
			Revised KPI, Update to: title, scope, data collection source, primary data source, definition, numerator, denominator, inclusions, exclusions, targets split by aboriginal and non-aboriginal cohort, useable data available from, frequency of reporting, time lag and business owner
21/05/2024	MS1102	Childhood Obesity: - Children with height/length and weight recorded in inpatient settings (%)	Revised KPI, Updated to wording in: Title, Framework objective, Scope, Goal, Desired outcome, Primary data source for analysis, Indicator definition, Numerator definition, Denominator definition, Denominator source, Inclusions, Exclusions, Targets and Useable data available from.
21/05/2024	PH-014C	Initial Hepatitis C Antiviral Treatment: - Direct acting- by District residents (% Variance from Target)	Revised wording: title, shortened title, scope, indicator definition, numerator definition, denominator definition, inclusions, exclusions, related policies/programs, Data Contact. Revised Targets. Version 2.0
11/06/2024	KF-0061, KF-0062	Sustaining NSW Families Programs	Revised wording
Health Outcome 4: **Our Staff are engaged and well supported**			
18/04/2024	KPI2105	Employment of Aboriginal Health Practitioners (Number)	KPI removed. Now Improvement Measure.
10/04/2024	KS4401	Compensable Workplace Injury - Claims (% of change over rolling 12-month period)	Revised: Numeration definition, Denominator definition, inclusions, Frequency of reporting. Target changed from 0 to 5%
15/05/2024	SSA140	Breast Screening Participation Rates	Updated context and targets.
18/06/2024	SPC111	Workplace Culture - People Matter Survey Culture Index (% variance from previous year)	Revision of targets
18/06/2024	SPC115	Take Action: People Matter Survey take action as a result of the survey – Variation from previous survey (%)	Revision of targets
18/06/2024	KPI21-01	Engagement and Experience – People Matter Survey - Racism experienced by staff - Variation from previous survey (%)	Revision of targets Revision 1.1
Health Outcome 5: **Research and innovation, and digital advances inform service delivery**			
01/05/2024	KPI2410	Concordance of Trials in: Clinical Trial Management System (CTMS) Vs Research Ethics and Governance Information System (REGIS) (%)	New KPI
01/05/2024	KPI21-03	Ethics Application Approvals - By the Human Research Ethics Committee within 90 calendar	KPI removed.

Date	Indicator No.	Measure	Version Control Change
		days - Involving greater than low risk to participants (%)	Now Improvement Measure.
Health Outcome 6: The health system is managed sustainably			
17/04/2024	KPI2408	Purchased Activity Volumes - Variance (%): Total (NWAU)	New KPI
17/04/2024	KPI2409	Purchased Activity Volumes - Variance (%): Total Commonwealth & State NHRA Contributions (NWAU)	New KPI
01/05/2024	AI-001	Purchased Activity Volumes - Variance (%): Acute admitted (NWAU)	KPI removed. Now Improvement Measure. Continue to be reported in HSP Report
01/05/2024	PH-018A	Purchased Activity Volumes - Variance (%): Alcohol and other drug related Acute Admitted (NWAU)	KPI removed. Now Improvement Measure. Continue to be reported in HSP Report
01/05/2024	PH-018B	Purchased Activity Volumes - Variance (%): Alcohol and other drug related Non-admitted (NWAU)	KPI removed. Now Improvement Measure. Continue to be reported in HSP Report
01/05/2024	ED-001	Purchased Activity Volumes - Variance (%): Emergency department (NWAU)	KPI removed. Now Improvement Measure. Continue to be reported in HSP Report
01/05/2024	KS8101	Purchased Activity Volumes - Variance (%): Mental health – Admitted (NWAU)	KPI removed. Now Improvement Measure. Continue to be reported in HSP Report
01/05/2024	MHDA-005	Purchased Activity Volumes - Variance (%): Mental health – Non-admitted (NWAU)	KPI removed. Now Improvement Measure. Continue to be reported in HSP Report
01/05/2024	NA-001	Purchased Activity Volumes - Variance (%): Non-admitted patients (NWAU)	KPI removed. Now Improvement Measure. Continue to be reported in HSP Report
01/05/2024	SA-001	Purchased Activity Volumes - Variance (%): Sub and non-acute services - Admitted (NWAU)	KPI removed. Now Improvement Measure. Continue to be reported in HSP Report
13/06/2024	PD-001	Purchased Activity Volumes – Variance: Public Dental Clinical Service - DWAU (%)	Retain as KPI Target Change
24/04/2024	DSR_7401	Asset maintenance Expenditure as a proportion of asset replacement value (%)	KPI removed. Now Improvement Measure.
24/04/2024	KPI22-01	Capital renewal as a proportion of asset replacement value (%)	KPI removed. Now Improvement Measure.
24/04/2024	KPI23-007	Energy Use Avoided Through Energy Efficiency and Renewable Energy Project Implementation (%)	KPI removed. Now Improvement Measure. Change to annually reported
24/04/2024	KPI23-010	Reducing off-contract spend (%)	KPI removed. Now Improvement Measure.

Date	Indicator No.	Measure	Version Control Change
15/05/2024	KPI23-004	Sustainability Towards 2030: Desflurane Reduction: Number of Vials of Desflurane Purchased as a Percent of All Volatile Anaesthetic Vials Purchased	KPI removed. Now Improvement Measure.
24/04/2024	KPI23-009	Use of Whole of Government and Whole of Health Contracts (%)	KPI removed. Now Improvement Measure.
17/06/2024	KPI23-008	Passenger Vehicle Fleet Optimisation (% Cost Reduction)	Update data representation and business owners
		Document Wide Updates	
18/06/2024	N/A	Term EDW replaced with Enterprise Data Warehouse (EDWARD) - Local Reporting Solution (LRS)	Replaced where appliable

TABLE OF CONTENTS

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 2024-25. 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 2024-25 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 a separate 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 that 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 six Strategic Health Outcomes identified in the NSW Health Strategic Outcome and Business Plan:

1. Patients and carers have positive experiences and outcomes that matter
2. Safe care is delivered across all settings
3. People are healthy and well
4. Our staff are engaged and well supported
5. Research and innovation, and digital advances inform service delivery
6. The health system is managed sustainably

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
X	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 (in Part 2) 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:

- Safety and Quality Framework
- Better Value Care
- Mental Health Reform

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 2024-25 KPI and Improvement Measures data supplement is also located on the NSW Health Information Resource Directory and accessible via the following link:
http://hird.health.nsw.gov.au/hird/view_data_resource_description.cfm?ItemID=49174

KEY PERFORMANCE INDICATORS FOR 2024-25

HEALTH STRATEGIC OUTCOME 1: Patients and carers have positive experiences and outcomes that matter

INDICATOR: KS2301	**Overall Patient Experience Index – adult admitted patients** (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
NSW Health Strategic Outcome	1: Patients and carers have positive experiences and outcomes that matter
Status	Final
Version number	1.3
Scope	Sample of adult patients who are admitted to hospitals in peer groups A1, A3, B1, B2, C1, C2 and hospitals in peer groups D and F if they are located in major cities. Hospitals are classified using the Accessibility and Remoteness Index of Australia (ARIA+), the Australian Bureau of Statistics' measure of remoteness. These hospitals contribute to the LHD total in proportion to the total number of admitted patients for all included hospitals in that LHD.
Goal	Improve patients' experience of care
Desired outcome	Increase LHD results for an index of four patient-reported experience measures (PREMs) on overall patient experience (maximum possible score 10)
Primary point of collection	Postal survey of recent adult admitted patients, with up to two reminders and alternative completion online and by phone (in up to 24 different languages)
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. Each patient's index is 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) • **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.
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 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.
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 and hospitals in peer groups D and F if they are in major cities. • Patients aged 18 years or older. • 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 For full details on exclusion criteria, classification of remoteness using the Accessibility and Remoteness Index of Australia (ARIA+), the Australian Bureau of Statistics' measure of remoteness, and diagnostic/procedure codes used, refer to the *Technical Supplement: Adult Admitted Patient Survey* at: http://www.bhi.nsw.gov.au/nsw_patient_survey_program
Targets	Target score of 8.7 out of 10.0 • Not performing <8.5 • Underperforming ≥8.5 to <8.7 • Performing - organisational score ≥8.7
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 2015 onwards.
Frequency of Reporting	Quarterly reporting at LHD level
Time lag to available data	Six months from the end of each quarter
Business owners	
Contact – Policy	Executive Director, System Purchasing Branch, Ministry of Health
Contact – Data	Director, Data Governance, Management and Analysis, 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, 2022 https://meteor.aihw.gov.au/content/740744

INDICATOR: KS2302	**Patient Engagement Index – adult admitted patients** (Number) 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.
Service Agreement Type	Key Performance Indicator
NSW Health Strategic Outcome	1: Patients and carers have positive experiences and outcomes that matter
Status	Final
Version number	1.3
Scope	Sample of adult patients who are admitted to hospitals in peer groups A1, A3, B1, B2, C1, C2 and hospitals in peer groups D and F if they are located in major cities. These hospitals contribute to the LHD total in proportion to the total number of admitted patients for all included 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 adult admitted patients, with up to two reminders and alternative completion online and by phone (in up to 24 different languages)
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 Engagement Index across all patients with a valid response within the reporting period
Numerator	
Numerator definition	The sum of engagement indices for all patients. Each patient's index is 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 (10); 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 (10); 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 (10); 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, C2 and hospitals in peer groups D and F if they are located in major cities. • Patients aged 18 years or older. • 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

	For full details on exclusion criteria, , classification of remoteness using the Accessibility and Remoteness Index of Australia (ARIA+), the Australian Bureau of Statistics' measure of remoteness, and diagnostic/procedure codes used, refer to the *Technical Supplement: Adult Admitted Patient Survey* at: http://www.bhi.nsw.gov.au/nsw_patient_survey_program
Targets	Target score of 8.7 out of 10.0 • Not performing <8.5 • Underperforming ≥8.5 to <8.7 (non-exclusive) • Performing - organisational score ≥8.7
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.
Related Policies/ Programs	
Useable data available from	Quarterly data is available for January to March.
Frequency of Reporting	Quarterly reporting at LHD level
Time lag to available data	Six months from the end of each quarter
Business owners	
Contact – Policy	Executive Director, System Purchasing Branch, Ministry of Health
Contact – Data	Director, Data Governance, Management and Analysis, 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, 2022 https://meteor.aihw.gov.au/content/740744

INDICATOR: KS2303	**Overall Patient Experience Index – ED patients** (Number) Patient Experience Survey index of emergency department patients of four scored questions on overall rating of care, rating of staff, rating how ED staff worked together, and speaking highly of care to family and friends
Shortened Title	Patient Experience Index – ED patients
Service Agreement Type	Key Performance Indicator
NSW Health Strategic Outcome	1: Patients and carers have positive experiences and outcomes that matter
Status	Final
Version number	1.3
Scope	Sample of patients who attend EDs in hospitals in peer groups A1, A2, A3, B1, B2, C1, C2 and Camden Hospital (peer group D). These hospitals contribute to the LHD total in proportion to the total number of ED patients for all included hospitals in that LHD.
Goal	Improve patients' experience of care
Desired outcome	Increase LHD results for an index of four patient-reported experience measures (PREMs) on overall patient experience (maximum possible score 10)
Primary point of collection	Postal survey of recent ED patients, with up to two reminders and alternative completion online and by phone (in up to 24 different languages)
Data Collection Source/System	NSW Patient Survey Program data
Primary data source for analysis	Weighted responses to Emergency Department 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. Each patient's index is 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 the ED health professionals worked together?** Very good (10); Good (7.5); Neither good nor poor (5); Poor (2.5); Very poor (0) • **Overall, how would you rate the ED health professionals who treated you?**

	Very good (10); Good (7.5); Neither good nor poor (5); Poor (2.5); Very poor (0) • **Overall, how would you rate the care you received while in the ED?** Very good (10); Good (7.5); Neither good nor poor (5); Poor (2.5); Very poor (0) • **If asked about your experience in the ED by friends and family, how would you respond?** I would speak highly of the ED (10); I would neither speak highly nor be critical (5); I would be critical of the ED (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 (admitted to hospital at end of ED visit or not admitted to hospital) 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 four questions (as specified in the list of response options under 'numerator') Data are weighted to represent the age and stay type (admitted to hospital at end of ED visit or not admitted to hospital) 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, A2, A3, B1, B2, C1, C2 and Camden hospital • Valid Australian postal address
Exclusions	For full details on exclusion criteria and diagnostic/procedure codes used, refer to the *Technical Supplement: Emergency Department Patient Survey* at: • http://www.bhi.nsw.gov.au/nsw_patient_survey_program
Targets	Target score of 8.6 out of 10.0 • Not performing <8.4 • Underperforming ≥8.4 to <8.6 • Performing - organisational score ≥8.6
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 July to September 2017 onwards.
Frequency of Reporting	Quarterly reporting at LHD level
Time lag to available data	Six months from the end of each quarter
Business owners	
Contact – Policy	Executive Director, System Purchasing Branch, Ministry of Health
Contact – Data	Director, Data Governance, Management and Analysis, 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	2019
Related National Indicator	For other patient experience indicators, see the National Healthcare Agreement: PI 32 - Patient satisfaction/experience, 2022 https://meteor.aihw.gov.au/content/740744

INDICATOR: KS2304	**Patient Engagement Index – ED patients not admitted to hospital** (Number) Patient Experience Survey index of emergency department patients of seven scored questions on Information provision, involvement in decisions on care and discharge, and continuity of care
Shortened Title	Patient Engagement Index – ED patients
Service Agreement Type	Key Performance Indicator
NSW Health Strategic Outcome	1: Patients and carers have positive experiences and outcomes that matter
Status	Final
Version number	1.3
Scope	Sample of patients who attend EDs in hospitals in peer groups A1, A2, A3, B1, B2, C1,C2 and Camden hospital (peer group D). These hospitals contribute to the LHD total in proportion to the total number of ED patients for all included hospitals in that LHD.
Goal	Improve patients' experience of care
Desired outcome	Increase LHD results for an index of seven patient-reported experience measures (PREMs) on provision of patient-centred care (maximum possible score 10)
Primary point of collection	Postal survey of recent ED patients, with up to two reminders and alternative completion online and by phone (in up to 24 different languages)
Data Collection Source/System	NSW Patient Survey Program data
Primary data source for analysis	Weighted responses to Emergency Department Patient Survey
Indicator definition	The weighted average Patient Engagement Index across all ED patients not admitted to hospital at the end of their ED visit, with a valid response within the reporting period
Numerator	
Numerator definition	The sum of engagement indices for all patients. Each patient's index is calculated using the sum of scores of the following seven questions divided by number of questions where a valid response was recorded for a patient: • **During your ED visit, how much information about your condition or treatment was given to you?** Not enough (0); The right amount (10); Too much (5) • **Were you involved, as much as you wanted to be, in decisions about your care and treatment?** Yes, definitely (10); Yes, to some extent (5); No (0)

- **Did you feel involved in decisions about your discharge from the ED?**
  Yes, definitely (10); Yes, to some extent (5); No (0)
- **Thinking about when you left the ED, were you given enough information about how to manage your care at home?**
  Yes, definitely (10); Yes, to some extent (5); No, I was not given enough information (0)
- **Did ED staff take your family and home situation into account when planning your discharge?**
  Yes, definitely (10); Yes, to some extent (5); No, staff did not take my situation into account (0)
- **Did ED staff tell you who to contact if you were worried about your condition or treatment after you left hospital?**
  Yes (10); No (0)
- **Thinking about your illness or treatment, did an ED health professional tell you about what signs or symptoms to watch out for after you went home?**
  Yes, completely (10); Yes, to some extent (5); No (0).

Only those patients who are not admitted to hospital at the end of their ED visit are included in the numerator, as defined by the survey question "what happened at the end of your ED visit?" – respondents who answered "I went home or went to stay with a friend, relative or elsewhere" are included in the numerator.

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

Data are weighted to represent the age and stay type (admitted to hospital at end of ED visit or not admitted to hospital) 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 seven questions (as specified in the list of response options under 'numerator'). Only those patients who are not admitted to hospital at the end of their ED visit are included in the denominator, as defined by the survey question "what happened at the end of your ED visit?" – respondents who answered "I went home or went to stay with a friend, relative or elsewhere" are included in the denominator. Data are weighted to represent the age and stay type (admitted to hospital at end of ED visit or not admitted to hospital) 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, A2, A3, B1, B2, C1,C2 and Camden hospital (peer group D). • Valid Australian postal address

Exclusions	• Deceased patients
	• Did not wait for treatment or left before treatment
	• Mode of separation is missing or unknown
	• Aged 18 years or above in A2 hospitals or less than 18 years in A3 hospitals
	• Patients who visited ED for COVID-19 test or those having a sensitive diagnosis:
	  ○ Intentional self-harmed
	  ○ Suicidal ideation
	  ○ Maltreatment syndromes/abuse
	  ○ Experienced a stillbirth [P96.9]
	  ○ Experienced pregnancy with an abortive outcome
	  ○ Received contraceptive management
	  ○ Admitted for a termination of pregnancy procedure
	  ○
	For full details on exclusion criteria and diagnostic/procedure codes used, refer to the *Technical Supplement: Emergency Department Patient Survey* at:
	• http://www.bhi.nsw.gov.au/nsw_patient_survey_program

Targets	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 facilitate the involvement and empowerment of patients and, where appropriate, partner with patients to achieve the best possible experiences of care.
Related Policies/ Programs	
Useable data available from	Quarterly data is available for July to September 2017 onwards.
Frequency of Reporting	Quarterly reporting at LHD level
Time lag to available data	Six months from the end of each quarter
Business owners	
Contact – Policy	Executive Director, System Purchasing Branch, Ministry of Health
Contact – Data	Director, Data Governance, Management and Analysis, 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	2019
Related National Indicator		For other patient experience indicators, see the National Healthcare Agreement: PI 32 - Patient satisfaction/experience, 2022 https://meteor.aihw.gov.au/content/740744

INDICATOR: KPI2413 **Previous IDs:**	**Communication and Engagement Experience Index** – Aboriginal Adult Admitted Patients Patient Experience Survey index of Aboriginal adult admitted patients of eight scored questions on communication and engagement.
Shortened Title	Aboriginal Patient Experience Index
Service Agreement Type	Key Performance Indicator
Framework Strategy	1: Patients and carers have positive experiences and outcomes that matter
Framework Objective	1.1 Partner with patients and communities to make decisions about their own care; 1.2 Bring kindness and compassion into the delivery of personalised and culturally safe care; 1.3 Drive greater health literacy and access to information
Status	Final
Version number	1.0
Scope	Census sample of Aboriginal adult patients who are admitted to hospitals in peer groups A1, A3, B1, B2, C1, C2 and hospitals in peer groups D and F if they are located in major cities, except for hospitals in HNELHD where there is an oversample of Aboriginal adult patients. Hospitals are classified using the Accessibility and Remoteness Index of Australia (ARIA+), the Australian Bureau of Statistics' measure of remoteness. These hospitals contribute to the LHD total in proportion to the total number of admitted patients for all included hospitals in that LHD.
Goal	Improve Aboriginal patients' experience of care
Desired outcome	Increase LHD results for an index of eight patient-reported experience measures (PREMs) on communication and engagement for Aboriginal patient experience (maximum possible score 10)
Primary point of collection	Postal survey of Aboriginal adult admitted patients, with up to two reminders and alternative completion online and by phone (in up to 24 different languages)
Data Collection Source/System	NSW Patient Survey Program data
Primary data source for analysis	Weighted responses of patients who self-identified as Aboriginal and/or Torres Strait Islander as part of the Adult Admitted Patient Survey
Indicator definition	The weighted average Aboriginal patient experience index across all Aboriginal patients with a valid response within the reporting period.

Numerator

Numerator definition	The sum of patient experience indices for all Aboriginal patients. Each index is calculated using the sum of scores to each of the eight following questions divided by number of questions where a valid response was recorded for a patient: • **Did health professionals explain what would happen during your tests, operations or procedures in a way you could understand?** Yes, always (10); Yes, sometimes (5); No (0) • **Did health professionals explain the results or outcome of your tests, operations or procedures in a way you could understand?** Yes, always (10); Yes, sometimes (5); No (0) • **Did the health professionals explain things in a way you could understand?** Yes, always (10); Yes, sometimes (5); No (0) • **Were you involved, as much as you wanted to be, in decisions about your care and treatment?** Yes, definitely (10); Yes, to some extent (5); No (0) • **Did the health professionals listen carefully to any views and concerns you had?** Yes, definitely (10); Yes, to some extent (5); No (0). • **Did you have enough time to discuss your health or medical problem with the health professionals?** Yes, definitely (10); Yes, to some extent (5); No (0) • **Did the health professionals give you the support you needed to help with any worries or fears related to your care and treatment?** Yes, definitely (10); Yes, to some extent (5); No (0) • **When the health professionals spoke about your care in front of you, were you included in the conversation?** Yes, definitely (10); Yes, to some extent (5); No (0) Missing values excluded from calculation. Respondent must have at least one valid response for the eight questions. Data are weighted to represent the age group,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 who identified as Aboriginal and/or Torres Strait Islander using administrative data with at least one valid response for the

	eight questions (as specified in the list of response options under 'numerator'). Data are weighted to represent the age-group and stay type (overnight or same day) profile of patients at each hospital.
Denominator source	NSW Patient Survey Program data
Denominator availability	Available
Inclusions	Aboriginal patients surveyed during the target period. • Facilities in peer groups A1, A3, B1, B2, C1,C2 and hospitals in peer groups D and F if they are located in major cities • Patients aged 18 years or older • 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 • Same day haemodialysis patients • Admitted patients treated in a mental health setting • Maltreatment codes (incl. sexual and physical abuse) • Patients that have died For full details on exclusion criteria, classification of remoteness using the Accessibility and Remoteness Index of Australia (ARIA+), the Australian Bureau of Statistics' measure of remoteness, and diagnostic/procedure codes used, refer to the *Technical Supplement: Adult Admitted Patient Survey* at: http://www.bhi.nsw.gov.au/nsw_patient_survey_program
Targets	
Target	Target score of 8.0 out of 10.0 • Not performing <7.8 • Underperforming ≥7.8 to <8.0 • Performing - ≥ 8.0
Context	Health services should not only be of good clinical quality but should also provide a positive experience for the Aboriginal patients.
Related Policies/ Programs	
Useable data available from	Six monthly data is available for January to June 2019 onwards.

Frequency of Reporting	Biennially (six monthly data) at the LHD level for those with sufficient respondents, annually for those with lower respondent numbers.
Time lag to available data	Six months from the end of the measurement period
Business owners	Centre for Aboriginal Health
Contact - Policy	Executive Director, Centre for Aboriginal Health
Contact - Data	Director, Data Governance, Management and Analysis and Management, Bureau of Health Information (BHI-enq@health.nsw.gov.au)
Representation	
Data type	Numeric
Form	Number
Representational layout	N.NN
Minimum size	3
Maximum size	4
Data domain	
Date effective	2024
Related National Indicator	For other patient experience indicators, see the National Healthcare Agreement: PI 32 - Patient satisfaction/experience, 2022 https://meteor.aihw.gov.au/content/740744

INDICATOR: KS3202	**Mental Health Consumer Experience**: Mental Health consumers with a score of Very Good or Excellent (%)
Shortened Title	Mental Health Consumer Experience
Service Agreement Type	Key Performance Indicator
NSW Health Strategic Outcome	1: Patients and carers have positive experiences and outcomes that matter
Status	Final
Version number	1.21
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/SHNs 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/SHN 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 * (Numerator 1/Denominator 1 + Numerator 2 /Denominator 2)/2.
Numerator	
Numerator definition	1. The number of valid YES questionnaires with overall Experience score in the Very Good to Excellent range (≥ 8/10) in inpatient settings 2. The number of valid YES questionnaires with overall Experience score in the Very Good to Excellent range (≥ 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.
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. • JHMFHN services
Targets	• Performing: ≥ 80% • Underperforming: ≥ 70% and <80% • Not performing: <70%
Related Policies/ Programs	
Useable data available from	July 2015
Frequency of Reporting	Quarterly
Time lag to available data	One quarter
Business owners	System Information and Analytics Branch, Ministry of Health
Contact - Policy	Executive Director, Mental Health Branch
Contact - Data	Director, InforMH, System Information and Analytics Branch
Representation	
Data type	Numeric
Form	Number, expressed as a percentage
Representational layout	NN.N
Minimum size	1
Maximum size	3
Data domain	
Date effective	1 July 2018
Related National Indicator	

HEALTH STRATEGIC OUTCOME 2: Safe care is delivered across all settings

INDICATOR: KPI2401	**Hospital Access Target –** Discharged from ED within 4 hours (%)
Shortened Title	Hospital access target - Discharged
Service Agreement Type	Key Performance Indicator (KPI)
NSW Health Strategic Outcome	1: Patients and carers have positive experiences and outcomes that matter.
Status	Final
Version number	1.0
Scope	All emergency department presentations for patients who have left the ED without being admitted or transferred to other hospitals, with ED departure date/ time falling in the reporting period.
Goal	To improve access to public hospital services
Desired outcome	• Improve patient satisfaction • Improve efficiency of Emergency Department services
Primary point of collection	Emergency Department Information System
Data Collection Source/System	Emergency Department Data Collection
Primary data source for analysis	Enterprise Data Warehouse (EDWARD) - Local Reporting Solution (LRS) CERTIFIED.v_FACT_ED_SE (or equivalent data source)
Indicator definition	The percentage of all ED presentations of patients, who departed the ED , who were not admitted to a ward of the hospital (including an EDSSU), who were not transferred to another hospital, and whose ED length of stay is ≤ 4 hours. ED length of stay is calculated by subtracting presentation date/time from ED departure ready date/time, where: • **Presentation date/time in the ED** is the date and time of the first recorded contact with an emergency department staff member (EDW: the earlier of CL_ARRIVAL_DTTM and SUB_EVNT_FIRST_TRIAGE_DTTM) and; • **Departure ready date/time** is the earliest of departure ready date/time (SUB_EVNT_FIRST_PT_DEPART_READY_DTTM) and actual departure date/time (CL_DEPART_DTTM) for non-admitted ED patients.
Numerator	
Numerator definition	The total number of ED presentations of all patients, who are not admitted to a ward, to an EDSSU, to ICU or to theatre from ED and are

	not transferred to another hospital from ED, and who have an ED length of stay from presentation time to departure ready date/time of ≤4 hours.
Numerator source	EDWARD (Emergency Department Data Collection)
Numerator availability	Available
Denominator	
Denominator definition	The total number of emergency department presentations of patients who were not admitted to the hospital from ED and were not transferred to another hospital from ED, where the CL_DEPART_DTTM falls within the reporting period.
Denominator source	EDWARD (Emergency Department Data Collection)
Denominator availability	Available
Inclusions	All patients that departed the ED during the reporting period without being admitted to hospital (including EDSSU), to ICU or to theatre from ED, and are not transferred to another hospital, with the following ED mode of separation codes (ED_SEPARATION_MODE_CD): 01.01- Expired: formally admitted and discharged within emergency department 02- Departed, not further defined 02.01 – Departed, treatment completed 02.03 – Departed, did not wait 02.04 – Departed, left at own risk 02.05 – Departed, for other clinical service location 03- Dead on both arrival and departure 04- Dead in emergency department
Exclusions	• Records where total time in ED is missing, less than zero or greater than 99,998 minutes • ED_VIS_TYPE_CD of '06', '12' or '13', (ED presentation without ED workup, Telehealth presentation, current admitted patient presentation). ED_SEPR_MODE_CD = '98' i.e. Data error – record pending deletion.02.02 – Departed, Transferred to another hospital • Duplicate record with same facility code, MRN, arrival date, arrival time and birth date (EDW: OSP_CBK, CL_ID, CL_ARRIVAL_DTTM and CL_DOB)
Targets	Target 80% • Performing: ≥=80% • Under Performing: ≥70% and <80% • Not Performing: <70%

Context	Improved public patient access to emergency department (ED) services by improving efficiency and capacity in public hospitals is a priority. Australasian College for Emergency Medicine (ACEM) has set Hospital Access Target (HAT) measures for ED services. NSW Health has approved four corresponding HAT indicators as KPIs to be included in the 2024/25 Service Agreements.
Related Policies/ Programs	• Intergovernmental Agreement on Federal Financial Relations • Whole of Health Program • Centre for Health Care Redesign
Useable data available from	July 2023
Frequency of Reporting	Monthly
Time lag to available data	48 hours
Business owners	
Contact - Policy	Executive Director, System Performance Support
Contact - Data	Executive Director, System Information and Analytics Branch
Representation	
Data type	Numeric
Form	Percentage (%)
Representational layout	NNN.N
Minimum size	3
Maximum size	5
Data domain	
Date effective	1 July 2024
Related National Indicator	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, 2020 Meteor ID: 716695 https://meteor.aihw.gov.au/content/index.phtml/itemId/716695

INDICATOR: KPI2403	**Hospital Access Target –** Admitted/transferred from ED within 6 hours **(%)**
Shortened Title	Hospital access target - Admitted
Service Agreement Type	Key Performance Indicator (KPI)
NSW Health Strategic Outcome	1: Patients and carers have positive experiences and outcomes that matter.
Status	Final
Version number	1.0
Scope	All emergency department presentations admitted to a ward (excluding admission to emergency department short stay unit (EDSSU)), to ICU (Intensive Care Unit), or to theatre from ED, and ED presentations transferred to another hospitals, for which departure date and time falls in the reporting period.
Goal	To improve access to public hospital services
Desired outcome	Improve patient satisfaction Improve efficiency of Emergency Department services
Primary point of collection	Emergency Department Information System
Data Collection Source/System	Emergency Department Data Collection
Primary data source for analysis	Enterprise Data Warehouse (EDWARD) - Local Reporting Solution (LRS) CERTIFIED.v_FACT_ED_SE (or equivalent data source), joined with related hospital admission records
Indicator definition	• The percentage of ED presentations of patients who were subsequently admitted to the same hospital (excluding an EDSSU), or who were transferred to another hospital, and whose ED length of stay is ≤ 6 hours. • The identification of ED presentations admitted to EDSSU needs a linked hospital admission for the same patient in the same hospital with a bed type SSU (code '59') immediately after the ED presentation. And ED presentations admitted to EDSSU should be excluded from the ED presentation set identified using the in-scope mode of separation codes to form the denominator scope for this indicator. • ED length of stay for ED presentations of patients admitted is calculated by subtracting presentation date/time from ED departure date/time, or for patients transferred to another hospital by subtracting presentation date/time from ED departure ready date/time, where: • Presentation date/time in the ED is the date and time 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 (EDW: the earlier of CL_ARRIVAL_DTTM or SUB_EVNT_FIRST_TRIAGE_DTTM) and; • The ED end date time point uses either actual departure date/time or departure ready date time according to the following business rules: • If the patient is later admitted to this hospital (either short-stay unit, hospital-in-the-home or non-emergency department hospital ward), record the date and time the patient leaves the emergency department to go to the admitted patient facility. For NSW, this corresponds to EDW Mode of Separation codes '01', '01.03', '01.04' ,'01.05'), and is calculated using the "Actual Departure Date and Time" field in source systems (CL_DEPART_DTTM); • if the ED patient was transferred to another hospital (ED mode of separation code '02.02'), then the earliest of departure ready date/time (SUB_EVNT_FIRST_PT_DEPART_READY_DTTM) or the actual departure date/time (CL_DEPART_DTTM) will be used as the ED presentation end date and time for the calculation of the ED length of stay.
Numerator	
Numerator definition	The number of all ED presentations of patients, whose CL_DEPART_DTTM falls within the reporting period, and who are admitted to a ward (excluding EDSSU), to ICU, or to operating theatre from ED, or are transferred to another hospital, and who have an ED length of stay of ≤6 hours.
Numerator source	EDWARD (Emergency Department Data Collection)
Numerator availability	Data to report on this indicator is not available due to the need to exclude ED presentations admitted to EDSSU and the data to identify ED admissions to EDSSU is not readily available in the EDW data. Data development is needed.
Denominator	
Denominator definition	The total number of ED presentations of patients, whose ED departure date/time CL_DEPART_DTTM falls within the reporting period, and who are admitted to a hospital ward (excluding EDSSU), to ICU, or to operating theatre from ED, or are transferred to another hospital.
Denominator source	EDWARD (Emergency Department Data Collection)
Denominator availability	Data to report on this indicator is not available due to the need to exclude ED presentations admitted to EDSSU and the data to identify ED presentations admitted to EDSSU is not readily available in the EDW data. Data development is needed.
Inclusions	All ED presentations of patients with CL_DEPART_DTTM during the reporting period.

	Only ED presentation records where "Presentation date/time" (i.e. triage or arrival date/time) and actual Departure date/time are present The following EDW Emergency Department Modes of Separation values are included: 01 - Formally admitted, not further defined 01.02 – Expired: Formally admitted then transferred to other hospital 01.03 – Formally admitted to admitted patient ward, not elsewhere classified. 01.04- formally admitted to operating theatre suite 01.05 – formally admitted to admitted patient critical care unit 02.02 – Departed, transferred to another hospital.
Exclusions	• Records where total time in ED is missing, less than zero or greater than 99,998 minutes • ED_VIS_TYPE_CD of '06', '12' or '13' (ED presentation without ED workup, Telehealth presentation, current admitted patient presentation). • ED_SEPR_MODE_CD = '98', i.e. Data error – record pending deletion. • Duplicate with same facility code, MRN, arrival date, arrival time and birth date (EDW: OSP_CBK, CL_ID, CL_ARRIVAL_DTTM and CL_DOB) • ED presentations admitted to EDSSU identified using their linked AP sub service event with a bed type '59'.
Targets	Target 80% • Performing: ≥=80% • Under Performing: ≥70% and <80% • Not Performing: <70%
Context	Improved public patient access to emergency department (ED) services by improving efficiency and capacity in public hospitals is a priority. Australasian College for Emergency Medicine (ACEM) has set the Hospital Access Target (HAT) measures for ED services. NSW Health has approved four corresponding HAT indicators as KPIs to be included in the 2024/25 Service Agreements.
Related Policies/ Programs	• Intergovernmental Agreement on Federal Financial Relations • Whole of Health Program • Centre for Health Care Redesign
Useable data available from	1 July 2023
Frequency of Reporting	Monthly
Time lag to available data	48 hours

Business owners	
Contact - Policy	Executive Director, System Performance Support
Contact - Data	Executive Director, System Information and Analytics Branch
Representation	
Data type	Numeric
Form	Percentage (%)
Representational layout	NNN.N
Minimum size	3
Maximum size	5
Data domain	
Date effective	1 July 2024
Related National Indicator	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, 2020. Meteor ID: 716695 https://meteor.aihw.gov.au/content/index.phtml/itemId/716695

INDICATOR: KPI2402	**Hospital Access Target –** Admitted to ED Short Stay Unit (EDSSU) within 4 hours (%)
Shortened Title	ED to EDSSU Admissions
Service Agreement Type	Key Performance Indicator (KPI)
NSW Health Strategic Outcome	1: Patients and carers have positive experiences and outcomes that matter.
Status	Final
Version number	1.0
Scope	All emergency department presentations admitted to an emergency department short stay unit (EDSSU) from ED, where ED departure date time falls in the reporting period.
Goal	To improve access to public hospital services
Desired outcome	• Improve patient satisfaction • Improve efficiency of Emergency Department services
Primary point of collection	Emergency Department Information System
Data Collection Source/System	Emergency Department Data Collection
Primary data source for analysis	Enterprise Data Warehouse (EDWARD) - Local Reporting Solution (LRS) CERTIFIED.v_FACT_ED_SE (or equivalent data), joined with corresponding admitted patient data for the same patient in the same hospital.
Indicator definition	The percentage of ED patients who were subsequently admitted to a short stay unit (EDSSU), whose ED length of stay is ≤ 4 hours. Admission from ED to EDSSU is identified using the ED mode of separation codes and a linked hospital admission for the same patient in the same hospital with a bed type for EDSSU (code '59') immediately after the ED presentation: ED presentations with mode of separation code of either: 01- Formally admitted, not further defined 01.03 – Formally admitted to admitted patient ward, not elsewhere classified. ED admissions to SSU are identified by linking an admitted ED presentations with admitted patient records for the same patient in the same hospital, with a bed type 59 in the AP sub service event immediately following the ED presentation. 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 date and time 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 (EDW: the earlier of CL_ARRIVAL_DTTM or SUB_EVNT_FIRST_TRIAGE_DTTM) and; • **Departure date/time** is measured using the following business rules: If the patient is later admitted to this hospital (either short-stay unit, hospital-in-the-home or non-emergency department hospital ward), record the date and time the patient leaves the emergency department to go to the admitted patient facility. For NSW, this corresponds to EDW Mode of Separation codes '01', '01.03', '01.04', '01.05', and is calculated using the "Actual Departure Date and Time" field in source systems (CL_DEPART_DTTM). If the recorded actual ED departure date/time is after the start date/time of the EDSSU admitted to (due to data quality), then use date/time of the EDSSU.
Numerator	
Numerator definition	The number of all ED presentations, where the departure date and time (CL_DEPART_DTTM) falls within the reporting period, and who are admitted to a short stay unit (EDSSU), and with ED length of stay from presentation date and time to actual departure date and time of ≤4 hours.
Numerator source	EDW (Emergency Department Data Collection)
Numerator availability	Data to report on this HAT EDSSU KPI is not readily available yet, and data development is needed to link ED and Admitted patient records in EDWARD
Denominator	
Denominator definition	The total number of emergency department presentations, where CL_DEPART_DTTM falls within the reporting period, and who are admitted to a short stay unit (EDSSU)
Denominator source	EDW (Emergency Department Data Collection linked to APDC)
Denominator availability	Data to report on this HAT EDSSU KPI is not readily available yet, and data development is needed.

Inclusions	• Only records where "Presentation date and time" (i.e. triage or arrival date and time) and actual Departure date/time are present.
	• The following EDW Emergency Department Modes of Separation values are included in calculation:
	  ○ 01 - Formally admitted, not further defined
	  ○ 01.03 - Formally admitted to admitted patient ward, not elsewhere classified
	• The above identified ED presentations need to be further restricted to ED presentations admitted to EDSSU indicated by bed type 59 in related admitted sub events of the episode of care in hospital immediately after the ED presentation.

Exclusions	• Records where total time in ED is missing, less than zero or greater than 99,998 minutes • ED_VIS_TYPE_CD of '06', '12' or '13', (ED presentation without ED workup, Telehealth presentation, current admitted patient presentation). • ED_SEPR_MODE_CD = '98', i.e. Data error – record pending deletion. • Duplicate with same facility, MRN, arrival date, arrival time and birth date (EDW: OSP_CBK, CL_ID, CL_ARRIVAL_DTTM and CL_DOB) • FWLHD
Targets	Target 60% • Performing: ≥60% • Under Performing: ≥55% and <60% • Not Performing: <55%
Context	Improved public patient access to emergency department (ED) services by improving efficiency and capacity in public hospitals. Australasian College for Emergency Medicine (ACEM) set Hospital Access Target (HAT) measures for ED services. NSW Health has approved four corresponding HAT indicators as KPIs to be included in the 2024/25 Service Agreements.
Related Policies/ Programs	• Intergovernmental Agreement on Federal Financial Relations • Whole of Health Program • Centre for Health Care Redesign
Useable data available from	1 July 2023
Frequency of Reporting	Monthly
Time lag to available data	48 hours
Business owners	
Contact - Policy	Executive Director, System Performance Support
Contact - Data	Executive Director, System Information and Analytics Branch
Representation	
Data type	Numeric
Form	Percentage (%)
Representational layout	NNN.N
Minimum size	3

Maximum size	5
Data domain	
Date effective	1 July 2024
Related National Indicator	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, 2020 Meteor ID: 716695 https://meteor.aihw.gov.au/content/index.phtml/itemId/716695

INDICATOR: KPI2405	**Hospital Access Target –** Admitted to a Psychiatric Emergency Care Centre (PECC) within 4 hours (%)
Shortened Title	PECC Admissions
Service Agreement Type	Key Performance Indicator (KPI)
NSW Health Strategic Outcome	1: Patients and carers have positive experiences and outcomes that matter.
Status	Final
Version number	1.0
Scope	All emergency presentations admitted to a Psychiatric Emergency Care Centre (PECC) for observations, of which departure date time falls in the reporting period.
Goal	To improve access to public hospital services
Desired outcome	• Improve patient satisfaction • Improve efficiency of Emergency Department services
Primary point of collection	Emergency Department Information System
Data Collection Source/System	Emergency Department Data Collection
Primary data source for analysis	EDWARD Emergency Department data (CERTIFIED.v_FACT_ED_SE or equivalent data), joined with corresponding admitted data for the same patient in the same hospital.
Indicator definition	The percentage of ED patients who were subsequently admitted to a Psychiatric Emergency Care Centre, whose clinical care in the ED has ceased because of their physically leaving the ED, and whose ED stay length is ≤ 4 hours. ED stay length is calculated as subtracting presentation date/time from ED physical departure date/time, where: Admission from ED to PECC is identified using the ED mode of separation codes (ED_MOS_CD) and a linked hospital admission for the same patient in the same hospital. This methodology has not been validated to date. ED presentations with mode of separation code of either: 02- Formally admitted, not further defined. 01.03 – Formally admitted to admitted patient ward, not elsewhere classified. 01.05 – formally admitted to admitted patient critical care unit

	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 (EDW: the earlier of CL_ARRIVAL_DTTM or SUB_EVNT_FIRST_TRIAGE_DTTM) and; • **Departure date/time** is measured using the following business rules: If the patient is later admitted to this hospital (either short-stay unit, hospital-in-the-home or non-emergency department hospital ward), record the time the patient leaves the emergency department to go to the PECC. For NSW, this corresponds to EDW Mode of Separation codes '01', '01.03', '01.04' ,'01.05', and is calculated using the "Actual Departure Date and Time" field in source systems (CL_DEPART_DTTM). **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. When patient is admitted from ED to a PECC, the PECC stay should not be recorded as part of the ED presentation. ED presentation departure date time should be the date time when the patient complete ED treatment before starting the PECC admission.
Numerator	
Numerator definition	All patients, whose CL_DEPART_DTTM falls within the reporting period, and who have a length of stay from presentation time to actual departure time of no longer than 4 hours, and who **are** admitted to a PECC unit.
Numerator source	EDWARD (Emergency Department Data Collection)
Numerator availability	Data to report on this KPI is not readily available yet, and data development is needed. PECC units will be defined using a ward table maintained by InforMH.
Denominator	
Denominator definition	The total number of emergency department presentations, which CL_DEPART_DTTM falls within the reporting period, and patients who **are** admitted to a PECC.
Denominator source	EDWARD (Emergency Department Data Collection linked to APDC)
Denominator availability	Data to report on this HAT PECC KPI is not readily available yet, and data development is needed.

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 EDW Emergency Department Modes of Separation values are included in calculation:
	  ○ 01 - Formally admitted, not further defined
	  ○ 01.03 - Formally admitted to admitted patient ward, not elsewhere classified
	  ○ 01.05 - Formally admitted to admitted patient critical care unit
	• The above identified ED presentations need to be further restricted to ED presentations admitted to PECC.
	• Includes: CCLHD, HNELHD, ISLHD, NBMLHD, NSLHD, SESLHD, SLHD, SWSLHD and WSLHD

Exclusions	• Records where total time in ED is missing, less than zero or greater than 99,998 minutes • ED_VIS_TYPE_CD of '06', '12' or '13', i.e. ED presentation without ED workup, Telehealth presentation, current admitted patient presentation. • ED_SEPR_MODE_CD = '98' i.e. Data error – record pending deletion. • Duplicate with same facility, MRN, arrival date, arrival time and birth date (EDW: OSP_CBK, CL_ID, CL_ARRIVAL_DTTM and CL_DOB)
Targets	Target: 60% • Performing: ≥=60% • Under Performing: ≥55% and <60% • Not Performing: <55%
Context	Improved public patient access to emergency department (ED) services by improving efficiency and capacity in public hospitals. ACEM developed a new set of Hospital Access Target (HAT) measures in 2023 for ED services. NSW Health has approved four corresponding HAT indicators as KPIs to be included in the 2024/25 Service Agreements.
Related Policies/ Programs	• Intergovernmental Agreement on Federal Financial Relations • Whole of Health Program • Centre for Health Care Redesign

Useable data available from	
Frequency of Reporting	Monthly
Time lag to available data	
Business owners	
Contact - Policy	Executive Director, System Performance Support
Contact - Data	Executive Director, System Information and Analytics Branch
Representation	
Data type	Numeric
Form	Percentage (%)
Representational layout	NNN.N
Minimum size	3
Maximum size	5
Data domain	
Date effective	1 July 2024
Related National Indicator	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, 2020 Meteor ID: 716695 https://meteor.aihw.gov.au/content/index.phtml/itemId/716695 National Health Performance Authority, Hospital Performance: Waiting times for emergency hospital care: Percentage completed within four hours, 2014 Meteor ID: 558277 (Retired 01/07/2016) http://meteor.aihw.gov.au/content/index.phtml/itemId/558277

INDICATOR: KPI2404	**Hospital Access Target -** ED extended stay of no greater than 12 hours (%)
Shortened Title	ED Extended Stays – 12 hours
Service Agreement Type	Key Performance Indicator.
NSW Health Strategic Outcome	1. Patients and carers have positive experiences and outcomes that matter.
Status	Final
Version number	1.0
Scope	All emergency department presentations, including admitted, non-admitted and those transferred to another hospital from ED, where the departure date/time falls within the reporting period
Goal	To improve access to services within the Emergency Departments and other admitted patient areas
Desired outcome	• Improve patient satisfaction • Improve efficiency of Emergency Department services
Primary point of collection	Emergency Department Information System
Data Collection Source/System	Emergency Department Data Collection
Primary data source for analysis	Enterprise Data Warehouse (EDWARD) - Local Reporting Solution (LRS) CERTIFIED.FACT_ED_SE (or equivalent data source)
Indicator definition	The percentage of ED presentations of patients whose ED length of stay was ≤12 hours, measured from presentation date/time to departure date/time where: • **Presentation date/time in the ED** is the date and time of the first recorded contact with an emergency department staff member. (EDW: the earlier of CL_ARRIVAL_DTTM or SUB_EVNT_FIRST_TRIAGE_DTTM) and • **Departure date/time** is the earliest of departure ready date/time (SUB_EVNT_FIRST_PT_DEPART_READY_DTTM) or actual departure date/time (CL_DEPART_DTTM) for non-admitted patients with a ED mode of separation codes (ED_SEPARATION_MODE_CD) of either: 01.01- Expired: formally admitted and discharged within emergency department 02- Departed, not further defined 02.01 – Departed, treatment completed 02.02 – Departed, transferred to another hospital 02.03 – Departed, did not wait 02.04 – Departed, left at own risk 02.05 – Departed, for other clinical service location 03- Dead on both arrival and departure

	04- Dead in emergency department; Otherwise, it is the actual departure date/time (CL_DEPART_DTTM).
Numerator	
Numerator definition	The number of ED presentations with ED length of stay ≤12 hours, where the ED departure date/time CL_DEPART_DTTM falls within the reporting period.
Numerator source	EDWARD (Emergency Department Data Collection)
Numerator availability	Available
Denominator	
Denominator definition	All ED presentations where the CL_DEPART_DTTM falls within the reporting period.
Denominator source	EDWARD (Emergency Department Data Collection)
Denominator availability	Available
Inclusions	All ED presentations where the CL_DEPART_DTTM falls within the reporting period.
Exclusions	• Records where total time in ED is missing, less than zero or greater than 99,998 minutes. • ED_VIS_TYPE_CD of '06', '12' or '13', i.e. ED presentation without ED workup, Telehealth presentation, current admitted patient presentation. • ED_SEPR_MODE_CD = '98' i.e. Data error – record pending deletion. • Duplicate with same facility, MRN, arrival date, arrival time and birth date (EDW: OSP_CBK, CL_ID, CL_ARRIVAL_DTTM and CL_DOB)
Targets	Target 95% • Performing: ≥=95% • Under Performing: ≥85% and <95% • Not Performing: <85% .
Context	Timely admission to a hospital bed, for those emergency department patients who require inpatient treatment, and timely treatment for all patients contributes to patient comfort and improves outcomes and the availability of Emergency Department services for other patients.

Related Policies/ Programs	Whole of Health Program
Useable data available from	July 2023
Frequency of Reporting	Monthly
Time lag to available data	48 hours.
Business owners	
Contact - Policy	Executive Director, System Performance Support
Contact - Data	Executive Director, System Information and Analytics Branch
Representation	
Data type	Numeric
Form	Percentage (%)
Representational layout	NNN.N
Minimum size	3
Maximum size	5
Data domain	
Date effective	1 July 2024
Related National Indicator	Meteor ID 746650 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: https://meteor.aihw.gov.au/content/index.phtml/itemId/746650 Meteor ID 746098 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: https://meteor.aihw.gov.au/content/index.phtml/itemId/746098

INDICATOR: KPI2407	**Hospital Access Target –** ED extended stay of no greater than 12 hours - Mental Health or Self-harm Related Presentations (%)
Shortened Title	ED Extended stays – 12 hours – Mental Health
Service Agreement Type	Key Performance Indicator.
NSW Health Strategic Outcome	2. Patients and carers have positive experiences and outcomes that matter.
Status	Final
Version number	1.0
Scope	All mental health or self-harm related Emergency Department presentations including those awaiting or transferred to another hospital from ED, of which the departure time falls within the reporting period
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 • improve the quality and safety of emergency care for mental health and self-harm related presentations
Primary point of collection	Emergency Department Information System
Data Collection Source/System	Emergency Department Data Collection
Primary data source for analysis	EDWARD (CERTIFIED.FACT_ED_SE or equivalent data view and data fields)
Indicator definition	The percentage of mental health or self-harm related presentations whose clinical care in the ED has ceased because of their physically leaving the ED, and whose total time spent in ED was ≤12 hours, measured from presentation time to departure time where: • **Presentation time in the ED** is the triage time (SUB_EVNT_FIRST_TRIAGE_DTTM). If the triage time is missing it is the arrival time (CL_ARRIVAL_DTTM) and • **Departure time** is the earliest of departure ready date/time (SUB_EVNT_FIRST_PT_DEPART_READY_DTTM) or actual departure date/time (CL_DEPART_DTTM) for non-admitted patients with a mode of separation (ED_SEPR_MODE_CD) = '02', '02.01' or '02.05'); otherwise it is the actual departure date/time (CL_DEPART_DTTM).

	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 in-scope presentations in the Emergency Department where total time spent in the ED <= 12 hours, where the CL_DEPART_DTTM falls within the reporting period. Mental-health or self-harm related presentations are defined as presentations with one or more of - A presenting problem/issue code for a primary or additional mental health condition - A presenting problem code for self-harm or suicidal ideation - Presenting problem text indicating self-harm or suicidal ideation Details of the testing and validation of the method are available. https://doi.org/10.17061/phrp33012303
Numerator source	EDWARD (Emergency Department Data Collection)
Numerator availability	Available
Denominator	
Denominator definition	All mental health of self-harm related ED presentations where the CL_DEPART_DTTM falls within the reporting period.
Denominator source	EDWARD (Emergency Department Data Collection)
Denominator availability	Available
Inclusions	• Emergency visit type with the following type codes (ED_VIS_TYPE_CD): '01' -Emergency Presentations '02' -Planned Return Visit '03' -Unplanned return visit for continuing condition '04' -Outpatient service event – public patient '05' -Outpatient service event – privately referred '07' - Expired: pre-arranged admission, Nursing & Clerical '08' -Pre-arranged admissions – with ED workup '09' -Person in transit '10' -Dead on arrival '11' -Disaster

Exclusions	• Records where total time in ED is missing, less than zero or greater than 99,998 minutes. • ED_VIS_TYPE_CD of '06', '12' or '13', i.e. ED presentation without ED workup, Telehealth presentation, current admitted patient presentation. • ED_SEPR_MODE_CD = '98' i.e. Data error – record pending deletion. • Duplicate with same facility, MRN, arrival date, arrival time and birth date (EDW: OSP_CBK, CL_ID, CL_ARRIVAL_DTTM and CL_DOB) • Records where client age at arrival is less than 10 years old for self-harm (EDW: CL_ARRIVAL_DTTM and CL_DOB)
Targets	Target: 95% • Performing: ≥=95% • Under Performing: ≥85% and <95% • Not Performing: <85% .
Context	Timely admission to a hospital bed, for those emergency department patients who require inpatient treatment, and timely treatment for all patients contributes to patient comfort and improves outcomes and the availability of Emergency Department services for other patients.
Related Policies/ Programs	Whole of Health Program
Useable data available from	July 2021
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, System Performance Support and Mental Health Branch.
Contact - Data	Executive Director, System Information and Analytics Branch
Representation	
Data type	Numeric
Form	Percentage (%)
Representational layout	NNN.N
Minimum size	3

Maximum size	5
Data domain	
Date effective	1 July 2024
Related National Indicator	Meteor ID 746650 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. https://meteor.aihw.gov.au/content/index.phtml/itemId/746650 Meteor ID 746098 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 https://meteor.aihw.gov.au/content/index.phtml/itemId/746098

INDICATOR: KPI2406	**Mental Health Inpatient Discharge Performance:** Discharges from Mental Health inpatient beds by midday (%)
Shortened Title	Discharges by midday - Mental Health
Service Agreement Type	Key Performance Indicator (KPI)
NSW Health Strategic Outcome	Strategy 2: Safe care is delivered across all settings
Status	Final
Version number	1.0
Scope	All overnight admitted patients discharged from Mental Health Inpatient care
Goal	To improve access to services within 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 • Improved safety and efficiency of transfer of care for patients awaiting access to treatment in the Emergency Department • Improve the access to inpatient services for patients admitted via the Emergency Department
Primary point of collection	Patient Medical Record
Data Collection Source/System	Hospital PAS systems
Primary data source for analysis	EDWARD (FACT_AP_SE_SEG)
Indicator definition	The percentage of overnight admitted patient discharges from mental health inpatient care The method for defining Mental Health inpatient care is being finalised: due to inconsistency in use of mental health bed types, initial construction will be based on separation from a designated mental health inpatient unit, with these units being defined by a ward reference list maintained by InforMH.
Numerator	
Numerator definition	The number of in-scope overnight admitted patient separations that occur before midday within the reporting period. Note: Where a patient's last bed type = '76' (Transit Lounge) or '25' (Hospital in the Home), then the time of discharge should be calculated as the time departed from mental health, defined by the end-time of the last mental health Service Event segment.

	For patients transferring to Transit Lounge or Hospital in the Home the date/time of the patient departing the Mental Health Inpatient bed is the time used for the calculation.
Numerator source	EDWARD (FACT_AP_SE_SEG)
Numerator availability	Available
Denominator	
Denominator definition	The number of in-scope overnight admitted patient separations that occur within the reporting period.
Denominator source	EDWARD (FACT_AP_SE_SEG)
Denominator availability	Available
Inclusions	• Numerator and Denominator • Admitted patient episodes separating from acute mental health units in hospitals with a co-located Emergency Department.
Exclusions	• Day only separations (patients whose formal admission date and time and formal discharge date and time occur on the same calendar day). • Patients with a Mode of Separation (EDW: Formal Discharge Mode Code) of: • '2' or '02' Discharge Own Risk • '6' or '06' Death with Autopsy • '7' or '07' Death without Autopsy • '10' Discharge on Leave
Targets	Target: ≥35% • Performing ≥ 35% • Underperforming ≥ 30% to <35% • Not Performing < 30%
Context	This target is a measure of timeliness of discharge performance, following on from a clinical decision that a patient is ready for discharge. It supports the timely admission to a hospital bed, for those emergency department patients who require inpatient treatment, as it contributes to patient comfort and improves outcomes and the availability of Emergency Department services for other patients.
Related Policies/ Programs	• PD2022_012 Admission to Discharge Care Coordination • • PD2019_045 Discharge Planning and Transfer of Care for Consumers of NSW Health Mental Health Services

Useable data available from	June 2021
Frequency of Reporting	Monthly
Time lag to available data	1 Month
Business owners	
Contact - Policy	Executive Directors, Mental Health Branch and System Performance Support
Contact - Data	Executive Director, System Information and Analytics Branch
Representation	
Data type	Numeric
Form	Number, presented as percentage (%)
Representational layout	NNN.N%
Minimum size	3
Maximum size	5
Data domain	
Date effective	1 July 2024
Related National Indicator	N/A

INDICATOR: IM21-006	**Inpatient Discharge Performance:** Inpatient Discharges from ED Accessible and Rehabilitation Beds by Midday (%)
Shortened Title	Inpatient Discharge Performance
Service Agreement Type	Key Performance Indicator
NSW Health Strategic Outcome	2: Safe care is delivered across all settings
Status	Final
Version number	2.1
Scope	All overnight admitted patients discharged from ED Accessible and Rehabilitation Beds
Goal	To improve access to services within 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 • Improved safety and efficiency of transfer of care for patients awaiting access to treatment in the Emergency department • Improve the access to inpatient services for patients admitted via the Emergency Department
Primary point of collection	Patient Medical Record
Data Collection Source/System	Hospital PAS systems
Primary data source for analysis	Enterprise Data Warehouse (EDWARD) - Local Reporting Solution (LRS)
Indicator definition	The percentage of overnight admitted patient discharges from ED Accessible and Rehabilitation Beds, in facilities with an Emergency Department, that occur before midday.
Numerator	
Numerator definition	The number of overnight admitted patient discharges where the final bed type is an ED Accessible or a Rehabilitation Bed, in facilities with an Emergency Department, that occur before midday within the reporting period. An ED accessible bed type is one of the following: '01', '33'. '46', '47', '87', '93' A rehabilitation bed type is '02'. Note: Where a patient's last bed type = '76' (Transit Lounge) or '25' (Hospital in the Home), then the bed type immediately prior to this is checked to see if it is an ED Accessible or Rehabilitation bed and included or excluded in the calculation. For patients transferring to Transit Lounge or Hospital in the Home the date/time of the patient departing the ED Accessible or a Rehabilitation Bed is the time used for the calculation.
Numerator source	EDWARD (FACT_AP_SE_SEG)

Numerator availability	Available
Denominator	
Denominator definition	The number of overnight admitted patient discharges where the final bed type is an ED Accessible or a Rehabilitation Bed, in facilities with an Emergency Department, within the reporting period. An ED accessible bed type is one of the following: '01', '33'. '46', '47', '87', '93'. A rehabilitation bed type is '02'. Note: Where a patient's last bed type = '76' (Transit Lounge) or '25' (Hospital in the Home), then the bed type immediately prior to this is checked to see if it is an ED Accessible or Rehabilitation bed and included or excluded in the calculation. For patients transferring to Transit Lounge or Hospital in the Home the date/time of the patient departing the ED Accessible or a Rehabilitation Bed is the time used for the calculation.
Denominator source	EDWARD (FACT_AP_SE_SEG)
Denominator availability	Available
Inclusions	**Numerator & Denominator:** (i) Organisations with an emergency department of any role delineation (ii) ED accessible bed types: • General mixed beds (Bed type = '01') • Coronary Care beds (Bed type = '33') • Medical beds (Bed type = '46') • Surgical beds (Bed type = '47') • Medical oncology beds (Bed type = '48') • Stroke beds (Bed type = '69') • Medical Assessment Units (MAUs) (Bed type = '87') • Close Observation Units (Bed type = '93') (iii) Rehabilitation bed type: • Rehabilitation (Bed type = '02')
Exclusions	**Numerator & Denominator:** • Discharges from Sydney Childrens Hospital Network. • Discharges from any other bed type. • Organisations that do not possess an emergency department. • Day only separations (patients whose formal admission date and time and formal discharge date and time occur on the same calendar day). • Patients with a Formal Discharge Mode Code of: ○ '2' or '02' Discharge Own Risk ○ '6' or '06' Death with Autopsy ○ '7' or '07' Death without Autopsy ○ '10' Discharge on Leave
Targets	Target: ≥35% • Performing: ≥35% • Under Performing: ≥30% and <35% • Not Performing: <30%

Context	This target is a measure of timeliness of discharge performance, following on from a clinical decision that a patient is ready for discharge. It supports the timely admission to a hospital bed, for those emergency department patients who require inpatient treatment, as it contributes to patient comfort and improves outcomes and the availability of Emergency Department services for other patients.
Related Policies/ Programs	
Useable data available from	July 2020
Frequency of Reporting	Daily (EDWARD)
Time lag to available data	Daily (EDWARD)
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	NN.NN
Minimum size	3
Maximum size	6
Data domain	
Date effective	
Related National Indicator	
Components	N/A

INDICATOR: KPI2411, KPI2412 **Previous ID: IM22-004b**	**Incomplete Emergency Department Attendances for Aboriginal Patients:** Patients who departed from an ED with a "Did not wait" or "Left at own risk" status (%) • Did not wait (KPI2411) • Left at own risk (KPI2412)
Shortened Title	Incomplete ED Aboriginal Patient Attendances
Service Agreement Type	Key Performance Indicator
NSW Health Strategic Outcome	2: Safe care is delivered across all settings
Status	Final
Version number	3.0
Scope	All Aboriginal patients presenting to public facility Emergency Departments in peer groups A1 – B2.
Goal	Culturally and clinically safe Emergency Department services for Aboriginal people
Desired outcome	Completion of care and better clinical outcomes for Aboriginal people who attend Emergency Departments
Primary point of collection	Front-line Emergency Department staff / Hospital PAS system
Data Collection Source/System	Emergency Department Data Collection
Primary data source for analysis	Enterprise Data Warehouse (EDWARD) - Local Reporting Solution (LRS) (FACT_ED_SE)
Indicator definition	Proportion of Emergency Department presentations where an Aboriginal person who leaves the ED before treatment is commenced or who leaves after treatment has commenced, against advice. **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 ED presentations with Mode of Separation (ED_SEPR_MODE_CD) is '02.03' or '02.04' (Did not wait or Left at own risk), where the Aboriginality Status code (CL_INDGNS_STUS_CD) = '1', '2', '3' only, and where the actual departure date (CL_DEPART_DTTM) falls within the reporting period.
Numerator source	Enterprise Data Warehouse (EDWARD) - Local Reporting Solution (LRS) (Emergency Department Data Collection)
Numerator availability	Available
Denominator	

Denominator definition	The number of presentations in the Emergency Department where the Aboriginality Status code (CL_INDGNS_STUS_CD) = '1', '2', '3' only, and where the actual departure date (CL_DEPART_DTTM) falls within the reporting period.
Denominator source	Enterprise Data Warehouse (EDWARD) - Local Reporting Solution (LRS) (Emergency Department Data Collection)
Denominator availability	Available
Inclusions	• Facilities in peer groups A1 – B2 • 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
Exclusions	• Facilities in peer groups below B2 • Records where total time in ED is missing, less than zero or greater than 99,998 minutes • Visit type (ED_VIS_TYPE_CD) of '12' or '13', i.e. Telehealth presentation, current admitted patient presentation • Separation mode (ED_SEPR_MODE_CD) = '03' or '98'; i.e. DoA and Registered in error • Duplicate with same facility, MRN, arrival date, arrival time and birth date (EDW: OSP_CBK, CL_ID, CL_ARRIVAL_DTTM and CL_DOB)
Targets	≥1 % point decrease on previous year • Performing: ≥1 % point decrease from previous year • Under performing: ≥0 and <1 % point decrease from previous year • Not performing: Increase on previous year.
Context	Incomplete Emergency Department Attendances (IEDA) comprise Emergency Department presentations where a person who leaves the ED before treatment is commenced or who leaves after treatment has commenced, against advice. IEDA is an indication of how culturally and clinically safe Emergency Department services are for the Aboriginal community they serve, and a reflection of Aboriginal peoples' satisfaction with their care. The underlying causes of IEDA can be broad and may begin outside the healthcare system. This can include factors related to the broader health institution, such as systemic racism, or the individual interactions within that healthcare system like communication breakdown between doctor and patient.
Related Policies/ Programs	• NSW Health Policy PD2013_047 Triage of Patients in NSW Emergency Departments

	• NSW Health Policy PD2018_010 Emergency Department Patients Awaiting Care 2022-24 NSW Implementation Plan for Closing the Gap • NSW Aboriginal Health Plan 2013-2023 • NSQHS Standards User guide for Aboriginal and Torres Strait Islander health | Australian Commission on Safety and Quality in Health Care • NSW Health Policy Directive *Aboriginal and Torres Strait Islander Origin - Recording of Information of Patients*
Useable data available from	2010
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, Centre for Aboriginal Health and 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.N
Minimum size	3
Maximum size	5
Data domain	
Date effective	July 2022
Related National Indicator	

INDICATOR: KSA101	**Transfer of Care** – patients transferred from Ambulance to ED ≤ 30 minutes (%)
Shortened Title	Transfer of Care
Service Agreement Type	Key Performance Indicator
NSW Health Strategic Outcome	2: Safe care is delivered across all settings
Status	Final
Version number	3.5
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 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
Numerator Inclusions	Patients arriving in the emergency department & all visit types where the Ambulance Priority is either: 1A Emergency 1B Emergency 1C Emergency 1CE Emergency 1CE Emergency ECP 2 Immediate 2 Immediate ECP 2A Emergency 30min 2AE Emergency ECP 30min 2Ah Emergency HAC 30min 2AHE Emergency HAC/ECP 30min 2B Emergency 60min 2BE Emergency ECP 60min 2Bh Emergency HAC 60min 2BHE Emergency HAC/ECP 60min 2BH Emergency HD 60min 2BHE Emergency HD/ECP 60min 2C Emergency 90min 2CE Emergency ECP 90min 2Ch Emergency HAC 90min 2CHE Emergency HAC/ECP 90min R3 Time Critical
Numerator 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 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 at the ED by ambulance
Denominator source	EDWARD, 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:

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

Exclusions

Patients where the Ambulance Priority is either:

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

- 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: 90%

- Performing ≥ 90%
- Under performing: ≥ 80% and < 90%
- Not performing: <80%

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 • PD2018_010 Emergency Department Patients Awaiting Care
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.
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 (MOH-SystemsInformationAndAnalytics@health.nsw.gov.au)
Representation	
Data type	Numeric
Form	Number, presented as a percentage (%)
Representational layout	NN.NN
Minimum size	4
Maximum size	6
Data domain	
Date effective	1 July 2016

INDICATOR: KS2142	**Potentially Preventable Hospital Services (%)**
Shortened Title	Potentially Preventable Hospital Services
Service Agreement Type	Key Performance Indicator
NSW Health Strategic Outcome	2: Safe care is delivered across all settings
Status	Final
Version number	1.2
Scope	All Emergency Department presentations and Admitted Patient episodes of care in NSW public hospitals
Goal	To reduce preventable visits to hospital by five per cent through to 2025 by caring for people in the community
Desired outcome	• Improved patient care experience and satisfaction • Improved efficiency of Hospital services • Strengthen the care provided to people in the community • Keep people healthier in the long-term
Primary point of collection	Patient Medical Record and Emergency Department Clerk
Data Collection Source/System	Admitted Patient Data Collection and Emergency Department Data Collection
Primary data source for analysis	Enterprise Data Warehouse (EDWARD) - Local Reporting Solution (LRS)
Indicator definition	Proportion of Emergency Department attendances or Admitted patient bed days for people with conditions where hospitalization or ED visit is potentially preventable.
Numerator	
Numerator definition	The numerator is the total number of ED service events or days spent in hospital by people with conditions where hospitalisation is potentially preventable. This is the sum of two broad categories: • Admitted patient component: days spent in hospital by discharged patients admitted with a potentially preventable condition. Potentially preventable conditions include conditions defined by AIHW, which are described at the AIHW's METeOR website: https://meteor.aihw.gov.au/content/740851 • ED component: number of Triage category 4 and 5 presentations to emergency departments
Numerator source	EDWARD (Admitted Patient Data Collection and Emergency Department Data Collection)
Numerator availability	Available

Denominator

Denominator definition	Total number of days of admitted patient care for patients discharged in the reporting period, plus the total number of emergency department presentations during the reporting period.
Denominator source	EDWARD (Admitted Patient Data Collection and Emergency Department Data Collection)
Denominator availability	Available

Inclusions

- ED component: All patients presenting to the emergency department, with a departure date within the reporting period.
- Admitted Patient component: all admitted patient service events (SE_TYPE_CD = '2') that were completed in NSW public hospitals during the reporting period.

Exclusions

- ED component: both numerator and denominator counts exclude:
  - Visit types (ED_VIS_TYPE_CD) = 6, 12 and 13) (Pre-arranged Admission: Without ED Workup, telehealth presentations and current admitted patient presentations, respectively);
  - Mode of separation (ED_SEPR_MODE_CD) = '98' for registered in error;
  - Vic-in-Reach LHD (Albury Hospital) (OSP_ID = 1000921)
- Admitted patient component of the numerator excludes:
  - Unit type ([FIRST_HEALTH_SERVICE_WARD_ATTRIBUTE_PROFILE].[HEALTH_SERVICE_WARD_PRIMARY_BED_TYPE_CD]) is 17 or 58 and no other episodes in that service encounter (ED Only)
  - Service category type 2 (Rehabilitation) (SE_SERVICE_CATEGORY_CD = 2)
  - Bed type on admission 25, 26 or 28 (Hospital in the Home) (HEALTH_SERVICE_WARD_PRIMARY_BED_TYPE_CD = 25, 26 or 28)
  - OSP health organisation identifier = 3015234
  - OSP LHD identifier is 1000170 or 1000921
  - Admitted patient service event length of stay > 120 days
  - Hospital boarder (SE_SERVICE_CATEGORY_CD = '0')
- Admitted patient component of the denominator excludes:
  - Unit type ([FIRST_HEALTH_SERVICE_WARD_ATTRIBUTE_PROFILE].[HEALTH_SERVICE_WARD_PRIMARY_BED_TYPE_CD]) is 17 or 58 and no other episodes in that service encounter (ED Only)
  - OSP LHD identifier is 1000170 or 1000921
  - Hospital boarder (SE_SERVICE_CATEGORY_CD = '0')

Targets	Performance targets are set relative to the benchmark percentage in the previous year for the LHD • Performing: 2% lower than benchmark (≤98% of individual benchmark percentage in the previous year) • Under Performing: within 2% of benchmark (>98% and ≤102% of individual benchmark the previous year) • Not Performing: 2% higher than benchmark (≥102% of individual benchmark the previous year)
Context	Supporting patients in the community using integrated approaches to care has demonstrated reductions in unnecessary hospital visits by delivering care closer to home. Focusing on preventative healthcare in the community also helps people stay as healthy as possible for as long as possible while ensuring the hospital system operates as efficiently as possible. The Premier's Priority aims to reduce potentially preventable visits to hospital by five per cent for people who can safely receive their care in the community.
Related Policies/ Programs	Premier's Priority NSW (https://www.nsw.gov.au/nsw-government/premier-of-nsw) and NSW Health Strategic Framework for Integrated Care (https://www.health.nsw.gov.au/integratedcare/Publications/strategic-framework-for-integrating-care.PDF)
Useable data available from	Available
Frequency of Reporting	Monthly
Time lag to available data	3 months
Business owners	
Contact – Policy	Executive Director, System Performance Support Branch and Director Integrated Care Implementation.
Contact – Data	Executive Director, System Information and Analytics Branch (MOH-SystemsInformationAndAnalytics@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 2020

Related National Indicator	National Healthcare Agreement: PI 18–Selected potentially preventable hospitalisations, 2022 Meteor ID: 740851 https://meteor.aihw.gov.au/content/740851 National Healthcare Agreement: PI 19–Selected potentially avoidable GP-type presentations to emergency departments, 2022 METeOR ID: 740847 https://meteor.aihw.gov.au/content/740847

INDICATOR: KS2128	**Hospital Acquired Pressure Injuries** (Rate per 10,000 admitted patient service events) Stage 3, 4, unspecified hospital acquired pressure injuries, unstageable and suspected deep tissue injury. – (Rate per 10,000 admitted patient service events)
Shortened Title	Hospital Acquired Pressure Injuries
Service Agreement Type	Key Performance Indicator
NSW Health Strategic Outcome	2: Safe care is delivered across all settings
Status	Final
Version number	2.0
Scope	All patients admitted to public hospitals in NSW
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	Admitted Patient Data Collection
Primary data source for analysis	Enterprise Data Warehouse (EDWARD) - Local Reporting Solution (LRS)
Indicator definition	The rate of completed admitted patient service events with stage 3 or 4, or unspecified, or unstageable, or deep tissue hospital acquired pressure injuries per 10,000 admitted patient service events.
Numerator	
Numerator definition	Total number of admitted patient service events (SE_TYPE_CD = '2')with separation dates in the reporting period, and with at least one of the ICD-10-AM codes listed in the Australian Commission on Safety and Quality in Health Care's (ACSQHC) HACs specification file for HACs V 3.1 (April 2022 release) downloadable from https://www.safetyandquality.gov.au/publications-and-resources/resource-library/hospital-acquired-complications-hacs-list-specifications-version-31 for the numerator for hospital acquired pressure injuries (HAC 1). The 12th Edition of ICD-10-AM coding should be used, which includes the following additional diagnosis codes: • Any of the listed ICD-10-AM 12th Edition codes recorded as an additional diagnosis. • **AND** condition onset flag code of 1. • **AND satisfying the criteria for the denominator**

	• For analysis relating to newborns with qualified days includes separations with any of specified ICD-10-AM codes as either the principal diagnosis or an additional diagnosis. For one inpatient service event, one type of HAC is only counted at most once if multiple diagnoses of the HAC are identified.
Numerator source	EDWARD
Numerator availability	Available from 1 September 2015
Denominator	
Denominator definition	Total number of admitted patient service events (SE_TYPE_CD = '2') with separation dates in the reporting period, excluding inpatient service events with any of the following: • Same-day chemotherapy - DRG V11: R63Z and SE_START_DTTM = SE_END_DTTM • Same-day haemodialysis - DRG V11: L61Z and SE_START_DTTM = SE_END_DTTM • Service Category is 'Newborn - unqualified days only ' (i.e. SE_SERVICE_CATEGORY_CD = '5' and COUNT_TOTAL_SE_QUAL_DAY_COUNT =0) • Hospital boarder (SE_SERVICE_CATEGORY_CD = '0') • Care type is 'Organ procurement-posthumous' - SE_SERVICE_CATEGORY_CD = '9'.
Denominator source	EDWARD
Denominator availability	Available
Inclusions	All admitted patient service events in NSW public hospitals Note: Mental health and drug and alcohol admitted patient service events are included in the current version (ACSQHC HAC V3.1).
Exclusions	Numerator exclusion: Admitted patient service events with the qualified diagnosis codes recorded as the principal diagnosis code. Numerator and denominator exclusions: • Same-day chemotherapy - DRG V11: R63Z and SE_START_DTTM = SE_END_DTTM • Same-day haemodialysis - DRG V11: L61Z and SE_START_DTTM = SE_END_DTTM • Service Category is 'Newborn - unqualified days only ' (i.e. SE_SERVICE_CATEGORY_CD = '5' and COUNT_TOTAL_SE_QUAL_DAY_COUNT =0) • Hospital boarder (SE_SERVICE_CATEGORY_CD = '0') • Care type is 'Organ procurement-posthumous' - SE_SERVICE_CATEGORY_CD = '9'. • Any uncoded records.
Targets	The risk adjusted targets for individual Local Health Districts and Local Specialty Health Networks are set for a 12-month rolling period (12

months to date). Provisional performance target for individual LHDs or Specialty Networks are:

Local Health District	Target	Not Performing	Under Performing	Performing
Central Coast LHD	<=6.3	>7.1	>6.3 and <=7.1	<=6.3
Far West LHD	<=5.1	>8.1	>5.1 and <=8.1	<=5.1
Hunter New England LHD	<=4.9	>5.4	>4.9 and <=5.4	<=4.9
Illawarra Shoalhaven LHD	<=6.4	>7.2	>6.4 and <=7.2	<=6.4
Justice Health	NA	NA	NA	NA
Murrumbidgee LHD	<=4.7	>5.6	>4.7 and <=5.6	<=4.7
Mid North Coast LHD	<=5.2	>6.0	>5.2 and <=6.0	<=5.2
Nepean Blue Mountains LHD	<=5.2	>5.9	>5.2 and <=5.9	<=5.2
Northern NSW LHD	<=5.4	>6.1	>5.4 and <=6.1	<=5.4
Northern Sydney LHD	<=6.7	>7.3	>6.7 and <=7.3	<=6.7
Sydney Children's Hospitals Network	<=1.4	>1.9	>1.4 and <=1.9	<=1.4
South Eastern Sydney LHD	<=5.0	>5.5	>5.0 and <=5.5	<=5.0
Southern NSW LHD	<=4.7	>5.8	>4.7 and <=5.8	<=4.7
St Vincent's Health Network	<=6.2	>7.4	>6.2 and <=7.4	<=6.2
South Western Sydney LHD	<=5.4	>5.9	>5.4 and <=5.9	<=5.4
Sydney LHD	<=6.0	>6.6	>6.0 and <=6.6	<=6.0
Western NSW LHD	<=4.9	>5.6	>4.9 and <=5.6	<=4.9
Western Sydney LHD	<=4.7	>5.2	>4.7 and <=5.2	<=4.7

The risk adjusted targets have been developed using risk adjusted models on the 2019 NSW APDC data. The risk adjustors used are largely in the same dimensions as those used for IHPA's service activity adjustors.

Rates of under and up to 80% upper control limits of expected rates are scored as 'Performing', rates between 80% and 95% upper control limits as 'Under Performing', and rates above the respective 95% upper control limits are flagged as 'Not Performing'. Targets are not applicable if the expected number of HACs is less than 1.

Context

Hospital-acquired pressure injuries extend the length of hospitalisation, which impacts on patients and their families. These injuries also increase the cost of admission incurred by the health service. This additional cost

	may be the result of an increased length of stay or more complex care requirements. While there is an increased financial cost, the most significant cost is the pain and discomfort experienced by the patient. Significant reductions in pressure injury rates are being achieved in some hospitals through preventive initiatives. Related information can be found on the Commission's website: Australian Commission on Safety and Quality in Health Care
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 5 Comprehensive Care • 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	Chief Executive, Clinical Excellence Commission
Contact - Data	Executive Director, System Information and Analytics Branch (MOH-SystemInformationAndAnalytics@health.nsw.gov.au)
Representation	
Data type	Numeric
Form	Number, presented as a rate per 10,000 admitted patient service events
Representational layout	NN.NN
Minimum size	4
Maximum size	6
Data domain	
Date effective	1 July 2019
Related National Indicator	This HAC indicator follows the ACSQHC's specification: Australian Commission on Safety and Quality in Health Care – ACSQHC's Hospital Acquired Complication (HAC 1) in release V 3.1: https://www.safetyandquality.gov.au/our-work/indicators/hospital-acquired-complications#hospital-acquired-complications -list

INDICATOR: KS2129	**Fall-Related Injuries in Hospital** – Resulting in fracture or intracranial injury (Rate per 10,000 admitted patient service events)
Shortened Title	Fall-Related Injuries in Hospital
Service Agreement Type	Key Performance Indicator
NSW Health Strategic Outcome	2: Safe care is delivered across all settings
Status	Final
Version number	2.0
Scope	All patients admitted to public hospitals in NSW
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	Enterprise Data Warehouse (EDWARD) - Local Reporting Solution (LRS)
Indicator definition	A fall occurring in health service area resulting in intracranial injury, fractured neck of femur or other fracture as a rate per 10,000 admitted patient service events.
Numerator	
Numerator definition	Total number of admitted patient service events (SE_TYPE_CD = '2') with separation dates in the reporting period, and with at least one of the ICD-10-AM codes listed in the Australian Commission on Safety and Quality in Health Care's (ACSQHC) HACs specification file for HACs V 3.1 (April 2022 release) downloadable from https://www.safetyandquality.gov.au/publications-and-resources/resource-library/hospital-acquired-complications-hacs-list-specifications-version-31 for the numerator for fall related injuries in hospitals (HAC 2). The 12th Edition of ICD-10-AM coding should be used, which includes the following additional diagnosis codes: • Any of the listed ICD-10-AM 12th Edition codes recorded as an additional diagnosis, • AND any external cause code of (falls): W01x, W03, W04, W05, W061, W062, W063, W064, W066, W068, W069, W07x, W08x, W10x, W130, W131, W132, W135, W138, W139, W18x, W19, • AND condition Onset Flag = '1'. • AND satisfying the criteria for the denominator

	• For analysis relating to newborns with qualified days includes separations with any of specified ICD-10-AM codes as either the principal diagnosis or an additional diagnosis. For one admitted patient service event, one type of HAC is only counted at most once if multiple diagnoses of the HAC are identified.
Numerator source	EDWARD
Numerator availability	Available from 1 September 2015
Denominator	
Denominator definition	Total number of admitted patient service events (SE_TYPE_CD = '2') with separation dates in the reporting period, **excluding** service events with any of the following: • Same-day chemotherapy - DRG V11: R63Z and SE_START_DTTM = SE_END_DTTM • Same-day haemodialysis - DRG V11: L61Z and SE_START_DTTM = SE_END_DTTM • Service Category is 'Newborn - unqualified days only ' (i.e. SE_SERVICE_CATEGORY_CD = '5' and COUNT_TOTAL_SE_QUAL_DAY_COUNT =0) • Hospital boarder (SE_SERVICE_CATEGORY_CD = '0') • Care type is 'Organ procurement-posthumous' - SE_SERVICE_CATEGORY_CD = '9'.
Denominator source	EDWARD
Denominator availability	Available
Inclusions	All admitted patient service events in NSW public hospitals. Note: Mental health and drug and alcohol admitted patient service events are included in the current version (ACSQHC HAC V3.1).
Exclusions	Numerator exclusions: Admitted patient service events with the qualified diagnosis codes recorded as the principal diagnosis code. Numerator and denominator exclusions: • Same-day chemotherapy - DRG V11: R63Z and SE_START_DTTM = SE_END_DTTM • Same-day haemodialysis - DRG V11: L61Z and SE_START_DTTM = SE_END_DTTM • Service Category is 'Newborn - unqualified days only ' (i.e. SE_SERVICE_CATEGORY_CD = '5' and COUNT_TOTAL_SE_QUAL_DAY_COUNT =0) • Hospital boarder (SE_SERVICE_CATEGORY_CD = '0') • Care type is 'Organ procurement-posthumous' - SE_SERVICE_CATEGORY_CD = '9'. • Any uncoded records.
Targets	The risk adjusted targets for individual Local Health Districts and Local Specialty Health Networks are set for a 12-month rolling period (12 months

to date). Provisional performance target for individual LHDs or Specialty Networks are:

Local Health District	Target	Not Performing	Under Performing	Performing
Central Coast LHD	<=9.3	>10.4	>9.3 and <=10.4	<=9.3
Far West LHD	<=9.4	>13.2	>9.4 and <=13.2	<=9.4
Hunter New England LHD	<=7.1	>7.7	>7.1 and <=7.7	<=7.1
Illawarra Shoalhaven LHD	<=9.6	>10.6	>9.6 and <=10.6	<=9.6
Justice Health	NA	NA	NA	NA
Murrumbidgee LHD	<=8.0	>9.0	>8.0 and <=9.0	<=8.0
Mid North Coast LHD	<=7.3	>8.2	>7.3 and <=8.2	<=7.3
Nepean Blue Mountains LHD	<=6.9	>7.8	>6.9 and <=7.8	<=6.9
Northern NSW LHD	<=7.8	>8.7	>7.8 and <=8.7	<=7.8
Northern Sydney LHD	<=8.6	>9.4	>8.6 and <=9.4	<=8.6
Sydney Children's Hospitals Network	<=0.5	>0.9	>0.5 and <=0.9	<=0.5
South Eastern Sydney LHD	<=7.2	>7.8	>7.2 and <=7.8	<=7.2
Southern NSW LHD	<=8.0	>9.4	>8.0 and <=9.4	<=8.0
St Vincent's Health Network	<=7.2	>8.6	>7.2 and <=8.6	<=7.2
South Western Sydney LHD	<=6.6	>7.2	>6.6 and <=7.2	<=6.6
Sydney LHD	<=7.3	>7.9	>7.3 and <=7.9	<=7.3
Western NSW LHD	<=7.4	>8.3	>7.4 and <=8.3	<=7.4
Western Sydney LHD	<=6.3	>6.9	>6.3 and <=6.9	<=6.3

The risk adjusted targets have been developed using risk adjusted models on the 2019 NSW APDC data. The risk adjustors used are largely in the same dimensions as those used for IHPA's service activity adjustors.

Rates of under and up to 80% upper control limits of expected rates are scored as 'Performing', rates between 80% and 95% upper control limits as 'Under Performing', and rates above the respective 95% upper control limits are flagged as 'Not Performing'. Targets are not applicable if the expected number of HACs is less than "1".

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. More contextual information can be found in the ACSQHC's HAC information kit, downloadable from the Commission's website: Australian Commission on Safety and Quality in Health Care
Related Policies/ Programs	
Useable data available from	1 September 2015
Frequency of Reporting	Monthly
Time lag to available data	1 month
Business owners	
Contact - Policy	Chief Executive, Clinical Excellence Commission
Contact - Data	Executive Director, System Information and Analytics Branch (MOH-SystemInformationAndAnalytics@health.nsw.gov.au)
Representation	
Data type	Numeric
Form	Number, presented as a rate per 10,000 admitted patient service events
Representational layout	NN.NN
Minimum size	4
Maximum size	6
Date effective	1 July 2019
Related National Indicator	This HAC indicator follows the ACSQHC's specification: Australian Commission on Safety and Quality in Health Care – ACSQHC's Hospital Acquired Complication (HAC 2) in release V 3.1: https://www.safetyandquality.gov.au/our-work/indicators/hospital-acquired-complications#hospital-acquired-complications -list

INDICATOR: KS2130	**Healthcare Associated Infections** (Rate per 10,000 admitted patient service events)
Shortened Title	Healthcare Associated Infections
Service Agreement Type	Key Performance Indicator
NSW Health Strategic Outcome	2: Safe care is delivered across all settings
Status	Final
Version number	2.0
Scope	All patients admitted to public hospitals in NSW
Goal	To reduce hospital associated infection by the provision of patient care that mitigates avoidable risks to patients.
Desired outcome	Reduction in the number of patients developing infections whilst an inpatient.
Primary point of collection	Patient medical record
Data Collection Source/System	Admitted patient data collection
Primary data source for analysis	Enterprise Data Warehouse (EDWARD) - Local Reporting Solution (LRS)
Indicator definition	Rate of healthcare associated infections per 10,000 admitted patient service events.
Numerator	
Numerator definition	Total number of admitted patient service events (SE_TYPE_CD = '2') with separation dates in the reporting period, and with at least one of the ICD-10-AM codes listed in the Australian Commission on Safety and Quality in Healt Care's (ACSQHC) HACs specification file for HACs V 3.1 (April 2022 release downloadable from https://www.safetyandquality.gov.au/publications-and-resources/resource-library/hospital-acquired-complications-hacs-list-specifications-version-31 for the numerator for healthcare associated infections (HAC 3). The 12th Edition of ICD-10-AM coding should be used, which includes the following additional diagnosis codes: • Any of the listed ICD-10-AM 12th Edition codes recorded as an additional diagnosis, • **AND** condition onset flag code of 1. • **AND satisfying the criteria for the denominator** • For analysis relating to newborns with qualified days includes separations with any of specified ICD-10-AM codes as either the principal diagnosis or an additional diagnosis. For one admitted patient service event, one type of HAC is only counted at most once if multiple diagnoses of the HAC are identified.
Numerator source	EDWARD

Numerator availability	Available from 1 September 2015
Denominator	
Denominator definition	Total number of admitted patient service events (SE_TYPE_CD = '2') with separation dates in the reporting period, **excluding** service events with any of the following: • Same-day chemotherapy - DRG V11: R63Z and SE_START_DTTM = SE_END_DTTM • Same-day haemodialysis - DRG V11: L61Z and SE_START_DTTM = SE_END_DTTM • Service Category is 'Newborn - unqualified days only ' (i.e. SE_SERVICE_CATEGORY_CD = '5' and COUNT_TOTAL_SE_QUAL_DAY_COUNT =0) • Hospital boarder (SE_SERVICE_CATEGORY_CD = '0') • Care type is 'Organ procurement-posthumous' - SE_SERVICE_CATEGORY_CD = '9'.
Denominator source	EDWARD
Denominator availability	Available
Inclusions	All admitted patient service events in NSW public hospitals Note: Mental health and drug and alcohol admitted patient service events are included in the current version (ACSQHC HAC V3.1).
Exclusions	Numerator exclusions: • Same-day chemotherapy - DRG V11: R63Z and SE_START_DTTM = SE_END_DTTM • Same-day haemodialysis - DRG V11: L61Z and SE_START_DTTM = SE_END_DTTM • Service Category is 'Newborn - unqualified days only ' (i.e. SE_SERVICE_CATEGORY_CD = '5' and COUNT_TOTAL_SE_QUAL_DAY_COUNT =0) • Hospital boarder (SE_SERVICE_CATEGORY_CD = '0') • Care type is 'Organ procurement-posthumous' - SE_SERVICE_CATEGORY_CD = '9'. • Any uncoded records.
Targets	The risk adjusted targets for individual Local Health Districts and Local Specialty Health Networks are set for a 12-month rolling period (12 months to date). Provisional performance target for individual LHDs or Specialty Networks are:

Local Health District	Target	Not Performing	Under Performing	Performing
Central Coast LHD	<=138.2	>141.9	>138.2 and <=141.9	<=138.2
Far West LHD	<=94.8	>105.6	>94.8 and <=105.6	<=94.8
Hunter New England LHD	<=112.0	>114.1	>112.0 and <=114.1	<=112.0
Illawarra Shoalhaven LHD	<=136.3	>140.0	>136.3 and <=140.0	<=136.3
Justice Health	<=157.0	>186.7	>157.0 and <=186.7	<=157.0
Murrumbidgee LHD	<=108.4	>112.2	>108.4 and <=112.2	<=108.4
Mid North Coast LHD	<=117.7	>121.3	>117.7 and <=121.3	<=117.7
Nepean Blue Mountains LHD	<=107.9	>111.2	>107.9 and <=111.2	<=107.9
Northern NSW LHD	<=119.1	>122.4	>119.1 and <=122.4	<=119.1
Northern Sydney LHD	<=155.0	>158.0	>155.0 and <=158.0	<=155.0
Sydney Children's Hospitals Network	<=26.5	>28.3	>26.5 and <=28.3	<=26.5
South Eastern Sydney LHD	<=109.8	>112.1	>109.8 and <=112.1	<=109.8
Southern NSW LHD	<=98.1	>102.6	>98.1 and <=102.6	<=98.1
St Vincent's Health Network	<=133.6	>139.0	>133.6 and <=139.0	<=133.6
South Western Sydney LHD	<=124.7	>126.9	>124.7 and <=126.9	<=124.7
Sydney LHD	<=149.0	>152.0	>149.0 and <=152.0	<=149.0
Western NSW LHD	<=104.0	>107.3	>104.0 and <=107.3	<=104.0
Western Sydney LHD	<=108.3	>110.7	>108.3 and <=110.7	<=108.3

The risk adjusted targets have been developed using risk adjusted models on the 2019 NSW APDC data. The risk adjustors used are largely in the same dimensions as those used for IHPA's service activity adjustors.

Rates of under and up to 80% upper control limits of expected rates are scored as 'Performing', rates between 80% and 95% upper control limits as 'Under Performing', and rates above the respective 95% upper control limits are flagged as 'Not Performing'. Targets are not applicable if the expected number of HACs is less than 1.

Context

A hospital-acquired infection often also results in a prolonged hospital stay which impacts on patients and their families. These infections increase the cost of admission incurred by the health service. This additional cost may be the result of an increased length of stay or more complex care requirements.

	While there is an increased financial cost, the most significant cost is the pain and discomfort experienced by the patient. Preventing hospital-acquired infections therefore presents an important challenge to clinicians and health service managers. Significant reductions in hospital-acquired infection rates are already being achieved in some hospitals through preventative initiatives. Related information can be found on the Commission's website: Australian Commission on Safety and Quality in Health Care
Related Policies/ Programs	
Useable data available from	1 September 2015
Frequency of Reporting	Monthly
Time lag to available data	1 month
Business owners	
Contact - Policy	Chief Executive, Clinical Excellence Commission
Contact - Data	Executive Director, Strategic Information and Analysis (MOH-SystemInformationAndAnalytics@health.nsw.gov.au.)
Representation	
Data type	Numeric
Form	Number, presented as a rate per 10,000 admitted patient service events.
Representational layout	NN.NN
Minimum size	4
Maximum size	6
Data domain	
Date effective	1 July 2019
Related National Indicator	This HAC indicator follows the ACSQHC's specification: Australian Commission on Safety and Quality in Health Care – ACSQHC's Hospital Acquired Complication (HAC 3) in release V 3.1: https://www.safetyandquality.gov.au/our-work/indicators/hospital-acquired-complications#hospital-acquired-complications -list

INDICATOR: KS2131

Hospital Acquired Respiratory Complications (Rate per 10,000 admitted patient service events)

Shortened Title	Hospital Acquired Respiratory Complications
Service Agreement Type	Key Performance Indicator
NSW Health Strategic Outcome	2: Safe care is delivered across all settings
Status	Final
Version number	2.0
Scope	All in-scope patients in NSW public hospitals
Goal	To reduce hospital acquired respiratory complications, improve quality of care and reduce length of stay and overall admission cost, and to reduce patient pain and discomfort in public health care.
Desired outcome	Reduction in the rate of patients developing respiratory complications whilst an inpatient in NSW public hospitals
Primary point of collection	Patient medical record
Data Collection Source/System	NSW Admitted Patient Data Collection
Primary data source for analysis	Enterprise Data Warehouse (EDWARD) - Local Reporting Solution (LRS)
Indicator definition	Rate of hospital acquired respiratory complications per 10,000 admitted patient service events
Numerator	
Numerator definition	Total number of admitted patient service events (SE_TYPE_CD = '2')with separation dates in the reporting period, and with at least one of the ICD-10-AM codes listed in the Australian Commission on Safety and Quality in Health Care's (ACSQHC) HACs specification file for HACs V 3.1 (April 2022 release) downloadable from https://www.safetyandquality.gov.au/publications-and-resources/resource-library/hospital-acquired-complications-hacs-list-specifications-version-31 for the numerator for hospital acquired respiratory complications (HAC 6). The 12th Edition of ICD-10-AM coding should be used, which includes the following additional diagnosis codes: • (ANY of diagnosis codes: J80, J96.00, J96.01, J96.09, J96.90, J96.91, J96.99) **AND** any of procedure codes: (13882-00, 13882-01, 13882-02, 92209-01, 92209-02) **OR** J69.0, J69.8, J95.4, J95.82, J81 • **AND** condition onset flag code of 1. • **AND satisfying the criteria for the denominator** • For analysis relating to newborns with qualified days includes separations with any of specified ICD-10-AM codes as either the principal diagnosis or an additional diagnosis. For one admitted patient service event, one type of HAC is only counted at most once if multiple diagnoses of the HAC are identified.
Numerator source	EDWARD
Numerator availability	Available from 1 September 2015
Denominator	

Denominator definition	Total number of admitted patient service events (SE_TYPE_CD = '2') with separation dates in the reporting period, **excluding** service events with any of the following: • Same-day chemotherapy - DRG V11: R63Z and SE_START_DTTM = SE_END_DTTM • Same-day haemodialysis - DRG V11: L61Z and SE_START_DTTM = SE_END_DTTM • Service Category is 'Newborn - unqualified days only ' (i.e. SE_SERVICE_CATEGORY_CD = '5' and COUNT_TOTAL_SE_QUAL_DAY_COUNT =0) • Hospital boarder (SE_SERVICE_CATEGORY_CD = '0') • Care type is 'Organ procurement-posthumous' - SE_SERVICE_CATEGORY_CD = '9'.
Denominator source	EDWARD
Denominator availability	Available
Inclusions	All admitted patient service events in NSW public hospitals Note: Mental health and drug and alcohol admitted patient service events are included in the current version (ACSQHC HACs V3.1)
Exclusions	Numerator exclusions: • Admitted patient service events with the qualified diagnosis codes recorded as the principal diagnosis code. Numerator and denominator exclusions: • Same-day chemotherapy - DRG V11: R63Z and SE_START_DTTM = SE_END_DTTM • Same-day haemodialysis - DRG V11: L61Z and SE_START_DTTM = SE_END_DTTM • Service Category is 'Newborn - unqualified days only ' (i.e. SE_SERVICE_CATEGORY_CD = '5' and COUNT_TOTAL_SE_QUAL_DAY_COUNT =0) • Hospital boarder (SE_SERVICE_CATEGORY_CD = '0') • Care type is 'Organ procurement-posthumous' - SE_SERVICE_CATEGORY_CD = '9'. • Any uncoded records.
Targets	

Local Health District	Target	Not Performing	Under Performing	Performing
Central Coast LHD	<=36.3	>38.3	>36.3 and <=38.3	<=36.3
Far West LHD	<=21.3	>26.7	>21.3 and <=26.7	<=21.3
Hunter New England LHD	<=26.0	>27.0	>26.0 and <=27.0	<=26.0
Illawarra Shoalhaven LHD	<=32.9	>34.7	>32.9 and <=34.7	<=32.9
Justice Health	<=66.4	>86.7	>66.4 and <=86.7	<=66.4
Murrumbidgee LHD	<=22.4	>24.2	>22.4 and <=24.2	<=22.4
Mid North Coast LHD	<=31.4	>33.3	>31.4 and <=33.3	<=31.4
Nepean Blue Mountains LHD	<=26.6	>28.3	>26.6 and <=28.3	<=26.6
Northern NSW LHD	<=30.8	>32.5	>30.8 and <=32.5	<=30.8
Northern Sydney LHD	<=45.2	>46.9	>45.2 and <=46.9	<=45.2
Sydney Children's Hospitals Network	<=8.3	>9.4	>8.3 and <=9.4	<=8.3
South Eastern Sydney LHD	<=27.8	>28.9	>27.8 and <=28.9	<=27.8
Southern NSW LHD	<=20.4	>22.5	>20.4 and <=22.5	<=20.4
St Vincent's Health Network	<=46.1	>49.3	>46.1 and <=49.3	<=46.1
South Western Sydney LHD	<=38.2	>39.4	>38.2 and <=39.4	<=38.2
Sydney LHD	<=45.9	>47.5	>45.9 and <=47.5	<=45.9
Western NSW LHD	<=23.0	>24.5	>23.0 and <=24.5	<=23.0
Western Sydney LHD	<=28.4	>29.7	>28.4 and <=29.7	<=28.4

Context

Hospital-acquired respiratory complications extend the length of hospitalisation, which impacts on patients and their families. These complications also increase the cost of admission incurred by the health service. This additional cost may be the result of an increased length of stay or more complex care requirements. While there is an increased financial cost, the most significant cost is the pain and discomfort experienced by the patient.

Related information can be found on the Commission's website:

Australian Commission on Safety and Quality in Health Care

Related Policies/Programs

Usable data available from

1 September 2015

Frequency of Reporting

Monthly

Time lag to available data

1 month

Business owners

Contact - Policy	Chief Executive, Clinical Excellence Commission
Contact - Data	Executive Director, System Information and Analytics Branch (MOH-SystemInformationAndAnalytics@health.nsw.gov.au)
Representation	
Data type	Numeric
Form	Number, presented as a rate per 10,000 admitted patient service events
Representational layout	NN.NN
Minimum size	4
Maximum size	6
Date effective	1 July 2019
Related National Indicator	This HAC indicator follows the ACSQHC's specification: Australian Commission on Safety and Quality in Health Care – ACSQHC's Hospital Acquired Complication (HAC 6) in release V 3.1: https://www.safetyandquality.gov.au/our-work/indicators/hospital-acquired-complications#hospital-acquired-complications -list

INDICATOR: KS2132	**Hospital Acquired Venous Thromboembolism** (Rate per 10,000 admitted patient service events)
Shortened Title	Hospital Acquired VTE Rate
Service Agreement Type	Key Performance Indicator
NSW Health Strategic Outcome	2: Safe care is delivered across all settings
Status	Final
Version number	2.0
Scope	All patients admitted to public hospitals in NSW
Goal	To reduce Hospital Acquired Venous Thromboembolism by the provision of patient care that mitigates avoidable risks to patients, and 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	Patient medical record
Data Collection Source/System	Admitted patient data collection
Primary data source for analysis	Enterprise Data Warehouse (EDWARD) - Local Reporting Solution (LRS)
Indicator definition	The rate of completed inpatient episodes with hospital acquired VTE per 10,000 admitted patient service events.
Numerator	
Numerator definition	Total number of admitted patient service events (SE_TYPE_CD = '2') with separation dates in the reporting period, and with at least one of the ICD-10-AM codes listed in the Australian Commission on Safety and Quality in Health Care's (ACSQHC) HACs specification file for HACs V 3.1 (April 2022 release) downloadable from https://www.safetyandquality.gov.au/publications-and-resources/resource-library/hospital-acquired-complications-hacs-list-specifications-version-31 for the numerator for Hospital Acquired VTE (HAC 7). The 12th Edition of ICD-10-AM coding should be used, which includes the following additional diagnosis codes: • Any of ICD 10 AM 12th Edition codes: I26.0, I26.9, I80.1, I80.20, I80.21, I80.22, I80.23, I80.42, I80.8; • **AND** condition onset flag code of 1. • **AND satisfying the criteria for the denominator** • For analysis relating to newborns with qualified days includes separations with any of specified ICD-10-AM codes as either the principal diagnosis or an additional diagnosis.

	For one admitted patient service event, one type of HAC is only counted at most once if multiple diagnoses of the HAC are identified.
Numerator source	EDWARD
Numerator availability	Available from 1 September 2015
Denominator	
Denominator definition	Total number of admitted patient service events (SE_TYPE_CD = '2') with separation dates in the reporting period, **excluding** service events with any of the following: • Same-day chemotherapy - DRG V11: R63Z and SE_START_DTTM = SE_END_DTTM • Same-day haemodialysis - DRG V11: L61Z and SE_START_DTTM = SE_END_DTTM • Service Category is 'Newborn - unqualified days only ' (i.e. SE_SERVICE_CATEGORY_CD = '5' and COUNT_TOTAL_SE_QUAL_DAY_COUNT =0) • Hospital boarder (SE_SERVICE_CATEGORY_CD = '0') • Care type is 'Organ procurement-posthumous' - SE_SERVICE_CATEGORY_CD = '9'.
Denominator source	EDWARD
Denominator availability	Available
Inclusions	All admitted patient service events in NSW public hospitals Note: Mental health and drug and alcohol admitted patient service events are included in the current version (ACSQHC HACs V 3.1).
Exclusions	Numerator exclusions: • Admitted patient service events with the qualified diagnosis codes recorded as the principal diagnosis code. Numerator and denominator exclusions: • Same-day chemotherapy - DRG V11: R63Z and SE_START_DTTM = SE_END_DTTM • Same-day haemodialysis - DRG V11: L61Z and SE_START_DTTM = SE_END_DTTM • Service Category is 'Newborn - unqualified days only ' (i.e. SE_SERVICE_CATEGORY_CD = '5' and COUNT_TOTAL_SE_QUAL_DAY_COUNT =0) • Hospital boarder (SE_SERVICE_CATEGORY_CD = '0') • Care type is 'Organ procurement-posthumous' - SE_SERVICE_CATEGORY_CD = '9'. • Any uncoded records.
Targets	The risk adjusted targets for individual Local Health Districts and Local Specialty Health Networks are set for a 12-month rolling period (12 months to date). Provisional performance target for individual LHDs or Specialty Networks are:

Local Health District	Target	Not Performing	Under Performing	Performing
Central Coast LHD	<=9.5	>10.5	>9.5 and <=10.5	<=9.5
Far West LHD	<=7.3	>10.7	>7.3 and <=10.7	<=7.3
Hunter New England LHD	<=7.3	>7.9	>7.3 and <=7.9	<=7.3
Illawarra Shoalhaven LHD	<=8.9	>9.9	>8.9 and <=9.9	<=8.9
Justice Health	NA	NA	NA	NA
Murrumbidgee LHD	<=6.2	>7.2	>6.2 and <=7.2	<=6.2
Mid North Coast LHD	<=8.4	>9.4	>8.4 and <=9.4	<=8.4
Nepean Blue Mountains LHD	<=7.9	>8.8	>7.9 and <=8.8	<=7.9
Northern NSW LHD	<=8.4	>9.3	>8.4 and <=9.3	<=8.4
Northern Sydney LHD	<=12.0	>12.8	>12.0 and <=12.8	<=12.0
Sydney Children's Hospitals Network	<=2.2	>2.8	>2.2 and <=2.8	<=2.2
South Eastern Sydney LHD	<=7.4	>8.0	>7.4 and <=8.0	<=7.4
Southern NSW LHD	<=6.4	>7.6	>6.4 and <=7.6	<=6.4
St Vincent's Health Network	<=11.7	>13.4	>11.7 and <=13.4	<=11.7
South Western Sydney LHD	<=9.5	>10.1	>9.5 and <=10.1	<=9.5
Sydney LHD	<=11.9	>12.7	>11.9 and <=12.7	<=11.9
Western NSW LHD	<=6.7	>7.6	>6.7 and <=7.6	<=6.7
Western Sydney LHD	<=7.5	>8.2	>7.5 and <=8.2	<=7.5

The risk adjusted targets have been developed using risk adjusted models on the 2019 NSW APDC data. The risk adjustors used are largely in the same dimensions as those used for IHPA's service activity adjustors. Rates of under and up to 80% upper control limits of expected rates are scored as 'Performing', rates between 80% and 95% upper control limits as 'Under Performing', and rates above the respective 95% upper control limits are flagged as 'Not Performing'. Targets are not applicable if the expected number of HACs is less than 1.

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.

The HAC information kit contains more contextual information:

Context	Australian Commission on Safety and Quality in Health Care
Related Policies/ Programs	*PD2019_057 Prevention of Venous Thromboembolism*
Useable data available from	1 September 2015
Frequency of Reporting	Monthly
Time lag to available data	1 month
Business owners	
Contact - Policy	Chief Executive, Clinical Excellence Commission
Contact - Data	Executive Director, System Information and Analytics Branch (MOH-SystemInformationAndAnalytics@health.nsw.gov.au)
Representation	
Data type	Numeric
Form	Number, presented as a rate per 10,000 admitted patient service events
Representational layout	NN.NN
Minimum size	4
Maximum size	6
Data domain	
Date effective	1 July 2019
Related National Indicator	This HAC indicator follows the ACSQHC's specification: Australian Commission on Safety and Quality in Health Care – ACSQHC's Hospital Acquired Complication (HAC 7) in release V 3.1: https://www.safetyandquality.gov.au/our-work/indicators/hospital-acquired-complications#hospital-acquired-complications -list

INDICATOR: KS2133	**Hospital Acquired Renal Failure** (Rate per 10,000 admitted patient service events)
Shortened Title	Hospital Acquired Renal failure
Service Agreement Type	Key Performance Indicator
NSW Health Strategic Outcome	2: Safe care is delivered across all settings
Status	Final
Version number	2.0
Scope	All patients in NSW public hospitals
Goal	To reduce hospital acquired renal failure by the provision of care that mitigates avoidable clinical risks to patients.
Desired outcome	Reduction of hospital acquired renal failure.
Primary point of collection	Patient medical record
Data Collection Source/System	Admitted patient data collection
Primary data source for analysis	Enterprise Data Warehouse (EDWARD) - Local Reporting Solution (LRS)
Indicator definition	Rate of hospital acquired renal failure per 10,000 admitted patient service events
Numerator	
Numerator definition	Total number of admitted patient service events (SE_TYPE_CD = '2') with separation dates in the reporting period, and with at least one of the ICD-10-AM codes listed in the Australian Commission on Safety and Quality in Health Care's (ACSQHC) HACs specification file for HACs V 3.1 (April 2022 release) downloadable from https://www.safetyandquality.gov.au/publications-and-resources/resource-library/hospital-acquired-complications-hacs-list-specifications-version-31 for the numerator for hospital acquired renal failure (HAC 8). The 12th Edition of ICD-10-AM coding should be used, which includes the following additional diagnosis codes: • Any of ICD 10 AM 12th Edition codes: N17.0, N17.1, N17.2, N17.8, N17.9, N19, O90.4, O08.4 • **AND** any of procedure codes: 13100-00, 13100-01,13100-02,13100-03, 13100-04 • **AND** condition onset flag code of 1. • **AND** satisfying the criteria for the denominator • For analysis relating to newborns with qualified days includes separations with any of specified ICD-10-AM codes as either the principal diagnosis or an additional diagnosis. • **Excluding**: admitted patient service events with either N18.4 or N18.5, regardless of any condition onset flag. For one admitted patient service event, one type of HAC is only counted at most once if multiple diagnoses of the HAC are identified.
Numerator source	EDWARD
Numerator availability	Available from 1 September 2015

Denominator

Denominator definition	Total number of admitted patient service events (SE_TYPE_CD = '2') with separation dates in the reporting period, **excluding** admitted patient service events with any of the following: • Same-day chemotherapy - DRG V11: R63Z and SE_START_DTTM = SE_END_DTTM • Same-day haemodialysis - DRG V11: L61Z and SE_START_DTTM = SE_END_DTTM • Service Category is 'Newborn - unqualified days only ' (i.e. SE_SERVICE_CATEGORY_CD = '5' and COUNT_TOTAL_SE_QUAL_DAY_COUNT =0) • Hospital boarder (SE_SERVICE_CATEGORY_CD = '0') • Care type is 'Organ procurement-posthumous' - SE_SERVICE_CATEGORY_CD = '9'.
Denominator source	EDWARD
Denominator availability	Available

Inclusions

All admitted patient service events in NSW public hospitals

Note: Mental health and drug and alcohol admitted patient service events are included in the current version (ACSQHC HACs V 3.1)

Exclusions

Numerator exclusions:

- Admitted patient service events with the qualified diagnosis codes recorded as the principal diagnosis code.
- **Excluding: admitted patient service events with either N18.4 or N18.5, regardless of any condition onset flag**

Numerator and denominator exclusions:

- Same-day chemotherapy - DRG V11: R63Z and SE_START_DTTM = SE_END_DTTM
- Same-day haemodialysis - DRG V11: L61Z and SE_START_DTTM = SE_END_DTTM
- Service Category is 'Newborn - unqualified days only ' (i.e. SE_SERVICE_CATEGORY_CD = '5' and COUNT_TOTAL_SE_QUAL_DAY_COUNT =0)
- Hospital boarder (SE_SERVICE_CATEGORY_CD = '0')
- Care type is 'Organ procurement-posthumous' - SE_SERVICE_CATEGORY_CD = '9'.
- Any uncoded records.

Targets

Local Health District	Target	Not Performing	Under Performing	Performing
Central Coast LHD	<=1.7	>2.2	>1.7 and <=2.2	<=1.7
Far West LHD	NA	NA	NA	NA
Hunter New England LHD	<=0.7	>0.9	>0.7 and <=0.9	<=0.7
Illawarra Shoalhaven LHD	<=0.8	>1.2	>0.8 and <=1.2	<=0.8
Justice Health	NA	NA	NA	NA
Murrumbidgee LHD	<=0.9	>1.3	>0.9 and <=1.3	<=0.9

Mid North Coast LHD	<=2.1	>2.6	>2.1 and <=2.6	<=2.1
Nepean Blue Mountains LHD	<=0.8	>1.2	>0.8 and <=1.2	<=0.8
Northern NSW LHD	<=1.7	>2.1	>1.7 and <=2.1	<=1.7
Northern Sydney LHD	<=3.1	>3.5	>3.1 and <=3.5	<=3.1
Sydney Children's Hospitals Network	NA	NA	NA	NA
South Eastern Sydney LHD	<=0.7	>1.0	>0.7 and <=1.0	<=0.7
Southern NSW LHD	<=0.9	>1.4	>0.9 and <=1.4	<=0.9
St Vincent's Health Network	<=4.0	>5.0	>4.0 and <=5.0	<=4.0
South Western Sydney LHD	<=2.3	>2.6	>2.3 and <=2.6	<=2.3
Sydney LHD	<=3.5	>4.0	>3.5 and <=4.0	<=3.5
Western NSW LHD	<=0.9	>1.2	>0.9 and <=1.2	<=0.9
Western Sydney LHD	<=1.1	>1.3	>1.1 and <=1.3	<=1.1

Context

"HACs affect patient's recovery, outcome and can result in a longer length of stay and higher costs to health service system, more work is needed to reduce HACs and improve the quality of care provided to patients.

Hospital-associated acute kidney injury (also known as acute renal failure) is common as it may be caused by impaired renal perfusion due to hypotension or dehydration, medicines, recent surgery, radiographic contrast media, or sepsis. Renal failure may cause distressing symptoms including fluid retention and swelling, dyspnoea, drowsiness, fatigue, cognitive clouding and confusion, persistent nausea, and seizures. The condition also has an extremely high mortality rate of 50%. Early recognition and intervention are important elements of effective treatment."

Related information can be found on the Commission's website: Australian Commission on Safety and Quality in Health Care.

Related Policies/Programs

Usable data available from 1 September 2015

Frequency of Reporting Monthly

Time lag to available data 1 month

Business owners

Contact - Policy: Chief Executive, Clinical Excellence Commission

Contact - Data: Executive Director, System Information and Analytics Branch (MOH-SystemInformationAndAnalytics@health.nsw.gov.au)

Representation

Data type: Numeric

	Form	Number, presented as a rate per 10,000 admitted patient service events
	Representational layout	NN.NN
	Minimum size	4
	Maximum size	6
	Date effective	1 July 2019
Related National Indicator		This HAC indicator follows the ACSQHC's specification: Australian Commission on Safety and Quality in Health Care – ACSQHC's Hospital Acquired Complication (HAC 8) in release V 3.1: https://www.safetyandquality.gov.au/our-work/indicators/hospital-acquired-complications#hospital-acquired-complications -list

INDICATOR: KS2134	**Hospital Acquired Gastrointestinal Bleeding** (Rate per 10,000 admitted patient service events)
Shortened Title	Hospital Acquired Gastrointestinal Bleeding
Service Agreement Type	Key Performance Indicator
NSW Health Strategic Outcome	2: Safe care is delivered across all settings
Status	Final
Version number	2.0
Scope	All patients in NSW public hospitals
Goal	To reduce hospital acquired gastrointestinal bleeding by the provision of care that mitigates avoidable clinical risks to patients.
Desired outcome	Reduction in Hospital Acquired Gastrointestinal Bleeding.
Primary point of collection	Patient medical record
Data Collection Source/System	Admitted patient data collection
Primary data source for analysis	Enterprise Data Warehouse (EDWARD) - Local Reporting Solution (LRS)
Indicator definition	Rate of hospital acquired gastrointestinal bleeding per 10,000 admitted patient service events
Numerator	
Numerator definition	Total number of admitted patient service events (SE_TYPE_CD = '2') with separation dates in the reporting period, and with at least one of the ICD-10-AM codes listed in the Australian Commission on Safety and Quality in Health Care's (ACSQHC) HACs specification file for HACs V 3.1 (April 2022 release) downloadable from https://www.safetyandquality.gov.au/publications-and-resources/resource-library/hospital-acquired-complications-hacs-list-specifications-version-31 for the numerator for hospital acquired gastrointestinal bleeding (HAC 9). The 12th Edition of ICD-10-AM coding should be used, which includes the following additional diagnosis codes: • Any of **ICD10AM 12th Edition** codes: K22.6, K25.0, K25.2, K25.4, K25.6, K26.0, K26.2, K26.4, K26.6, K27.0, K27.2, K27.4, K27.6, K28.0, K28.2, K28.4, K28.6, K29.0, K92.0, K92.1, K92.2, • **AND** condition onset flag code of 1. • **AND satisfying the criteria for the denominator** • For analysis relating to newborns with qualified days includes separations with any of specified ICD-10-AM codes as either the principal diagnosis or an additional diagnosis. For one admitted patient service event, one type of HAC is only counted at most once if multiple diagnoses of the HAC are identified.
Numerator source	EDWARD
Numerator availability	Available from 1 September 2015

Denominator

Denominator definition	Total number of admitted patient service events (SE_TYPE_CD = '2') with separation dates in the reporting period, **excluding** admitted patient service events with any of the following: • Same-day chemotherapy - DRG V11: R63Z and SE_START_DTTM = SE_END_DTTM • Same-day haemodialysis - DRG V11: L61Z and SE_START_DTTM = SE_END_DTTM • Service Category is 'Newborn - unqualified days only ' (i.e. SE_SERVICE_CATEGORY_CD = '5' and COUNT_TOTAL_SE_QUAL_DAY_COUNT =0) • Hospital boarder (SE_SERVICE_CATEGORY_CD = '0') • Care type is 'Organ procurement-posthumous' - SE_SERVICE_CATEGORY_CD = '9'.
Denominator source	EDWARD
Denominator availability	Available
Inclusions	All admitted patient service events in NSW public hospitals Note: Mental health and drug and alcohol admitted patient service events are included in the current version (ACSQHC HACs V 3.1)
Exclusions	Numerator exclusions: • Admitted patient service events with the qualified diagnosis codes recorded as the principal diagnosis code. Numerator and denominator exclusions: • Same-day chemotherapy - DRG V11: R63Z and SE_START_DTTM = SE_END_DTTM • Same-day haemodialysis - DRG V11: L61Z and SE_START_DTTM = SE_END_DTTM • Service Category is 'Newborn - unqualified days only ' (i.e. SE_SERVICE_CATEGORY_CD = '5' and COUNT_TOTAL_SE_QUAL_DAY_COUNT =0) • Hospital boarder (SE_SERVICE_CATEGORY_CD = '0') • Care type is 'Organ procurement-posthumous' - SE_SERVICE_CATEGORY_CD = '9'. • Any uncoded records.
Targets	The risk adjusted targets for individual Local Health Districts and Local Specialty Health Networks are set for a 12 month rolling period (12 months to date). Provisional performance target for individual LHDs or Specialty Networks are:

Local Health District	Target	Not Performing	Under Performing	Performing
Central Coast LHD	<=11.9	>13.0	>11.9 and <=13.0	<=11.9
Far West LHD	<=9.4	>13.2	>9.4 and <=13.2	<=9.4
Hunter New England LHD	<=8.9	>9.5	>8.9 and <=9.5	<=8.9
Illawarra Shoalhaven LHD	<=11.4	>12.5	>11.4 and <=12.5	<=11.4

Justice Health	<=21.9	>34.7	>21.9 and <=34.7	<=21.9
Murrumbidgee LHD	<=8.6	>9.7	>8.6 and <=9.7	<=8.6
Mid North Coast LHD	<=9.9	>11.0	>9.9 and <=11.0	<=9.9
Nepean Blue Mountains LHD	<=9.0	>10.0	>9.0 and <=10.0	<=9.0
Northern NSW LHD	<=10.1	>11.1	>10.1 and <=11.1	<=10.1
Northern Sydney LHD	<=12.3	>13.1	>12.3 and <=13.1	<=12.3
Sydney Children's Hospitals Network	<=2.9	>3.5	>2.9 and <=3.5	<=2.9
South Eastern Sydney LHD	<=9.0	>9.7	>9.0 and <=9.7	<=9.0
Southern NSW LHD	<=8.7	>10.1	>8.7 and <=10.1	<=8.7
St Vincent's Health Network	<=11.7	>13.4	>11.7 and <=13.4	<=11.7
South Western Sydney LHD	<=10.4	>11.0	>10.4 and <=11.0	<=10.4
Sydney LHD	<=11.9	>12.7	>11.9 and <=12.7	<=11.9
Western NSW LHD	<=8.5	>9.5	>8.5 and <=9.5	<=8.5
Western Sydney LHD	<=8.7	>9.4	>8.7 and <=9.4	<=8.7

The risk adjusted targets have been developed using risk adjusted models on the 2019 NSW APDC data. The risk adjustors used are largely in the same dimensions as those used for IHPA's service activity adjustors.

Rates of under and up to 80% upper control limits of expected rates are scored as 'Performing', rates between 80% and 95% upper control limits as 'Under Performing', and rates above the respective 95% upper control limits are flagged as 'Not Performing'. Targets are not applicable if the expected number of HACs is less than 1.

Context

Hospital-acquired gastrointestinal bleeding extends the length of hospitalisation, which impacts on patients, their families and increases the cost of admission. A majority of gastrointestinal bleeds are preventable. Significant reductions in gastrointestinal bleeding rates are being achieved in some hospitals by preventative initiatives.

The above information is sourced from the ACSQHC's HAC information kit, downloadable from the Commission's website:

Australian Commission on Safety and Quality in Health Care

The HAC information kit contains more contextual information.

Related Policies/Programs

Usable data available from

1 September 2015

Frequency of Reporting

Monthly

Time lag to available data	1 month
Business owners	
Contact - Policy	Chief Executive, Clinical Excellence Commission
Contact - Data	Executive Director, System Information and Analytics Branch (MOH-SystemInformationAndAnalytics@health.nsw.gov.au)
Representation	
Data type	Numeric
Form	Number, presented as a rate per 10,000 admitted patient service events
Representational layout	NN.NN
Minimum size	4
Maximum size	6
Date effective	1 July 2019
Related National Indicator	This HAC indicator follows the ACSQHC's specification: Australian Commission on Safety and Quality in Health Care – ACSQHC's Hospital Acquired Complication (HAC 9) in release V 3.1: https://www.safetyandquality.gov.au/our-work/indicators/hospital-acquired-complications#hospital-acquired-complications -list

INDICATOR: KS2135	**Hospital Acquired Medication Complications** (Rate per 10,000 admitted patient service events)
Shortened Title	HAC Medication Complications
Service Agreement Type	Key Performance Indicator
NSW Health Strategic Outcome	2: Safe care is delivered across all settings
Status	Final
Version number	2.0
Scope	All patients admitted to public hospitals in NSW
Goal	To improve the quality use of medicines and to reduce complications and adverse events arising from medication use.
Desired outcome	Reduction in the number of patients developing complications due to the intake of medications.
Primary point of collection	Patient medical record
Data Collection Source/System	Admitted patient data collection
Primary data source for analysis	Enterprise Data Warehouse (EDWARD) - Local Reporting Solution (LRS)
Indicator definition	The rate of completed admitted patient service events within the reporting period where a medication complication has occurred in a public hospital per 10,000 admitted patient service events.
Numerator	
Numerator definition	Total number of admitted patient service events (SE_TYPE_CD = '2') with separation dates in the reporting period, and with at least one of the ICD-10-AM codes listed in the Australian Commission on Safety and Quality in Health Care's (ACSQHC) HACs specification file for HACs V 3.1 (April 2022 release) downloadable from https://www.safetyandquality.gov.au/publications-and-resources/resource-library/hospital-acquired-complications-hacs-list-specifications-version-31 for the numerator for Hospital Acquired Medication Complications (HAC 10). The 12th Edition of ICD-10-AM coding should be used, which includes the following additional diagnosis codes: • 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 admitted patient service event) 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 as an additional diagnosis AND a condition onset flag (COF) code of 1 (Condition with onset during the admitted patient service event); OR

	• Any of ICD-10-AM codes G21.1, G24.0, G24.5, G24.8, G24.9, G25.1, G25.2, G25.3, G25.4, G25.6, G25.8, G25.9, R25.1, R25.3, R26.3, R26.0, R27.0, R29.2, R45.1, R40.0, R40.1, R40.2, S06.01, S06.02, R55 as an additional diagnosis AND a condition onset flag (COF) code of 1 (Condition with onset during the admitted patient service event), AND any external cause codes of Y46.x, Y47.x, Y49.x, Y50.x • **AND** satisfying the criteria for the denominator • For analysis relating to newborns with qualified days includes separations with any of specified ICD-10-AM codes as either the principal diagnosis or an additional diagnosis. For one admitted patient service event, one type of HAC is only counted at most once if multiple diagnoses of the HAC are identified.
Numerator source	EDWARD
Numerator availability	Available from 1 September 2015
Denominator	
Denominator definition	Total number of admitted patient service events (SE_TYPE_CD = '2') with separation dates in the reporting period, **excluding** admitted patient service events with any of the following: • Same-day chemotherapy - DRG V11: R63Z and SE_START_DTTM = SE_END_DTTM • Same-day haemodialysis - DRG V11: L61Z and SE_START_DTTM = SE_END_DTTM • Service Category is 'Newborn - unqualified days only ' (i.e. SE_SERVICE_CATEGORY_CD = '5' and COUNT_TOTAL_SE_QUAL_DAY_COUNT =0) • Hospital boarder (SE_SERVICE_CATEGORY_CD = '0') • Care type is 'Organ procurement-posthumous' - SE_SERVICE_CATEGORY_CD = '9'.
Denominator source	EDWARD
Denominator availability	Available
Inclusions	All admitted patient service events in NSW public hospitals Note: Mental health and drug and alcohol admitted patient service events are included in the current version (ACSQHC HACs V 3.1).
Exclusions	Numerator exclusions: • Admitted patient service events with the qualified diagnosis codes recorded as the principal diagnosis code. Numerator and denominator exclusions: • Same-day chemotherapy - DRG V11: R63Z and SE_START_DTTM = SE_END_DTTM • Same-day haemodialysis - DRG V11: L61Z and SE_START_DTTM = SE_END_DTTM

- Service Category is 'Newborn - unqualified days only ' (i.e. SE_SERVICE_CATEGORY_CD = '5' and COUNT_TOTAL_SE_QUAL_DAY_COUNT =0)
- Hospital boarder (SE_SERVICE_CATEGORY_CD = '0')
- Care type is 'Organ procurement-posthumous' - SE_SERVICE_CATEGORY_CD = '9'.
- Any uncoded records.

Targets

The risk adjusted targets for individual Local Health Districts and Local Specialty Health Networks are set for a 12 month rolling period (12 months to date). Provisional performance target for individual LHDs or Specialty Networks are:

Local Health District	Target	Not Performing	Under Performing	Performing
Central Coast LHD	<=10.0	>11.0	>10.0 and <=11.0	<=10.0
Far West LHD	<=11.4	>15.5	>11.4 and <=15.5	<=11.4
Hunter New England LHD	<=8.2	>8.8	>8.2 and <=8.8	<=8.2
Illawarra Shoalhaven LHD	<=10.2	>11.2	>10.2 and <=11.2	<=10.2
Justice Health	<=31.3	>46.1	>31.3 and <=46.1	<=31.3
Murrumbidgee LHD	<=7.5	>8.6	>7.5 and <=8.6	<=7.5
Mid North Coast LHD	<=8.7	>9.7	>8.7 and <=9.7	<=8.7
Nepean Blue Mountains LHD	<=8.5	>9.5	>8.5 and <=9.5	<=8.5
Northern NSW LHD	<=8.7	>9.6	>8.7 and <=9.6	<=8.7
Northern Sydney LHD	<=10.7	>11.5	>10.7 and <=11.5	<=10.7
Sydney Children's Hospitals Network	<=1.6	>2.1	>1.6 and <=2.1	<=1.6
South Eastern Sydney LHD	<=7.9	>8.5	>7.9 and <=8.5	<=7.9
Southern NSW LHD	<=8.4	>9.7	>8.4 and <=9.7	<=8.4
St Vincent's Health Network	<=11.4	>13.0	>11.4 and <=13.0	<=11.4
South Western Sydney LHD	<=8.9	>9.5	>8.9 and <=9.5	<=8.9
Sydney LHD	<=11.1	>12.0	>11.1 and <=12.0	<=11.1
Western NSW LHD	<=8.0	>9.0	>8.0 and <=9.0	<=8.0
Western Sydney LHD	<=8.3	>9.0	>8.3 and <=9.0	<=8.3

	The risk adjusted targets have been developed using risk adjusted models on the 2019 NSW APDC data. The risk adjustors used are largely in the same dimensions as those used for IHPA's service activity adjustors. Rates of under and up to 80% upper control limits of expected rates are scored as 'Performing', rates between 80% and 95% upper control limits as 'Under Performing', and rates above the respective 95% upper control limits are flagged as 'Not Performing'. Targets are not applicable if the expected number of HACs is less than 1.
Context	Contextual information can be found in the ACSQHC's HAC information kit, downloadable from the Commission's website: Australian Commission on Safety and Quality in Health Care
Related Policies/ Programs	
Useable data available from	1 September 2015
Frequency of Reporting	Monthly
Time lag to available data	1 month
Business owners	
Contact - Policy	Chief Executive, Clinical Excellence Commission
Contact - Data	Executive Director, Systems Information and Analytics (MOH-SystemsInformationAndAnalytics@health.nsw.gov.au)
Representation	
Data type	Numeric
Form	Number, presented as a rate per 10,000 admitted patient service events
Representational layout	NN.NN
Minimum size	4
Maximum size	6
Data domain	
Date effective	1 July 2019
Related National Indicator	This HAC indicator follows the ACSQHC's specification: Australian Commission on Safety and Quality in Health Care – ACSQHC's Hospital Acquired Complication (HAC 10) in release V 3.1: https://www.safetyandquality.gov.au/our-work/indicators/hospital-acquired-complications#hospital-acquired-complications -list

INDICATOR: KS2136

Hospital Acquired Delirium (Rate per 10,000 admitted patient service events)

Shortened Title	Hospital Acquired Delirium
Service Agreement Type	Key Performance Indicator
NSW Health Strategic Outcome	2: Safe care is delivered across all settings
Status	Final
Version number	2.0
Scope	All patients admitted to public hospitals in NSW
Goal	To reduce hospital acquired delirium by the provision of care that mitigates avoidable clinical risks to patients.
Desired outcome	Reduction in hospital acquired delirium
Primary point of collection	Patient medical record
Data Collection Source/System	Admitted patient data collection
Primary data source for analysis	Enterprise Data Warehouse (EDWARD) - Local Reporting Solution (LRS)
Indicator definition	Rate of hospital acquired delirium per 10,000 admitted patient service events
Numerator	
Numerator definition	Total number of admitted patient service events (SE_TYPE_CD = '2') with separation dates in the reporting period, and with at least one of the ICD-10-AM codes listed in the Australian Commission on Safety and Quality in Health Care's (ACSQHC) HACs specification file for HACs V 3.1 (April 2022 release) downloadable from https://www.safetyandquality.gov.au/publications-and-resources/resource-library/hospital-acquired-complications-hacs-list-specifications-version-31 for the numerator for hospital acquired Delirium (HAC 11). The 12th Edition of ICD-10-AM coding should be used, which includes the following additional diagnosis codes: • Any of ICD 10 AM 12th Edition codes: F05.0, F05.1, F05.8, F05.9, and R41.0. • **AND** condition onset flag code of 1. • **AND** satisfying the criteria for the denominator • For analysis relating to newborns with qualified days includes separations with any of specified ICD-10-AM codes as either the principal diagnosis or an additional diagnosis. For one admitted patient service event, one type of HAC is only counted at most once if multiple diagnoses of the HAC are identified.
Numerator source	EDWARD
Numerator availability	Available from 1 September 2015
Denominator	

Denominator definition	Total number of admitted patient service events (SE_TYPE_CD = '2') with separation dates in the reporting period, **excluding** admitted patient service events with any of the following: • Same-day chemotherapy - DRG V11: R63Z and SE_START_DTTM = SE_END_DTTM • Same-day haemodialysis - DRG V11: L61Z and SE_START_DTTM = SE_END_DTTM • Service Category is 'Newborn - unqualified days only ' (i.e. SE_SERVICE_CATEGORY_CD = '5' and COUNT_TOTAL_SE_QUAL_DAY_COUNT =0) • Hospital boarder (SE_SERVICE_CATEGORY_CD = '0') • Care type is 'Organ procurement-posthumous' - SE_SERVICE_CATEGORY_CD = '9'.
Denominator source	EDWARD
Denominator availability	Available

Inclusions

All admitted patient service events in NSW public hospitals

Note: Mental health and drug and alcohol admitted patient service events are included in the current version (ACSQHC V3.1).

Exclusions

Numerator exclusions:

Admitted patient service events with the qualified diagnosis codes recorded as the principal diagnosis code.

Numerator and denominator exclusions:

- Same-day chemotherapy - DRG V11: R63Z and SE_START_DTTM = SE_END_DTTM
- Same-day haemodialysis - DRG V11: L61Z and SE_START_DTTM = SE_END_DTTM
- Service Category is 'Newborn - unqualified days only ' (i.e. SE_SERVICE_CATEGORY_CD = '5' and COUNT_TOTAL_SE_QUAL_DAY_COUNT =0)
- Hospital boarder (SE_SERVICE_CATEGORY_CD = '0')
- Care type is 'Organ procurement-posthumous' - SE_SERVICE_CATEGORY_CD = '9'.
- Any uncoded records.

Targets

The risk adjusted targets for individual Local Health Districts and Local Specialty Health Networks are set for a 12-month rolling period (12 months to date). Provisional performance target for individual LHDs or Specialty Networks are:

Local Health District	Target	Not Performing	Under Performing	Performing
Central Coast LHD	<=49.7	>52.0	>49.7 and <=52.0	<=49.7
Far West LHD	<=30.8	>37.2	>30.8 and <=37.2	<=30.8
Hunter New England LHD	<=37.1	>38.4	>37.1 and <=38.4	<=37.1
Illawarra Shoalhaven LHD	<=46.9	>49.1	>46.9 and <=49.1	<=46.9

Justice Health	<=21.9	>34.7	>21.9 and <=34.7	<=21.9
Murrumbidgee LHD	<=33.0	>35.1	>33.0 and <=35.1	<=33.0
Mid North Coast LHD	<=44.7	>46.9	>44.7 and <=46.9	<=44.7
Nepean Blue Mountains LHD	<=35.1	>37.0	>35.1 and <=37.0	<=35.1
Northern NSW LHD	<=42.6	>44.6	>42.6 and <=44.6	<=42.6
Northern Sydney LHD	<=60.0	>61.9	>60.0 and <=61.9	<=60.0
Sydney Children's Hospitals Network	<=5.2	>6.1	>5.2 and <=6.1	<=5.2
South Eastern Sydney LHD	<=38.3	>39.6	>38.3 and <=39.6	<=38.3
Southern NSW LHD	<=32.3	>34.9	>32.3 and <=34.9	<=32.3
St Vincent's Health Network	<=52.0	>55.4	>52.0 and <=55.4	<=52.0
South Western Sydney LHD	<=45.1	>46.5	>45.1 and <=46.5	<=45.1
Sydney LHD	<=56.3	>58.1	>56.3 and <=58.1	<=56.3
Western NSW LHD	<=33.6	>35.4	>33.6 and <=35.4	<=33.6
Western Sydney LHD	<=35.3	>36.7	>35.3 and <=36.7	<=35.3

The risk adjusted targets have been developed using risk adjusted models on the 2019 NSW APDC data. The risk adjustors used are largely in the same dimensions as those used for IHPA's service activity adjustors.

Rates of under and up to 80% upper control limits of expected rates are scored as 'Performing', rates between 80% and 95% upper control limits as 'Under Performing', and rates above the respective 95% upper control limits are flagged as 'Not Performing'. Targets are not applicable if the expected number of HACs is less than 1.

Context

Hospital-acquired delirium prolongs the length of hospitalisation, increases the cost of admission, and adds pain and discomfort to the patient. Prevention is the most effective strategy, but outcomes for patients with delirium can also be improved by early recognition and intervention. Significant reductions in delirium rates are being achieved in some hospitals through preventive initiatives.

Related information can be found on the Commission's website:

Australian Commission on Safety and Quality in Health Care

Related Policies/Programs

Usable data available from

1 September 2015

Frequency of Reporting

Monthly

Time lag to available data

1 month

Business owners	
Contact - Policy	Chief Executive, Clinical Excellence Commission
Contact - Data	Executive Director, System Information and Analytics Branch (MOH-SystemInformationAndAnalytics@health.nsw.gov.au)
Representation	
Data type	Numeric
Form	Number, presented as a rate per 10,000 admitted patient service events
Representational layout	NN.NN
Minimum size	4
Maximum size	6
Date effective	1 July 2019
Related National Indicator	This HAC indicator follows the ACSQHC's specification: Australian Commission on Safety and Quality in Health Care – ACSQHC's Hospital Acquired Complication (HAC 11) in release V 3.1: https://www.safetyandquality.gov.au/our-work/indicators/hospital-acquired-complications#hospital-acquired-complications -list

INDICATOR: KS2137	**Hospital Acquired Incontinence** (Rate per 10,000 admitted patient service events)
Shortened Title	Hospital Acquired Incontinence
Service Agreement Type	Key Performance Indicator
NSW Health Strategic Outcome	2: Safe care is delivered across all settings
Status	Final
Version number	2.0
Scope	All patients admitted to public hospitals in NSW
Goal	To reduce Hospital Acquired Incontinence by the provision of care that mitigates avoidable clinical risks to patients.
Desired outcome	Reduction in Hospital Acquired Incontinence
Primary point of collection	Patient medical record
Data Collection Source/System	Admitted patient data collection
Primary data source for analysis	Enterprise Data Warehouse (EDWARD) - Local Reporting Solution (LRS)
Indicator definition	Rate of hospital acquired urinary and faecal incontinence per 10,000 admitted patient service events
Numerator	
Numerator definition	Total number of admitted patient service events (SE_TYPE_CD = '2') with separation dates in the reporting period, and with at least one of the ICD-10-AM codes listed in the Australian Commission on Safety and Quality in Health Care's (ACSQHC) HACs specification file for HACs V 3.1 (April 2022 release) downloadable from https://www.safetyandquality.gov.au/publications-and-resources/resource-library/hospital-acquired-complications-hacs-list-specifications-version-31 for the numerator for hospital acquired Persistent Incontinence (HAC 12). The 12th Edition of ICD-10-AM coding should be used, which includes the following additional diagnosis codes: • Any of ICD10AM 12th Edition codes: R32, N39.30, N39.31, N39.4, or R15. • **AND** condition onset flag code of 1. • **AND** satisfying the criteria for the denominator • For analysis relating to newborns with qualified days includes separations with any of specified ICD-10-AM codes as either the principal diagnosis or an additional diagnosis. For one admitted patient service event, one type of HAC is only counted at most once if multiple diagnoses of the HAC are identified.
Numerator source	EDWARD
Numerator availability	Available from 1 September 2015
Denominator	

Denominator definition	Total number of admitted patient service events (SE_TYPE_CD = '2') with separation dates in the reporting period, **excluding** admitted patient service events with any of the following: • Same-day chemotherapy - DRG V11: R63Z and SE_START_DTTM = SE_END_DTTM • Same-day haemodialysis - DRG V11: L61Z and SE_START_DTTM = SE_END_DTTM • Service Category is 'Newborn - unqualified days only ' (i.e. SE_SERVICE_CATEGORY_CD = '5' and COUNT_TOTAL_SE_QUAL_DAY_COUNT =0) • Hospital boarder (SE_SERVICE_CATEGORY_CD = '0') • Care type is 'Organ procurement-posthumous' - SE_SERVICE_CATEGORY_CD = '9'.
Denominator source	EDWARD
Denominator availability	Available
Inclusions	All admitted patient service events in NSW public hospitals Note: Mental health and drug and alcohol admitted patient service events are included in the current version (ACSQHC HACs V 3.0).
Exclusions	Numerator exclusions: • Admitted patient service events with the qualified diagnosis codes recorded as the principal diagnosis code. Numerator and denominator exclusions: • Same-day chemotherapy - DRG V11: R63Z and SE_START_DTTM = SE_END_DTTM • Same-day haemodialysis - DRG V11: L61Z and SE_START_DTTM = SE_END_DTTM • Service Category is 'Newborn - unqualified days only ' (i.e. SE_SERVICE_CATEGORY_CD = '5' and COUNT_TOTAL_SE_QUAL_DAY_COUNT =0) • Hospital boarder (SE_SERVICE_CATEGORY_CD = '0') • Care type is 'Organ procurement-posthumous' - SE_SERVICE_CATEGORY_CD = '9'. • Any uncoded records.
Targets	The risk adjusted targets for individual Local Health Districts and Local Specialty Health Networks are set for a 12 month rolling period (12 months to date). Provisional performance target for individual LHDs or Specialty Networks are:

Local Health District	Target	Not Performing	Under Performing	Performing
Central Coast LHD	<=2.6	>3.1	>2.6 and <=3.1	<=2.6
Far West LHD	NA	NA	NA	NA
Hunter New England LHD	<=2.6	>2.9	>2.6 and <=2.9	<=2.6
Illawarra Shoalhaven LHD	<=2.9	>3.4	>2.9 and <=3.4	<=2.9
Justice Health	NA	NA	NA	NA

Murrumbidgee LHD	<=2.9	>3.6	>2.9 and <=3.6	<=2.9
Mid North Coast LHD	<=2.3	>2.8	>2.3 and <=2.8	<=2.3
Nepean Blue Mountains LHD	<=2.9	>3.5	>2.9 and <=3.5	<=2.9
Northern NSW LHD	<=2.3	>2.8	>2.3 and <=2.8	<=2.3
Northern Sydney LHD	<=2.7	>3.1	>2.7 and <=3.1	<=2.7
Sydney Children's Hospitals Network	<=0.5	>0.9	>0.5 and <=0.9	<=0.5
South Eastern Sydney LHD	<=2.7	>3.0	>2.7 and <=3.0	<=2.7
Southern NSW LHD	<=3.1	>3.9	>3.1 and <=3.9	<=3.1
St Vincent's Health Network	<=1.8	>2.5	>1.8 and <=2.5	<=1.8
South Western Sydney LHD	<=2.7	>3.1	>2.7 and <=3.1	<=2.7
Sydney LHD	<=3.0	>3.4	>3.0 and <=3.4	<=3.0
Western NSW LHD	<=2.6	>3.2	>2.6 and <=3.2	<=2.6
Western Sydney LHD	<=3.1	>3.5	>3.1 and <=3.5	<=3.1

The risk adjusted targets have been developed using risk adjusted models on the 2019 NSW APDC data. The risk adjustors used are largely in the same dimensions as those used for IHPA's service activity adjustors.

Rates of under and up to 80% upper control limits of expected rates are scored as 'Performing', rates between 80% and 95% upper control limits as 'Under Performing', and rates above the respective 95% upper control limits are flagged as 'Not Performing'. Targets are not applicable if the expected number of HACs is less than 1.

Context

Hospital-acquired persistent incontinence prolongs the length of hospitalisation, increases the cost of admission, and adds pain and discomfort to the patient. The majority of persistent incontinence can also be prevented. Significant reductions in hospital-acquired persistent incontinence rates are being achieved in some hospitals through preventive initiatives.

Related information can be found on the Commission's website:

Australian Commission on Safety and Quality in Health Care

Related Policies/Programs

Usable data available from

1 September 2015

Frequency of Reporting

Monthly

Time lag to available data

1 month

Business owners

Contact - Policy

Chief Executive, Clinical Excellence Commission

Contact - Data	Executive Director, System Information and Analytics Branch (MOH-SystemInformationAndAnalytics@health.nsw.gov.au)
Representation	
Data type	Numeric
Form	Number, presented as a rate per 10,000 admitted patient service events
Representational layout	NN.NN
Minimum size	4
Maximum size	6
Date effective	1 July 2019
Related National Indicator	This HAC indicator follows the ACSQHC's specification: Australian Commission on Safety and Quality in Health Care – ACSQHC's Hospital Acquired Complication (HAC 12) in release V 3.1: https://www.safetyandquality.gov.au/our-work/indicators/hospital-acquired-complications#hospital-acquired-complications -list

INDICATOR: KS2138	**Hospital Acquired Endocrine Complications** (Rate per 10,000 admitted patient service events)
Shortened Title	Hospital Acquired Endocrine Complications
Service Agreement Type	Key Performance Indicator
NSW Health Strategic Outcome	2: Safe care is delivered across all settings
Status	Final
Version number	2.0
Scope	All patients admitted to public hospitals in NSW
Goal	To reduce hospital acquired endocrine complications by the provision of patient care that mitigates avoidable risks to patients.
Desired outcome	Reduction in Hospital Acquired Endocrine Complications
Primary point of collection	Patient medical record
Data Collection Source/System	Admitted patient data collection
Primary data source for analysis	Enterprise Data Warehouse (EDWARD) - Local Reporting Solution (LRS)
Indicator definition	Rate of hospital acquired endocrine complications per 10,000 admitted patient service events.
Numerator	
Numerator definition	Total number of admitted patient service events (SE_TYPE_CD = '2') with separation dates in the reporting period, and with at least one of the ICD-10-AM codes listed in the Australian Commission on Safety and Quality in Health Care's (ACSQHC) HACs specification file for HACs V 3.1 (April 2022 release) downloadable from https://www.safetyandquality.gov.au/publications-and-resources/resource-library/hospital-acquired-complications-hacs-list-specifications-version-31 for the numerator for hospital acquired endocrine complications (HAC 13). The 12th Edition of ICD-10-AM coding should be used, which includes the following additional diagnosis codes: • Any of ICD 10 AM 12th Edition codes: E43, E44.0, E44.1, E46, E10.64, E11.64, E13.64, E14.64, E16.0, E16.1, E16.2. • **AND** condition onset flag code of 1. • **AND** satisfying the criteria for the denominator • For analysis relating to newborns with qualified days includes separations with any of specified ICD-10-AM codes as either the principal diagnosis or an additional diagnosis. For one admitted patient service event, one type of HAC is only counted at most once if multiple diagnoses of the HAC are identified.
Numerator source	EDWARD
Numerator availability	Available from 1 September 2015
Denominator	

Denominator definition	Total number of admitted patient service events (SE_TYPE_CD = '2') with separation dates in the reporting period, **excluding** admitted patient service events with any of the following: • Same-day chemotherapy - DRG V11: R63Z and SE_START_DTTM = SE_END_DTTM • Same-day haemodialysis - DRG V11: L61Z and SE_START_DTTM = SE_END_DTTM • Service Category is 'Newborn - unqualified days only ' (i.e. SE_SERVICE_CATEGORY_CD = '5' and COUNT_TOTAL_SE_QUAL_DAY_COUNT =0) • Hospital boarder (SE_SERVICE_CATEGORY_CD = '0') • Care type is 'Organ procurement-posthumous' - SE_SERVICE_CATEGORY_CD = '9'.
Denominator source	EDWARD
Denominator availability	Available
Inclusions	All admitted patient service events in NSW public hospitals Note: Mental health and drug and alcohol admitted patient service events are included in the current version (ACSQHC HACs V 3.1).
Exclusions	Numerator exclusions: Admitted patient service events with the qualified diagnosis codes recorded as the principal diagnosis code. Numerator and denominator exclusions: • Same-day chemotherapy - DRG V11: R63Z and SE_START_DTTM = SE_END_DTTM • Same-day haemodialysis - DRG V11: L61Z and SE_START_DTTM = SE_END_DTTM • Service Category is 'Newborn - unqualified days only ' (i.e. SE_SERVICE_CATEGORY_CD = '5' and COUNT_TOTAL_SE_QUAL_DAY_COUNT =0) • Hospital boarder (SE_SERVICE_CATEGORY_CD = '0') • Care type is 'Organ procurement-posthumous' - SE_SERVICE_CATEGORY_CD = '9'. • Any uncoded records.
Targets	The risk adjusted targets for individual Local Health Districts and Local Specialty Health Networks are set for a 12 month rolling period (12 months to date). Provisional performance target for individual LHDs or Specialty Networks are:

Local Health District	Target	Not Performing	Under Performing	Performing
Central Coast LHD	<=36.6	>38.6	>36.6 and <=38.6	<=36.6
Far West LHD	<=30.8	>37.2	>30.8 and <=37.2	<=30.8
Hunter New England LHD	<=29.8	>30.9	>29.8 and <=30.9	<=29.8
Illawarra Shoalhaven LHD	<=35.3	>37.2	>35.3 and <=37.2	<=35.3
Justice Health	<=40.4	>56.8	>40.4 and <=56.8	<=40.4

Murrumbidgee LHD	<=25.6	>27.4	>25.6 and <=27.4	<=25.6
Mid North Coast LHD	<=29.7	>31.6	>29.7 and <=31.6	<=29.7
Nepean Blue Mountains LHD	<=30.3	>32.1	>30.3 and <=32.1	<=30.3
Northern NSW LHD	<=30.1	>31.8	>30.1 and <=31.8	<=30.1
Northern Sydney LHD	<=34.9	>36.4	>34.9 and <=36.4	<=34.9
Sydney Children's Hospitals Network	<=7.5	>8.5	>7.5 and <=8.5	<=7.5
South Eastern Sydney LHD	<=28.7	>29.9	>28.7 and <=29.9	<=28.7
Southern NSW LHD	<=26.1	>28.4	>26.1 and <=28.4	<=26.1
St Vincent's Health Network	<=32.4	>35.1	>32.4 and <=35.1	<=32.4
South Western Sydney LHD	<=32.5	>33.7	>32.5 and <=33.7	<=32.5
Sydney LHD	<=33.2	>34.6	>33.2 and <=34.6	<=33.2
Western NSW LHD	<=28.0	>29.7	>28.0 and <=29.7	<=28.0
Western Sydney LHD	<=29.2	>30.5	>29.2 and <=30.5	<=29.2

The risk adjusted targets have been developed using risk adjusted models on the 2019 NSW APDC data. The risk adjustors used are largely in the same dimensions as those used for IHPA's service activity adjustors.

Rates of under and up to 80% upper control limits of expected rates are scored as 'Performing', rates between 80% and 95% upper control limits as 'Under Performing', and rates above the respective 95% upper control limits are flagged as 'Not Performing'. Targets are not applicable if the expected number of HACs is less than 1.

Context

Hospital Acquired Malnutrition prolongs the length of hospitalisation, increases the cost of admission, and adds pain and discomfort to the patient. Significant reductions in malnutrition rates are being achieved in some hospitals by suitable preventive initiatives.

Related information can be found on the Commission's website:

Australian Commission on Safety and Quality in Health Care

Related Policies/Programs

Usable data available from 1 September 2015

Frequency of Reporting Monthly

Time lag to available data 1 month

Business owners

Contact - Policy: Chief Executive, Clinical Excellence Commission

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

	(MOH-SystemInformationAndAnalytics@health.nsw.gov.au)
Representation	
Data type	Numeric
Form	Number, presented as a rate per 10,000 admitted patient service events
Representational layout	NN.NN
Minimum size	4
Maximum size	6
Date effective	1 July 2019
Related National Indicator	This HAC indicator follows the ACSQHC's specification: Australian Commission on Safety and Quality in Health Care – ACSQHC's Hospital Acquired Complication (HAC 13) in release V 3.1: https://www.safetyandquality.gov.au/our-work/indicators/hospital-acquired-complications#hospital-acquired-complications -list

INDICATOR: KS2139	**Hospital Acquired Cardiac Complications** (Rate per 10,000 admitted patient service events)
Shortened Title	Hospital Acquired Cardiac Complications
Service Agreement Type	Key Performance Indicator
NSW Health Strategic Outcome	2: Safe care is delivered across all settings
Status	Final
Version number	2.0
Scope	All patients admitted to public hospitals in NSW
Goal	To reduce hospital acquired cardiac complications by the provision of patient care that mitigates avoidable risks to patients
Desired outcome	Reduction in Hospital Acquired Cardiac Complications
Primary point of collection	Patient medical record
Data Collection Source/System	Admitted patient data collection
Primary data source for analysis	Enterprise Data Warehouse (EDWARD) - Local Reporting Solution (LRS)
Indicator definition	Rate of hospital acquired cardiac complications per 10,000 admitted patient service events.
Numerator	
Numerator definition	Total number of admitted patient service events (SE_TYPE_CD = '2') with separation dates in the reporting period, and with at least one of the ICD-10-AM codes listed in the Australian Commission on Safety and Quality in Health Care's (ACSQHC) HACs specification file for HACs V 3.1 (April 2022 release) downloadable from https://www.safetyandquality.gov.au/publications-and-resources/resource-library/hospital-acquired-complications-hacs-list-specifications-version-31 for the numerator for hospital acquired Cardiac complications (HAC 14). The 12th Edition of ICD-10-AM coding should be used, which includes the following additional diagnosis codes: • Any of ICD 10 AM 12th Edition codes: I50.0, I50.1, I50.9, I47.0, I47.1, I48.9, I49.0, I49.8, I49.9; OR • Diagnosis code R00.1, AND with any of the procedure codes 38256-00, 38256-01,38350-00,38368-00,38390-00,38390-01,38390-02,38470-00,38470-01,38473-00,38473-01,38654-00,38654-03,90202-00,90202-01,90202-02; OR • Any of I46.0, I46.1, I46.9, I20.0, I21.0, I21.1, I21.2, I21.3, I21.4, I21.9, I22.0, I22.1, I22.8, I22.9, I33.0; • **AND** condition onset flag code of 1 for the qualified diagnosis. • **AND** satisfying the criteria for the denominator • For analysis relating to newborns with qualified days includes separations with any of specified ICD-10-AM codes as either the principal diagnosis or an additional diagnosis.

	For one admitted patient service event, one type of HAC is only counted at most once if multiple diagnoses of the HAC are identified.
Numerator source	EDWARD
Numerator availability	Available from 1 September 2015
Denominator	
Denominator definition	Total number of admitted patient service events (SE_TYPE_CD = '2') with separation dates in the reporting period, **excluding** admitted patient service events with any of the following: • Same-day chemotherapy - DRG V11: R63Z and SE_START_DTTM = SE_END_DTTM • Same-day haemodialysis - DRG V11: L61Z and SE_START_DTTM = SE_END_DTTM • Service Category is 'Newborn - unqualified days only ' (i.e. SE_SERVICE_CATEGORY_CD = '5' and COUNT_TOTAL_SE_QUAL_DAY_COUNT =0) • Hospital boarder (SE_SERVICE_CATEGORY_CD = '0') • Care type is 'Organ procurement-posthumous' - SE_SERVICE_CATEGORY_CD = '9'.
Denominator source	EDWARD
Denominator availability	Available
Inclusions	All admitted patient service events in NSW public hospitals Note: Mental health and drug and alcohol admitted patient service events are included in the current version (ACSQHC HACs V 3.1).
Exclusions	Numerator exclusions: Admitted patient service events with the qualified diagnosis codes recorded as the principal diagnosis code. Numerator and denominator exclusions: • Same-day chemotherapy - DRG V11: R63Z and SE_START_DTTM = SE_END_DTTM • Same-day haemodialysis - DRG V11: L61Z and SE_START_DTTM = SE_END_DTTM • Service Category is 'Newborn - unqualified days only ' (i.e. SE_SERVICE_CATEGORY_CD = '5' and COUNT_TOTAL_SE_QUAL_DAY_COUNT =0) • Hospital boarder (SE_SERVICE_CATEGORY_CD = '0') • Care type is 'Organ procurement-posthumous' - SE_SERVICE_CATEGORY_CD = '9'. • Any uncoded records.
Targets	The risk adjusted targets for individual Local Health Districts and Local Specialty Health Networks are set for a 12-month rolling period (12 months to date). Provisional performance target for individual LHDs or Specialty Networks are:

Local Health District	Target	Not Performing	Under Performing	Performing
Central Coast LHD	<=39.7	>41.7	>39.7 and <=41.7	<=39.7
Far West LHD	<=25.1	>30.9	>25.1 and <=30.9	<=25.1
Hunter New England LHD	<=29.2	>30.3	>29.2 and <=30.3	<=29.2
Illawarra Shoalhaven LHD	<=35.6	>37.5	>35.6 and <=37.5	<=35.6
Justice Health	<=31.3	>46.1	>31.3 and <=46.1	<=31.3
Murrumbidgee LHD	<=26.8	>28.7	>26.8 and <=28.7	<=26.8
Mid North Coast LHD	<=38.1	>40.2	>38.1 and <=40.2	<=38.1
Nepean Blue Mountains LHD	<=29.5	>31.3	>29.5 and <=31.3	<=29.5
Northern NSW LHD	<=35.1	>36.9	>35.1 and <=36.9	<=35.1
Northern Sydney LHD	<=49.4	>51.1	>49.4 and <=51.1	<=49.4
Sydney Children's Hospitals Network	<=4.8	>5.6	>4.8 and <=5.6	<=4.8
South Eastern Sydney LHD	<=30.1	>31.3	>30.1 and <=31.3	<=30.1
Southern NSW LHD	<=23.0	>25.2	>23.0 and <=25.2	<=23.0
St Vincent's Health Network	<=57.0	>60.5	>57.0 and <=60.5	<=57.0
South Western Sydney LHD	<=42.5	>43.8	>42.5 and <=43.8	<=42.5
Sydney LHD	<=53.5	>55.3	>53.5 and <=55.3	<=53.5
Western NSW LHD	<=26.3	>28.0	>26.3 and <=28.0	<=26.3
Western Sydney LHD	<=32.2	>33.5	>32.2 and <=33.5	<=32.2

The risk adjusted targets have been developed using risk adjusted models on the 2019 NSW APDC data. The risk adjustors used are largely in the same dimensions as those used for IHPA's service activity adjustors.

Rates of under and up to 80% upper control limits of expected rates are scored as 'Performing', rates between 80% and 95% upper control limits as 'Under Performing', and rates above the respective 95% upper control limits are flagged as 'Not Performing'. Targets are not applicable if the expected number of HACs is less than 1.

Context

Hospital-acquired cardiac complications prolong the length of hospitalisation, increase the cost of admission, and adds pain and discomfort to the patient. Significant reductions in hospital-acquired cardiac complication rates are being achieved in some hospitals by suitable preventive initiatives.

Related information can be found on the Commission's website:

Australian Commission on Safety and Quality in Health Care

	The HAC information kit contains more contextual information.
Related Policies/Programs	
Usable data available from	1 September 2015
Frequency of Reporting	Monthly
Time lag to available data	1 month
Business owners	
Contact - Policy	Chief Executive, Clinical Excellence Commission
Contact - Data	Executive Director, System Information and Analytics Branch (MOH-SystemInformationAndAnalytics@health.nsw.gov.au)
Representation	
Data type	Numeric
Form	Number, presented as a rate per 10,000 admitted patient service events
Representational layout	NN.NN
Minimum size	4
Maximum size	6
Date effective	1 July 2019
Related National Indicator	This HAC indicator follows the ACSQHC's specification: Australian Commission on Safety and Quality in Health Care – ACSQHC's Hospital Acquired Complication (HAC 14) in release V3.1: https://www.safetyandquality.gov.au/our-work/indicators/hospital-acquired-complications#hospital-acquired-complications -list

INDICATOR: KS2140	**Third or Fourth Degree Perineal Lacerations** (Rate per 10,000 admitted patient service events)
Shortened Title	3rd or 4th Degree Perineal Laceration Rate
Service Agreement Type	Key Performance Indicator
NSW Health Strategic Outcome	2: Safe care is delivered across all settings
Status	Final
Version number	2.0
Scope	All patients admitted to public hospitals in NSW
Goal	Improve maternity safety and increase quality outcomes.
Desired outcome	Reduction in the number of patients developing third or fourth degree perineal lacerations during the vaginal birth of a newborn.
Primary point of collection	Patient medical record
Data Collection Source/System	Admitted patient data collection
Primary data source for analysis	Enterprise Data Warehouse (EDWARD) - Local Reporting Solution (LRS)
Indicator definition	Rate of 3rd or 4th Degree Perineal Laceration per 10,000 admitted patient service events
Numerator	
Numerator definition	Total number of admitted patient service events (SE_TYPE_CD = '2') with separation dates in the reporting period, and with at least one of the ICD-10-AM codes listed in the Australian Commission on Safety and Quality in Health Care's (ACSQHC) HACs specification file for HACs V 3.1 (April 2022 release) downloadable from https://www.safetyandquality.gov.au/publications-and-resources/resource-library/hospital-acquired-complications-hacs-list-specifications-version-31 for the numerator for 3rd or 4th Degree Perineal Lacerations (HAC 15). The 12th Edition of ICD-10-AM coding should be used, which includes the following additional diagnosis codes: • any of O70.2 and O70.3 as an additional diagnosis, with **any** condition onset flag code. • AND all the criteria for the denominator. For one admitted patient service event, one type of HAC is only counted at most once if multiple diagnoses of the HAC are identified.
Numerator source	EDWARD
Numerator availability	Available from 1 September 2015
Denominator	

Denominator definition	Total number of admitted patient service events (SE_TYPE_CD = '2') that resulted in vaginal birth with separation dates in the reporting period, with: • Any of ICD-10-AM 12th Edition codes: Z37.0, Z37.1, Z37.2, Z37.3, Z37.4, Z37.5, Z37.6, Z37.7, Z37.9, any onset flag • AND a Caesarean birth was NOT recorded (No ACHI procedure codes 16520-00, 16520-01, 16520-02, 16520-03, 16520-04, 16520-05. **excluding** admitted patient service events with any of the following: • Admitted patients transferred in from another hospital. • Service Category is 'Newborn - unqualified days only ' (i.e. SE_SERVICE_CATEGORY_CD = '5' and COUNT_TOTAL_SE_QUAL_DAY_COUNT =0) • Hospital boarder (SE_SERVICE_CATEGORY_CD = '0') • Care type is 'Organ procurement-posthumous' - SE_SERVICE_CATEGORY_CD = '9'.
Denominator source	EDWARD
Denominator availability	Available
Inclusions	All admitted patient service events in NSW public hospitals Note: Mental health and drug and alcohol admitted patient service events are included in the current version (ACSQHC HAC V 3.1).
Exclusions	**Numerator exclusions:** • Admitted patient service events where an O70.2 or O70.3 ICD10AM code has been recorded as a principal diagnosis. • Admitted patient service events with a birth via a Caesarean Section. • Admitted patient service events where admitted patients transferred in from another hospital. **Numerator and denominator exclusions:** • Admitted patients transferred in from another hospital • Service Category is 'Newborn - unqualified days only ' (i.e. SE_SERVICE_CATEGORY_CD = '5' and COUNT_TOTAL_SE_QUAL_DAY_COUNT =0) • Hospital boarder (SE_SERVICE_CATEGORY_CD = '0') • Care type is 'Organ procurement-posthumous' - SE_SERVICE_CATEGORY_CD = '9'. • Any uncoded records.
Targets	The targets for individual Local Health Districts are set for a 12-month rolling period (12 months to date). Provisional performance target for individual LHDs or Specialty Networks are:

Local Health District	Target	Not Performing	Under Performing	Performing
Central Coast LHD	<=352.5	>387.6	>352.5 and <=387.6	<=352.5
Far West LHD	<=490.6	>668.1	>490.6 and <=668.1	<=490.6
Hunter New England LHD	<=341.1	>361.5	>341.1 and <=361.5	<=341.1
Illawarra Shoalhaven LHD	<=353.2	>388.1	>353.2 and <=388.1	<=353.2
Murrumbidgee LHD	<=362.7	>407.6	>362.7 and <=407.6	<=362.7
Mid North Coast LHD	<=364.1	>406.7	>364.1 and <=406.7	<=364.1
Nepean Blue Mountains LHD	<=348.6	>378.5	>348.6 and <=378.5	<=348.6
Northern NSW LHD	<=357.5	>393.6	>357.5 and <=393.6	<=357.5
Northern Sydney LHD	<=355.8	>391.4	>355.8 and <=391.4	<=355.8
South Eastern Sydney LHD	<=342.6	>365.6	>342.6 and <=365.6	<=342.6
Southern NSW LHD	<=365.9	>416.3	>365.9 and <=416.3	<=365.9
South Western Sydney LHD	<=337.4	>355.4	>337.4 and <=355.4	<=337.4
Sydney LHD	<=349.1	>377.4	>349.1 and <=377.4	<=349.1
Western NSW LHD	<=351.9	>385.1	>351.9 and <=385.1	<=351.9
Western Sydney LHD	<=338.7	>357.6	>338.7 and <=357.6	<=338.7

NSW average rate was used to calculate the expected rates, no risk adjustment was applied. Rates of under and up to 80% upper control limits of expected rates are scored as 'Performing', rates between 80% and 95% upper control limits as 'Under Performing', and rates above the respective 95% upper control limits are flagged as 'Not Performing'.

Context

Related information can be found on the Commission's website:
Australian Commission on Safety and Quality in Health Care

Related Policies/ Programs

Useable data available from

1 September 2015

Frequency of Reporting

Monthly

Time lag to available data

1 month

Business owners

Contact - Policy

Chief Executive, Clinical Excellence Commission

Contact - Data	Executive Director, Systems Information and Analytics (MOH-SystemsInformationAndAnalytics@health.nsw.gov.au)
Representation	
Data type	Numeric
Form	Number, presented as a rate per 10,000 admitted patient service events
Representational layout	NN.NN
Minimum size	4
Maximum size	6
Data domain	
Date effective	1 July 2019
Related National Indicator	This HAC indicator follows the ACSQHC's specification: Australian Commission on Safety and Quality in Health Care – ACSQHC's Hospital Acquired Complication (HAC 15) in release V 3.1: https://www.safetyandquality.gov.au/our-work/indicators/hospital-acquired-complications#hospital-acquired-complications -list

INDICATOR: KS2141	**Hospital Acquired Neonatal Birth Trauma** (Rate per 10,000 admitted patient service events)
Shortened Title	Neonatal Birth Trauma
Service Agreement Type	Key Performance Indicator
NSW Health Strategic Outcome	2: Safe care is delivered across all settings
Status	Final
Version number	2.0
Scope	All neonatal patients admitted to public hospitals in NSW
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	Enterprise Data Warehouse (EDWARD) - Local Reporting Solution (LRS)
Indicator definition	The rate of completed newborn admitted patient service events within the reporting period where neonatal birth trauma has occurred in a public hospital per 10,000 admitted patient service events
Numerator	
Numerator definition	Total number of admitted patient service events (SE_TYPE_CD = '2') with separation dates in the reporting period, and with at least one of the ICD-10-AM codes listed in the Australian Commission on Safety and Quality in Health Care's (ACSQHC) HACs specification file for HACs V 3.1 (April 2022 release) downloadable from https://www.safetyandquality.gov.au/publications-and-resources/resource-library/hospital-acquired-complications-hacs-list-specifications-version-31 for the numerator Neonatal Birth Trauma (HAC 16). The 12th Edition of ICD-10-AM coding should be used, which includes the following additional diagnosis codes: • Any of the listed ICD-10-AM 12th Edition codes recorded as an additional diagnosis • **AND** with any condition onset flag. • **AND** satisfying the criteria for the denominator For one admitted patient service event, one type of HAC is only counted at most once if multiple diagnoses of the HAC are identified.
Numerator source	EDWARD
Numerator availability	Available from 1 September 2015

Denominator

Denominator definition	Total number of completed newborn admitted patient service events (SE_TYPE_CD = '2') with separation dates in the reporting period, All newborns with SE_SERVICE_CATEGORY_CD = '5', **excluding** admitted patient service events with any of the following: • Preterm infants, with any of ICD-10-AM 12th Edition codes P07.40, P07.41, P07.42, P07.43, P07.44, P07.45, P07.46, P07.47, P07.50, P07.51, P07.52, P07.53, P07.54, P07.55, P07.56, P07.57, P07.58, P07.59; • Cases with injury to brachial plexus (P14.0, or P14.1 or P14.3) • Cases with osteogenesis imperfecta (Q78.0) • Patients transferred in from another hospital. • Hospital boarder (SE_SERVICE_CATEGORY_CD = '0') • Care type is 'Organ procurement-posthumous' - SE_SERVICE_CATEGORY_CD = '9'.
Denominator source	EDWARD
Denominator availability	Available
Inclusions	**Numerator inclusions:** All newborn admitted patient service events with a Service Category = 5 in NSW public hospitals. (SE_SERVICE_CATEGORY_CD = '5').
Exclusions	Numerator and denominator exclusions: • Preterm infants with birth weight less than 2000 grams, with any of ICD-10-AM 12th Edition codes P07.40, P07.41, P07.42, P07.43, P07.44, P07.45, P07.46, P07.47, P07.50, P07.51, P07.52, P07.53, P07.54, P07.55, P07.56, P07.57, P07.58, P07.59; • Cases with injury to brachial plexus (P14.0, or P14.1 or P14.3) • Cases with osteogenesis imperfecta (Q78.0) • Patients transferred in from another hospital. • Hospital boarder (SE_SERVICE_CATEGORY_CD = '0') • Care type is 'Organ procurement-posthumous' - SE_SERVICE_CATEGORY_CD = '9'. • Any uncoded records.
Targets	The targets for individual Local Health Districts are set for a 12-month rolling period (12 months to date). Provisional performance target for individual LHDs or Specialty Networks are:

Local Health District	Target	Not Performing	Under Performing	Performing
Central Coast LHD	<=75.9	>89.6	>75.9 and <=89.6	<=75.9
Far West LHD	<=153.6	>243.3	>153.6 and <=243.3	<=153.6
Hunter New England LHD	<=70.5	>78.1	>70.5 and <=78.1	<=70.5
Illawarra Shoalhaven LHD	<=76.3	>89.6	>76.3 and <=89.6	<=76.3
Murrumbidgee LHD	<=80.6	>97.9	>80.6 and <=97.9	<=80.6
Mid North Coast LHD	<=80.9	>97.7	>80.9 and <=97.7	<=80.9
Nepean Blue Mountains LHD	<=74.3	>85.6	>74.3 and <=85.6	<=74.3
Northern NSW LHD	<=75.5	>89.8	>75.5 and <=89.8	<=75.5
Northern Sydney LHD	<=73.6	>84.4	>73.6 and <=84.4	<=73.6
South Eastern Sydney LHD	<=72.3	>81.2	>72.3 and <=81.2	<=72.3
Southern NSW LHD	<=82.2	>102.2	>82.2 and <=102.2	<=82.2
South Western Sydney LHD	<=69.8	>76.8	>69.8 and <=76.8	<=69.8
Sydney LHD	<=72.3	>82.7	>72.3 and <=82.7	<=72.3
Western NSW LHD	<=76.8	>90.0	>76.8 and <=90.0	<=76.8
Western Sydney LHD	<=69.8	>77.1	>69.8 and <=77.1	<=69.8

NSW average rate was used to calculate the expected rates, no risk adjustment was applied. Rates of under and up to 80% upper control limits of expected rates are scored as 'Performing', rates between 80% and 95% upper control limits as 'Under Performing', and rates above the respective 95% upper control limits are flagged as 'Not Performing'

Context

Related information can be found on the Commission's website: Australian Commission on Safety and Quality in Health Care

Related Policies/ Programs

Useable data available from

1 September 2015

Frequency of Reporting

Monthly

Time lag to available data

1 month

Business owners

Contact - Policy

Chief Executive, Clinical Excellence Commission

Contact - Data

Executive Director, Strategic Information and Analysis
(MOH-SystemInformationAndAnalytics@health.nsw.gov.au)

Representation	
Data type	Numeric
Form	Number, presented as a rate per 10,000 admitted patient service events.
Representational layout	NN.NN
Minimum size	4
Maximum size	6
Data domain	
Date effective	1 July 2019
Related National Indicator	This HAC indicator follows the ACSQHC's specification: Australian Commission on Safety and Quality in Health Care – ACSQHC's Hospital Acquired Complication (HAC 16) in release V 3.1: https://www.safetyandquality.gov.au/our-work/indicators/hospital-acquired-complications#hospital-acquired-complications -list

INDICATOR: SSQ114	**Discharged Against Medical Advice for Aboriginal Inpatients (%)** The proportion of Aboriginal patients who discharge from hospital against medical advice, reported by Aboriginal People
Shortened Title	Patients Discharged Against Medical Advice
Service Agreement Type	Key Performance Indicator
NSW Health Strategic Outcome	2: Safe care is delivered across all settings
Status	Final
Version number	2.01
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 culturally safe 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 of or person 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	Enterprise Data Warehouse (EDWARD) - Local Reporting Solution (LRS) 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. Note that Aboriginal people includes people who identify as Aboriginal and/or Torres Strait Islander.
Numerator	
Numerator definition	Number of admitted patient service events (SE_TYPE_CD = '2') for Aboriginal people where the mode of separation is recorded as "left against medical advice / discharge at own risk" during the reporting period. (See: Meteor, AIHW, "Episode of admitted patient care—separation mode, code NN". https://meteor.aihw.gov.au/content/722644).
Numerator source	Hospital PAS Systems. EDWARD. NSW Admitted Patient Data Collection (SAPHaRI)

Numerator availability	Data routinely collected and available
Denominator	
Denominator definition	The total number of admitted patient service events (SE_TYPE_CD = '2') for Aboriginal people during the reporting period.
Denominator source	Hospital PAS Systems. 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. Decrease on previous year, with the reporting period comparison being against the previous full year's results as at 30 June of that financial year. • Performing - ≥1% decrease on previous year for prior year results at 2.0% or above • Under performing - ≥ 0 to <1% decrease on previous year • Not performing – Increase on previous year 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 safety of hospital services, and the extent of patient satisfaction with the quality of care provided.
Related Policies/ Programs	2022-24 NSW Implementation Plan for Closing the Gap NSW Aboriginal Health Plan 2013-23 NSQHS Standards User guide for Aboriginal and Torres Strait Islander health NSW Health Policy Directive *Aboriginal and Torres Strait Islander Origin - Recording of Information of Patients*.
Useable data available from	2000
Frequency of Reporting	Three-monthly
Time lag to available data	Data fed to EDWARD daily, but data entry may be several months late.
Business owners	

Contact - Policy	Executive Director, Centre for Aboriginal Health
Contact - Data	Executive Director, System Information and Analytics Director, Evidence and Evaluation Branch, Centre for Epidemiology and 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	2013

Related National Indicator

INDICATOR: SSA108, SSA109, SSA110	**Overdue Elective Surgery Patients** (Number) • Category 1 Ready-for-care patients (RFC) > 30 days (number) (SSA108) • Category 2 Ready-for-care patients (RFC) > 90 days (number) (SSA109) • Category 3 Ready-for-care patients (RFC) > 365 days (number) (SSA110)
Shortened Title	Overdue Elective Surgery Patients
Service Agreement Type	Key Performance Indicator
NSW Health Strategic Outcome	2: Safe care is delivered across all settings
Status	Final
Version number	7.7
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).
Primary data source for analysis	Wait List/Scheduling Data Stream (via Enterprise Data Warehouse (EDWARD)
Indicator definition	Number of elective surgical patients on the NSW Health Elective Surgery 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 EDW: Whereas WLCOS received the last 3 clinical urgency/priority category changes for a given booking, EDW receives all clinical urgency/priority category changes for a given booking. As a result, EDW will report a more accurate value.
Numerator source	EDWARD
Numerator availability	Available Monthly
Inclusions	Ready for Care patients (clinical urgency/priority categories 1, 2 and 3) on the elective surgical waiting list. For EDW, WL_BKG_PRIORITY_CLIN_PRIORITY_CD = '1', '2' and '3'.
Exclusions	• Not Ready for Care (NRFC) patients are excluded. For EDW, the NRFC status is identified through the presence of a current NRFC_REC_ID record. • Elective surgery patients with an Indicator Procedure Code (EDW: IND_PROC_CD) of 277 (Peritonectomy)
Targets	Target: 0 (zero) For each category • Performing: 0 (zero) • Underperforming: N/A • Not performing: ≥ 1
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. National Elective Surgery Targets
Related Policies/ Programs	• PD2022_001 Elective Surgery Access Policy • Agency for Clinical Innovation: Surgical Services Taskforce and Anaesthesia and Perioperative Care Network • Operating Theatre Efficiency Guidelines: A guide to the efficient management of operating theatres in New South Wales hospitals http://www.aci.health.nsw.gov.au/resources/surgical-services/efficiency/theatre-efficiency
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	

Contact – Policy	Executive Director, System Purchasing Branch
Contact – Data	Executive Director, System Information and Analytics Branch (MOH-SystemsInformationAndAnalytics@health.nsw.gov.au)
Representation	
Data type	Numeric
Form	Number
Layout	NN,NNN
Minimum size	1
Maximum size	6
Related National Indicator	Meteor identifier: 732461 Elective surgery waiting list episode—overdue patient status, code N http://meteor.aihw.gov.au/content/index.phtml/itemId/732461

INDICATOR: SSQ106, SSQ107	**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
NSW Health Strategic Outcome	2: Safe care is delivered across all settings
Status	Final
Version number	3.5
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	Enterprise Data Warehouse (EDWARD) - Local Reporting Solution (LRS)
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 Service Encounters, not Service Events) with admission date within reference period and patient previously discharged from same facility in previous 28 days for any purpose, disaggregated by Aboriginality status. Where: Unplanned is defined as Urgency of Admission (FORMAL_ADMIT_URGN_CD) = '1'. A readmission is defined as an admission with a FORMAL_ADMIT_DTTM within 28 days of the FORMAL_DISCH_DTTM of a previous stay for the same patient at the same facility (identified by OSP_CBK and CL_ID). Aboriginality status = CL_INDGNS_STUS_CD
Numerator source	EDWARD
Numerator availability	Available monthly
Inclusions	• SE_TYPE_CD = '2' • Readmissions that result in death

Exclusions	Transfers in from other hospitals. Transfers are not counted in the Numerator as these are considered 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 Service Encounters, not Service Events) with admission dates within the reference period, disaggregated by Aboriginality status.
Denominator source	EDWARD
Denominator availability	Available monthly
Inclusions	SE_TYPE_CD = '2' Transfers from other hospitals Transfers in are included in the denominator as these service encounters 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 Service Events created through a change in service category); • Hospital boarders and organ procurement (SE_SERVICE_CATEGORY_CD '0' or '9'); • Health organisations in peer groups (OSP_PEER_GRP_CD) below D1b.
Targets	Reduction from previous year • Performing: Decrease 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 person's disaggregation, the presence of an Aboriginal person in the numerator and denominator is dependent on the recording of the value in both admitted patient service events. 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 admitted patient service event 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 reference period.

- 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 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 patients 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, including connection with care in the community.
Useable data available from	2001/02
Frequency of Reporting	• Monthly/Annual, financial year, biannual • State Plan - quarterly
Time lag to available data	• Data has a 6 month lag, available December for previous financial year • Availability depends on refresh frequency
Business owners	
Contact – Policy	Executive Director, System Management Branch
Contact – Data	Executive Director, System Information and Analytics Branch
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	National Healthcare Agreement: PI 23-Unplanned hospital readmission rates, 2020 https://meteor.aihw.gov.au/content/index.phtml/itemId/716786

INDICATOR: KQS206	**Mental Health: Acute Seclusion Occurrence** – (Episodes per 1,000 bed days) Number of acute seclusion episodes as a rate per 1000 bed days
Shortened Title	Acute Seclusion Occurrence
Service Agreement Type	Key Performance Indicator
NSW Health Strategic Outcome	2: Safe care is delivered across all settings
Status	Final
Version number	1.41
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 – Enterprise Data Warehouse (EDWARD) - Local Reporting Solution (LRS) 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 health units within the reporting period
Numerator source	Seclusion Collection (Manual collection through InforMH)
Numerator availability	Data available since the statewide collection commenced in January 2008
Denominator	
Denominator definition	Number of bed days in acute mental health units within the reporting period
Denominator source	EDWARD
Denominator availability	Available
Inclusions	All acute mental health units
Exclusions	Leave days are excluded from the denominator

Targets	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	• PD 2020_004 Seclusion and Restraint in NSW Health Settings • Annual National Mental Health Seclusion and Restraint forums convened by the Safety and Quality Partnership Standing Committee (SQPSC).
Useable data available from	Data has 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 is supplied daily to EDWARD. Submission of local seclusion data may take up to one month after the end of reporting period.
Business owners	System Information and Analytics Branch, Ministry of Health
Contact - Policy	Executive Director, Mental Health Branch
Contact - Data	Director, InforMH, System Information and Analytics Branch
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 Australian Health Performance Framework: PI 2.2.4–Rate of seclusion, 2020 Number of seclusion events per 1,000 patient days within public acute admitted patient specialised mental health service units. https://meteor.aihw.gov.au/content/728345

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 721814 Establishment—accrued mental health care days, total N[N(7)]

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.

https://meteor.aihw.gov.au/content/index.phtml/itemId/721814

INDICATOR: SSQ123	**Mental Health: Acute Seclusion Duration** – Average (Hours) Average hours per seclusion episode
Shortened Title	Acute Seclusion Duration
Service Agreement Type	Key Performance Indicator
NSW Health Strategic Outcome	2: Safe care is delivered across all settings
Status	Final
Version number	1.31
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	Local seclusion registers
Primary data source for analysis	Seclusion Collection (manual collection through InforMH)
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 collection through InforMH)
Numerator availability	Data available since the statewide collection commenced in January 2008
Denominator	
Denominator definition	Number of seclusion episodes in acute mental health units within the reporting period
Denominator source	Seclusion Collection (manual collection through InforMH)
Denominator availability	Data available since the statewide collection commenced in January 2008
Inclusions	All acute mental health units
Exclusions	
Targets	Target < 4.0 hours

	• Performing: < 4.0 hours • Under performing: ≥ 4.0 hours and ≤ 5.5 hours • Not performing: > 5.5 hours
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	PD2020_004: Seclusion and Restraint in NSW Health Settings.
Useable data available from	Data has 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	System Information and Analytics Branch, Ministry of Health
Contact - Policy	Executive Director, Mental Health Branch
Contact - Data	Director, InforMH, System Information and Analytics Branch
Representation	
Data type	Numeric
Form	Number
Representational layout	NNN.N
Minimum size	2
Maximum size	6
Data domain	
Date effective	2015
Related National Indicator	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: SSQ124	**Mental Health: Frequency of Seclusion (%)** Percentage of acute mental health admitted care episodes with seclusion
Shortened Title	Mental Health: Frequency of Seclusion
Service Agreement Type	Key Performance Indicator
NSW Health Strategic Outcome	2: Safe care is delivered across all settings
Status	Final
Version number	1.41
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	Numerator: Local seclusion registers Denominator: Inpatient data; Patient Administration Systems
Data Collection Source/System	Numerator: Seclusion Collection (manual collection through InforMH) Denominator: Inpatient data from Admitted Patient Data Collection – EDWARD LRS.
Primary data source for analysis	Local seclusion registers. Inpatient data from Admitted Patient Data Collection. Enterprise Data Warehouse (EDWARD) - Local Reporting Solution (LRS)
Indicator definition	Percent of acute mental health admitted patient service events where seclusion occurs
Numerator	
Numerator definition	Number of admitted patient service events (SE_TYPE_CD = '2') in all acute mental health units with at least one episode of seclusion during the reporting period
Numerator source	Seclusion Collection (manual collection through InforMH)
Numerator availability	Data available since the statewide collection commenced in January 2008
Denominator	
Denominator definition	Number of admitted patient service events (SE_TYPE_CD = '2') in acute mental health units
Denominator source	Admitted Patient Data Collection – EDWARD
Denominator availability	Available
Inclusions	All acute mental health units
Exclusions	

Targets	Target: <4.1 • Performing: <4.1 • Not performing: >5.3 • Under performing: ≥4.1 and ≤5.3 Note: JHFMHN performance thresholds are as follows: (Performing <=30%; Not performing >40%; Underperforming >=30% and <=40%)
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	PD2020_004: Seclusion and Restraint in NSW Health Settings.
Useable data available from	Data for both numerator and denominator have been available since January 2008.
Frequency of Reporting	Quarterly
Time lag to available data	Numerator: Submission of local seclusion episodes data may take up to one month after the end of reporting period. Denominator: Admitted Patient reporting is required by the 13th calendar day of each month for previous month. Data is supplied daily to EDWARD.
Business owners	System Information and Analytics Branch, Ministry of Health
Contact - Policy	Executive Director, Mental Health Branch
Contact - Data	Director, InforMH, System Information and Analytics Branch
Representation	
Data type	Numeric
Form	Number, presented as a percentage
Representational layout	NNN.N
Minimum size	2
Maximum size	6
Data domain	
Date effective	2015
Related National Indicator	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: KQS204, KQS204a	**Mental Health Acute Post-Discharge Community Care** - Follow up by Community Care within seven days of discharge (%) • All persons (KQS204) • Aboriginal persons (KQS204a)
Shortened Title	Mental Health: Acute Post Discharge Community Care
Service Agreement Type	Key Performance Indicator
NSW Health Strategic Outcome	2: Safe care is delivered across all settings
Status	Final
Version number	3.1
Scope	Mental Health Services
Goal	Improve the effectiveness of a District'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, iPM.
Primary data source for analysis	Enterprise Data Warehouse (EDWARD) - Local Reporting Solution (LRS) Admitted Patient Data Collection Community Mental Health Data Collection (CHAMB) Enterprise Unique Person Identifier (EUID)
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, disaggregated by Aboriginality status. Note that Aboriginal persons include people who identify as Aboriginal and/or Torres Strait Islander.
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, disaggregated by Aboriginality status. Aboriginality status = CL_INDGNS_STUS_CD.

Numerator source	Admitted Patient and CHAMB data in EDWARD LRS, linked via the NSW Health Enterprise Unique Person Identifier (EUID).
Numerator availability	Admitted Patient data available. CHAMB data available.
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 AP Service Event 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 EDWARD LRS.
Denominator availability	Available.
Inclusions	Includes only overnight separations where the last ward is a designated acute mental health unit. Uses only separations with EUID 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.

Exclusions	Excludes:
	• same-day separations,
	• separations where the length of stay is one night only and a procedure code for Electroconvulsive Therapy (ECT) or Trans-cranial Magnetic Stimulation (TMS) is recorded and
	• separations where the mode of separation is:
	  • death;
	  • transfer to another acute or psychiatric inpatient hospital;
	  • service category change.
	Note: 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/CMO service providers.

Targets	On average expect 75% of overnight separations from NSW acute mental health units to be followed by a recorded community contact within 7 days of discharge.

	• Performing: ≥ 75% • Under Performing: ≥ 60% and < 75% • Not Performing: <60%
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. An electronic copy of Desktop Audit: Acute 7 Days Post Discharge Community Care is available from, InforMH, System Information and Analytics Branch, Ministry of Health.
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. *Source: Key Performance Indicators for Australian Public Mental Health Services, third edition 2013. Australian Govt, Canberra.*
Related Policies/ Programs	The NSW Health Policy Directive "Discharge Planning and Transfer of Care for Consumers of NSW Health Mental Health Services" (PD2019_045), 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 2005/2006
Frequency of Reporting	*Monthly:* Health System Performance (HSP) report. *Annual/Financial:* NSW Health Annual Report, National Mental Health KPIs for Australian Public Mental Health Services.
Time lag to available data	Admitted patient reporting is required by the 13th calendar day of each month for previous month. Data is supplied daily to EDWARD Community mental health data entry into source systems may be several months late.
Business owners	

Contact - Policy	Executive Director, Mental Health Branch
Contact - Data	Director InforMH, System Information and Analytics Branch
Representation	
Data type	Numeric
Form	Number, presented as a percentage (%)
Representational layout	NNN
Minimum size	1
Maximum size	3
Data domain	HIRD (Health Information Resource Directory), Indicator specifications in Technical Paper (noted in comment)
Date effective	2005/2006
Related National Indicator	KPIs for Australian Public Mental Health Services (2020) https://meteor.aihw.gov.au/content/index.phtml/itemId/720219 Meteor ID: 720219

INDICATOR: KQS203, KQS203a	**Mental Health: Acute Readmission** - within 28 days (%) • All persons **(KQS203)** • Aboriginal persons ***(KQS203a)***
Shortened Title	Mental Health: Acute Readmissions
Service Agreement Type	Key Performance Indicator
NSW Health Strategic Outcome	2: Safe care delivered across all settings
Status	Final
Version number	4.0
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	Enterprise Data Warehouse (EDWARD) - Local Reporting Solution (LRS) Admitted Patient Data Collection NSW Health Enterprise Unique Person Identifier (EUID)
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, disaggregated by Aboriginality status. Note that Aboriginal persons include people who identify as Aboriginal and/or Torres Strait Islander.
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, disaggregated by Aboriginality status, where SE_TYP_CD = '2'. Aboriginality status = CL_INDGNS_STUS_CD.
Numerator source	Admitted Patient Data Collection (EDWARD LRS). Readmission between facilities detected by (i) EUID where available or (ii) CL_ID_CBK (CLIENT_ID_CBK) where EUID not available.

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 2 months, e.g. a June report will measure readmissions following separations in April.
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 Admitted Patient Service Event tables, where ward identifier = designated MH units and unit type=MH bed types, from Mental Health Service Entity Register (MH-SER) ward table.
Denominator source	Admitted Patient Data Collection in EDWARD LRS
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	**Numerator:** Separations where the length of stay is one night only and a procedure code for Electroconvulsive Therapy (ECT) is recorded. **Denominator:** • Separations where "mode of separation" = death, transfer or service category change change. • Same day separations. This exclusion applies to each separation in the denominator and any subsequent readmission. • Separations where the length of stay is one night only and a procedure code for Electroconvulsive Therapy (ECT) or Trans-cranial Magnetic Stimulation (TMS) is recorded. 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% for readmission to another facility/Area). • Performing: ≤ 13% • Under Performing: > 13% and ≤20% • Not Performing: > 20% An electronic copy of Desktop Audit: Acute 28 Day Readmission is available from, InforMH, System Information and Analytics Branch, Ministry of Health.

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". *Source: Key Performance Indicators for Australian Public Mental Health Services, third edition 2013. Australian Govt, Canberra.*
Related Policies/ Programs	The NSW Health Policy Directive *Discharge Planning and Transfer of Care for Consumers of NSW Health Mental Health Services" (PD2019_045)*, 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	*Monthly:* Health System Performance (HSP) report. *Annual/Financial:* NSW Health Annual Report, National Mental Health KPIs for Australian Public Mental Health Services.
Time lag to available data	Admitted Patient reporting is required by the 13th calendar day of each month for previous month. Data is supplied daily to EDWARD.
Business owners	
Contact - Policy	Executive Director, Mental Health Branch
Contact - Data	Director, InforMH, System Information and Analytics Branch
Representation	
Data type	Numeric
Form	Number, presented as a percentage (%)
Representational layout	NNN
Minimum size	1
Maximum size	3
Data domain	HIRD (Health Information Resource Directory), Indicator specifications in Technical Paper (noted in comment)
Date effective	2002/2003

Related National Indicator	KPIs for Australian Public Mental Health Service (2020) https://meteor.aihw.gov.au/content/index.phtml/itemId/720219 Meteor ID: 720219

INDICATOR: SSQ127	**Mental health:** Involuntary Patients Absconded from an Inpatient Mental Health Unit – Incident Types 1 and 2 (rate per 1,000 bed days)
Shortened Title	Rate of Involuntary Patients Absconded
Service Agreement Type	Key Performance Indicator
NSW Health Strategic Outcome	2: Safe care is delivered across all settings
Status	Final
Version number	1.6
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	Numerator: Local incident management systems (IMS+) Denominator: Inpatient data; Patient Administration Systems
Primary data source for analysis	Numerator: Mental Health Consolidated Data Collection (manual collection through InforMH) Denominator: Inpatient data: Admitted Patient Data Collection – Enterprise Data Warehouse (EDWARD) - Local Reporting Solution (LRS)
Indicator definition	The rate of Type 1 and 2 incidents reported where involuntary patients absconded from an acute mental health inpatient unit per 1,000 occupied bed days in acute mental health units.
Numerator	
Numerator definition	The number of Type 1 and 2 incidents reported where involuntary patients absconded from an acute mental health inpatient unit within the reporting period.
Numerator source	Mental Health Consolidated Data Collection (manual collection through InforMH)
Numerator availability	Data available since statewide collection commenced in July 2016
Denominator	
Denominator definition	Number of bed days in acute mental health units within the reporting period
Denominator source	EDWARD LRS
Denominator availability	Available

Inclusions	All acute mental health inpatient units
Exclusions	Leave days are excluded from the denominator
Targets	Target <0.8 • Performing: <0.8 • Underperforming: ≥0.8 and <1.4 • Not performing: ≥1.4
Related Policies/ Programs	NSW Health PD2019_045 Discharge Planning and Transfer of Care for Consumers of NSW Health Mental Health Services SN:004/16 Assessment and management of risk of absconding from declared mental health inpatient units
Useable data available from	Data for both numerator and denominator has been available since July 2016
Frequency of Reporting	Quarterly
Time lag to available data	Numerator: Finalisation of mental health consolidated data may take up to 5 weeks after the end of reporting period. Denominator: Admitted Patient reporting is required by the 13th calendar day of each month for previous month. Data is supplied daily to EDWARD.
Business owners	Mental Health Branch, Ministry of Health
Contact - Policy	Executive Director, Mental Health Branch
Contact - Data	Director, InforMH, System Information and Analytics Branch
Representation	
Data type	Numeric
Form	Number, presented as a rate per 1,000 bed days
Representational layout	N{NNN}
Minimum size	1
Maximum size	4
Data domain	
Date effective	01/07/2016
Related National Indicator	N/A

INDICATOR: MS2213	**Virtual Care Access:** Non-admitted services provided through Virtual Care (%)
Previous IDs:	Previously known as *Telehealth Service Access: Non-admitted services provided through telehealth (%)*
Shortened Title	Virtual Care Access
Service Agreement Type	Key Performance Indicator
NSW Health Strategic Outcome	2: Safe care is delivered across all settings
Status	Final
Version number	5.0
Scope	All non-admitted patient occasions of service
Goal	To sustainably scale virtual care and comprehensively embed it as a safe, effective, accessible and ongoing option to deliver healthcare across NSW.
Desired outcome	Increase the number of virtual occasions of service 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. Titanium (for dental health), MOSAIQ (for oncology services) etc.
Primary data source for analysis	Enterprise Data Warehouse (EDWARD) - Local Reporting Solution (LRS) Non-admitted Patient Data Mart
Indicator definition	The percentage of YTD non-admitted patient occasions of service provided through an audio, videoconferencing or remote client monitoring modality . Activity type is described in service contact codes 2, C, P, T or X.
Numerator	
Numerator definition	Total number of non-admitted patient occasions of service with an audio or videoconferencing modality, where the CLINICAL_SERVICE_FLAG= 'Y'
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 occasions of service where the CLINICAL_SERVICE_FLAG = 'Y'
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 “2”, “C”, “P”, “T” or X. The code labels can be viewed here: http://hird.health.nsw.gov.au/hird/view_domain_values_list.cfm?ItemID=9437 **Numerator & Denominator:** CLINICAL_SERVICE_FLAG = 'Y'
Exclusions	**Numerator & Denominator:** NAP occasions of service provided by service units with the following Establishment Types: 11.04 Needle Exchange Allied Health/ Nursing Unit 11.05 Supervised Administration of Opioid Treatment Program Medication 13.01 Pathology (Microbiology, Haematology, Biochemistry) Unit 13.02 Pharmacy Dispensing 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 13.12 Interventional Imaging Procedure Unit 14.10 Information Management Service Unit 15.03 Cancer - Chemotherapy / Other Cancer Facility-based Treatment Procedure Unit 16.05 Angioplasty / Angiography Procedure Unit 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 20.02 Endoscopy - Gastrointestinal Procedure Unit 20.03 Endoscopy - Urological/Gynaecological Procedure Unit 20.04 Endoscopy - Orthopaedic Procedure Unit 20.05 Endoscopy - Respiratory/ENT Procedure Unit 21.04 Total Parenteral Nutrition - Home Delivered - Procedure Unit 21.05 Enteral Nutrition - Home Delivered - Procedure Unit 27.02 Cataract Extraction Procedure Unit 28.01 Oral Health/Dental, nfd Procedure Unit 28.02 Oral Health/Adult Dental Procedure Unit 28.03 Oral Health/Child Dental Procedure Unit 28.04 Oral Health/Combined Adult and Child Dental Procedure Unit 32.32 Staff Health Unit (Excluded data - service not in scope) 32.42 Respite Care / Day Care - Facility-based Allied Health / Nursing Unit 32.59 COVID-19 Response - Vaccination Unit

	34.03 Haemodialysis Unit - In Hospital 34.04 Peritoneal Dialysis Unit - In Hospital 34.09 Haemodialysis - Home Delivered Procedure Unit 34.10 Peritoneal Dialysis - Home Delivered Procedure Unit 35.02 Residential Aged Care Unit, nfd 36.23 Ventilation - Home Delivered Procedure Unit 37.04 Minor Surgery Unit 38.07 Bone Marrow Transplantation Procedure Unit 39.02 Minor Medical Procedure Unit 39.12 Pain Management Intervention Unit 39.21 Health Transport Unit (Patient) 39.26 Hyperbaric Medicine Procedure Unit 40.01 Home Modification/Maintenance Service Unit 41.02 Meals - Home Delivered Service Unit
Targets	Target: 30% An increase of 5 percentage points from previous FY year until 30% of non-admitted patient service events are performed virtually. The KPI is calculated as follows: The percentage of year-to-date non-admitted patient Service Contacts using Service Contact Mode codes “2”, “C”, “P”, “T” or X compared to the percentage for the same YTD period in FY 23/24. • Performing: ≥ 5% points increase on previous year • Under performing: >0 and < 5% points increase on previous year. • Not performing: No change or decrease on previous year
Context	Embedding virtual care in NSW health services is a key priority for NSW Health. The NSW Virtual Care Strategy 2021-2026 supports a coordinated and consistent approach to comprehensively integrate virtual care as a complement to face to face care across NSW health services.
Related Policies/ Programs	
Useable data available from	2019
Frequency of Reporting	Monthly
Time lag to available data	4 weeks
Business owners	
Contact - Policy	Director, Virtual Care, Strategic Reform and Planning Branch
Contact - Data	Director, Virtual Care, Strategic Reform and Planning Branch
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: PI-03	**Hospital in the Home:** Admitted Activity (%)
Shortened Title	Hospital in the Home
Service Agreement Type	Key Performance Indicator
NSW Health Strategic Outcome	2: Safe care is delivered across all settings
Status	Final
Version number	1.3
Scope	All patients commencing Hospital in the Home (HITH) services as Admitted (Daily) HITH
Goal	To treat an increased number of patients receiving acute care in Hospital in the Home as a substitution for hospitalisation
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	Enterprise Data Warehouse (EDWARD) - Local Reporting Solution (LRS)
Indicator definition	The % of acute overnight episodes of care with all or part of the admitted patient service event in Bed Type '25'
Numerator	
Numerator definition	The number of acute overnight episodes of care with all or part of the episode of care in Bed Type '25'.
Numerator source	EDWARD (FACT_AP_SE_SEG.DIM_HLTH_SVC_BED_WARD_SK)
Numerator availability	Available
Denominator	
Denominator definition	The number of all acute overnight episodes of care in in-scope hospitals
Denominator source	EDWARD (FACT_AP_SE.DIM_HLTH_SVC_BED_WARD_SK)
Denominator availability	Available
Inclusions	All admitted acute overnight episodes of care in Peer Group A-C facilities, plus APAC facilities (OSP_ID = 3015234) and Balmain Hospital (OSP_ID = 1300002), further restricted to facilities with at least one episode of care involving HITH (hospital Bed Type '25'). Admitted patient service events (SE_TYPE_CD = '2').
Exclusions	Justice Health and Forensic Mental Health Network

Targets	Target 5% • Performing: ≥ 5% • Under Performing: ≥ 3.5% and < 5% • Not Performing: < 3.5%
Context	Evidence shows that patients/carers and the health system benefit from acute care provided in an alternate location to a hospital facility. This indicator definition is planned for review for 2025/26.
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 Indicator	
Components	Hospital-in-the-home care Meteor ID: 327308 http://meteor.aihw.gov.au/content/index.phtml/itemId/327308

INDICATOR: KPI23-003	**Dental Access Performance**: Non-Admitted Dental Patients Treated on Time (%)
	Proportion of patients on the public dental waiting list who have waited less than the maximum recommended waiting time for care. (Combined measure of patients on all assessment and treatment waiting lists for public dental services – Assessment categories 1-6 & treatment categories A-F)
Shortened Title	Dental Access Performance
Service Agreement Type	Key Performance Indicator
NSW Health Strategic Outcome	2: Safe care is delivered across all settings
Status	Final
Version number	1.0
Scope	Patients on non-admitted dental assessment and treatment waiting lists.
Goal	To ensure that public dental patients receive care within the clinically recommended timeframe in NSW public oral health clinics.
Desired outcome	To ensure that patients are treated within the maximum recommended waiting time for their priority code for dental assessment or treatment.
Primary point of collection	Oral Health Clinics
Data Collection Source/System	Titanium electronic oral health record
Primary data source for analysis	Titanium electronic oral health record - ODS
Indicator definition	The proportion of patients on non-admitted dental assessment and treatment waiting lists who have not exceeded the maximum recommended waiting time for their waiting list urgency category.
Numerator	
Numerator definition	Total patients on non-admitted dental assessment and treatment waiting lists who are within the maximum recommended waiting time at the time of measurement.
Numerator source	Titanium electronic oral health record - ODS
Numerator availability	Currently available
Denominator	
Denominator definition	The total number of patients on non-admitted dental assessment and treatment waiting lists at the time of measurement.
Denominator source	Titanium electronic oral health record - ODS
Denominator availability	Currently available
Inclusions	All patients on non-admitted dental assessment and treatment waiting lists.

Exclusions	Patients waiting for specialist dental treatment Patients waiting for general anaesthetic dental treatment
Targets	Target 97% of patients within recommended waiting time for their urgency category. • Performing: ≥ 97% • Underperforming: ≥ 90% and < 97% • Not performing: < 90%.
Related Policies/ Programs	Priority Oral Health Program and Waiting List Management Policy
Useable data available from	2018-19
Frequency of Reporting	Monthly
Time lag to available data	3-5 days
Business owners	Centre for Oral Health Strategy
Contact - Policy	Brad Pogson, Manager, Oral Health Information Systems
Contact - Data	Brad Pogson, Manager, Oral Health Information Systems
Representation	
Data type	Percentage %
Form	Quantitative Value
Representational layout	NNN%
Minimum size	0%
Maximum size	100%
Data domain	0-100%
Date effective	1 July 2023
Related National Indicator	N/A

INDICATOR: SSA105b, SSA105c	**Emergency Department Presentations Treated within Benchmark Times – Triage 2 and 3** (%) Emergency Department Presentations -Treated Within Benchmark • Triage 2 (SSA105b) • Triage 3 (SSA105c)
Shortened Title	ED presentations treated within benchmark times
Service Agreement Type	Key Performance Indicator
NSW Health Strategic Outcome	2: Safe care is delivered across all settings
Status	Final
Version number	2.0
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 Information System
Data Collection Source/System	Emergency Department Data Collection
Primary data source for analysis	Enterprise Data Warehouse (EDWARD) - Local Reporting Solution (LRS) ED - Service Event Fact Table.
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 2**: seen within 10 minutes **Triage category 3**: seen within 30 minutes where: • **Presentation time** is the triage date/time (SUB_EVNT_FIRST_TRIAGE_DTTM). If the triage time is missing it is the arrival date/time (CL_ARRIVAL_DTTM) and; • **Commencement of clinical care** is the earliest of first seen clinician date/time or first seen nurse date/time (earliest of SUB_EVNT_FIRST_NURSE_PROTOCOL_DTTM, SUB_EVNT_FIRST_NURSE_PRAC_SEEN_DTTM, SUB_EVNT_FIRST_DOC_SEEN_DTTM, or SUB_EVNT_FIRST_PHYSICIAN_SEEN_DTTM) **Notes:** • 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.

- 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 (CL_DEPART_DTTM) falls within the reporting period.
Numerator source	EDWARD (Emergency Department Data Collection)
Numerator availability	Available

Denominator

Denominator definition	The total number of presentations in each triage category, where the actual departure date (CL_DEPART_DTTM) falls within the reporting period.
Denominator source	EDWARD (Emergency Department Data Collection)
Denominator availability	Available

Inclusions

- Only records where Presentation time, and clinical care commenced time are present
- Emergency visit type (ED_VIS_TYPE_CD = '01', '03', '11') i.e. Emergency presentation, unplanned return visit for continuing condition or disaster
- Triage category (ED_TRIAGE_CD) in ('1','2','3')

Exclusions

- Records where waiting time in ED is missing or greater than 99,998 minutes
- Separation mode in (ED_SEPR_MODE_CD in '02.03', '03' or '98') i.e. registered in error, did not wait or dead on arrival
- Duplicate with same facility, MRN, arrival date, arrival time and birth date (EDW: OSP_CBK, CL_ID, CL_ARRIVAL_DTTM and CL_DOB)

Targets

Performing:

- Triage Category 2 ≥ 80%
- Triage Category 3 ≥ 75%

Underperforming:

- Triage Category 2 ≥ 70% - <80%
- Triage Category 3 ≥ 65% - <75%

Not Performing:

- Triage Category 2 <70%
- Triage Category 3 <65%

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 • 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 Purchasing Branch
Contact – Data	Executive Director, System Information and Analytics
Representation	
Data type	Numeric
Form	Number, presented as a percentage (%)
Representational layout	NNN.N
Minimum size	1
Maximum size	3
Data domain	
Date effective	1 July 2007
Related National Indicator	National Healthcare Agreement: PI 21a-Waiting times for emergency hospital care: Proportion seen on time, 2020 Meteor ID 716686 https://meteor.aihw.gov.au/content/index.phtml/itemId/716686 National Health Performance Authority, Hospital Performance: Percentage of patients who commenced treatment within clinically recommended time 2014 Meteor ID: 563081 (Retired 01/07/2016) http://meteor.aihw.gov.au/content/index.phtml/itemId/563081
Components	Meteor ID 746119 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
https://meteor.aihw.gov.au/content/index.phtml/itemId/746119

Meteor ID 746098 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

https://meteor.aihw.gov.au/content/index.phtml/itemId/746098

HEALTH STRATEGIC OUTCOME 3: People are healthy and well

INDICATOR: PH-011C	**Get Healthy Information and Coaching Service** – Get Healthy in Pregnancy Referrals (% variance from target)
Shortened title	Get Healthy Information and Coaching Service - Get Healthy in Pregnancy Referrals
Service Agreement Type	Key Performance Indicator
NSW Health Strategic Outcome	3: People are healthy and well
Status	Final
Version number	1.2
Scope	Pregnant women aged 16 years and over and referrals from maternity professionals across NSW.
Goal	Get the best start in life from conception to age five.
Desired outcome	Improve the health outcomes of both women and babies by supporting pregnant women across NSW to achieve a healthy gestational weight gain and avoid alcohol during their pregnancy.
Primary point of collection	Service provider of the Get Healthy Service.
Data Collection Source/System	Customer Relationship Management (CRM) system (Service Provider)
Primary data source for analysis	Monthly referral data entered into the CRM system and transferred by Secure File Transfer to Centre for Population Health for independent analysis.
Indicator definition	Number of Get Healthy in Pregnancy referrals into the Get Healthy Information and Coaching Service. Get Healthy in Pregnancy referral is identified as: being pregnant or/and referred by midwife or maternity service or/and enrolling into the Get Healthy in Pregnancy coaching program.
Numerator	
Numerator definition	Total number of Get Healthy in Pregnancy referrals in the 2024-25 reporting period.
Numerator source	CRM
Numerator availability	Monthly
Denominator	
Denominator definition	Target number of Get Healthy in Pregnancy referrals in the 2024-25 reporting period

Denominator source	N/A
Denominator availability	N/A
Inclusions	NSW Adults aged 16 years and over, a Get Healthy in Pregnancy referral is identified as: being pregnant or/and referred by midwife or maternity service.
Exclusions	Children and young people aged less than 16 years of age
Targets	The targets are based on approximately 19.5% of the women who gave birth in public hospitals in 2022 • CCLHD – 586 • FWLHD – 39 • HNELHD – 1,772 • ISLHD – 645 • MNCLHD - 429 • MLHD - 425 • NBMLHD 894 • NNSWLHD 542 • NSLHD – 945 • SESLHD - 1,338 • SWSLHD – 2,024 • SNSWLHD – 312 • SLHD – 1,001 • WNSWLHD – 678 • WSLHD – 1,920 Targets indicate the number of Get Healthy in Pregnancy referrals to the Get Healthy Service. • Performing: ≥100% of target • Under Performing: ≥90% and <100% of target • Not Performing: <90% of target
Context	The Get Healthy Service supports the delivery of the Future Health: Strategic Framework, People are healthy and well. The NSW Healthy Eating and Active Living Strategy commits NSW to achieving targets related to the delivery of the Get Healthy Information and Coaching Service.
Related Policies/ Programs	NSW Healthy Eating and Active Living Strategy 2022-2032
Useable data available from	February 2017-18
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

Contact - Data	Principal Adviser, Program Manager Office, CPH
Representation	
Data type	Numeric
Form	Number, presented as a percentage (%)
Representational layout	NNN.NN
Minimum size	3
Maximum size	6
Data domain	N/A
Date effective	The date when the use of the particular version of the health indicator commenced.
Related National Indicator	N/A

INDICATOR: SPH012	**Children fully immunised at one year of age (%)** Percentage (%) of children fully immunised at 12 to 15 months of age*, disaggregated by: i. Aboriginal children ii. Non-Aboriginal Children
Shortened Title	Children fully immunised at one year of age
Service Agreement Type	Key Performance Indicator
NSW Health Strategic Outcome	3: People are healthy and well
Status	Final
Version number	1.42
Scope	All children 12 to15 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 Community Controlled Health Services 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.
Numerator	
Numerator definition	Number of children aged 12 to 15 months who have received all age-appropriate vaccinations as prescribed by the Australian Immunisation Register.
Numerator source	Australian Immunisation Register
Numerator availability	Available
Denominator	
Denominator definition	Children registered with Medicare Australia in 12 to 15 months age group.
Denominator source	Medicare Australia
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	Target 95% • Performing: ≥95% • Under- performing: ≥90 and <95% • Not performing: <90%.
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, Health Protection NSW
Contact - Data	Manager, Immunisation Unit, Health Protection NSW
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	
	Federation Funding Agreement-Health: Essential Vaccines Schedule (EVS)Benchmark 2. Maintained or increased vaccination rates in Aboriginal and Torres Strait Islander children. https://federalfinancialrelations.gov.au/sites/federalfinancialrelations.gov.au/files/2022-02/essential-vaccine-schedule-to-2023.pdf

INDICATOR: PH-014C	**Initial Hepatitis C Antiviral Treatment -** Direct acting - by District residents (% Variance from Target)
	Initial Hepatitis C direct acting antiviral treatment by LHD residents - (% Variance)
Shortened Title	Initial Hepatitis C Antiviral Treatment
Service Agreement Type	Key Performance Indicator
NSW Health Strategic Outcome	3: People are healthy and well
Framework Objective	The current NSW Health Strategic Priority Strategy Objective. E.g. "1.5: Embed Aboriginal social and cultural concepts of health and wellbeing".
Status	Final
Version number	2.0
Scope	All NSW residents with chronic hepatitis C prescribed initial 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 Program 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 an eight-week time lag as the PBS closes off the data six weeks post the relevant quarter)
Indicator definition	Number of initial hepatitis C direct acting antiviral treatments among LHD residents
Numerator	
Numerator definition	Total number of initial hepatitis C treatments by LHD residents with chronic hepatitis C.
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 initial hepatitis C treatments by LHD residents with chronic hepatitis C.
Denominator source	N/A
Denominator availability	N/A
Inclusions	• Patients who reside in NSW • Only Initial hepatitis C received by patient (one per patient) • 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	• Subsequent treatments for hepatitis C reinfection or previous failed treatment • 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	• SESLHD – 520 • SLHD – 460 • SWSLHD – 620 • HNELHD – 390 • NNSWLHD – 290 • WSLHD – 500 • NSLHD – 100 • MNCLHD – 170 • ISLHD – 220 • CCLHD – 170 • SNSWLHD – 140 • WNSWLHD – 200 • NBMLHD – 210 • MLHD – 130 • FWLHD – 20 • Performing ≥100% of target • Underperforming ≥98% and <100% of target • Not performing < 98% of target
Context	NSW Health has committed to eliminating hepatitis C as a public health concern by 2028. Achieving hepatitis C elimination requires increased treatment coverage in every local health district.
Related Policies/ Programs	• NSW Hepatitis C Strategy • Fifth National Hepatitis C Strategy 2022-2025
Useable data available from	01/03/2016

Frequency of Reporting	Quarterly
Time lag to available data	Reporting data available eight weeks post last reporting period; PBS closes off the data six weeks post the relevant quarter.
Business owners	Office of the Chief Health Officer
Contact - Policy	Executive Director, Centre for Population Health
Contact - Data	Executive Director, Centre for Population Health
Representation	
Data type	Numeric
Form	Number
Representational layout	N
Minimum size	1
Maximum size	6
Data domain	Number
Date effective	
Related National Indicator	N/A

INDICATOR: KPI23-002	**Human Papillomavirus Vaccination (%)**
	Percentage (%) of 15 year olds receiving a dose of HPV vaccine
Shortened Title	HPV Vaccination
Service Agreement Type	Key Performance Indicator
NSW Health Strategic Outcome	3 People are healthy and well
Status	Final
Version number	1.0
Scope	All adolescents aged 15 years.
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 public health units, general practitioners, community health centres, Aboriginal medical centres and community pharmacies.
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 adolescents aged 15 years who are registered with Medicare and have received a dose of human papillomavirus vaccine, as defined by the Australian Immunisation Register.
Numerator	
Numerator definition	Number of adolescents aged 15 years who have received a dose of HPV vaccine as prescribed by the Australian Immunisation Register.
Numerator source	Australian Immunisation Register
Numerator availability	Available
Denominator	
Denominator definition	15 years registered with Medicare Australia.
Denominator source	Australian Immunisation Register
Denominator availability	Available
Inclusions	All adolescents 15 years of age
Exclusions	Vaccinations which are not prescribed by Australian Immunisation Register
Targets	Target 80% • Performing: ≥80%

	• Under- performing: ≥75 and <80% • Not performing: <75%
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 immunisation coverage
Related Policies/ Programs	National Immunisation Program
Useable data available from	2013
Frequency of Reporting	Quarterly
Time lag to available data	90 days
Business owners	Health Protection NSW
Contact - Policy	Manager, Immunisation Unit, Health Protection NSW
Contact - Data	Manager, Immunisation Unit, Health Protection NSW
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	July 1 2023
Related National Indicator	Federation Funding Agreement-Health: Essential Vaccines Schedule (ESV) Benchmark 3. Increased vaccination coverage rate for both adolescent boys and adolescent girls. https://federalfinancialrelations.gov.au/sites/federalfinancialrelations.gov.au/files/2022-02/essential-vaccine-schedule-to-2023.pdf

INDICATOR: KPI2414, KPI2415 **Previous ID: DPH_1201**	**Pregnant Women Quitting Smoking - By the second half of pregnancy** (% change) • Aboriginal women giving birth (KPI2414) • Non-Aboriginal women giving birth (KPI2415)
Shortened Title	Pregnant Women Quitting Smoking
Service Agreement Type	Key Performance Indicator
NSW Health Strategic Outcome	3: People are healthy and well
Status	Final
Version number	1.0
Scope	All women giving birth in NSW public hospitals
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 Midwifes
Data Collection Source/System	QIDS Maternity Intelligence System (QIDS MatIQ)
Primary data source for analysis	QIDS Maternity Intelligence System (QIDS MatIQ)
Indicator definition	Proportion of pregnant women who quit smoking by the second half of pregnancy, disaggregated by Aboriginality. Indicator is reported by Local Health District of the birth hospital. Women who quit smoking by the second half of pregnancy (%) = *Total number of women who reported smoking in the first half of pregnancy and did not smoke in 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, disaggregated by Aboriginality.* --- *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, disaggregated by Aboriginality.*
Numerator	
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, disaggregated by Aboriginality.
Numerator source	QIDS Maternity Intelligence System (QIDS MatIQ)
Numerator availability	Three-monthly, data lag one month after the end of three-month period based on date of birth of the baby

Denominator	
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, disaggregated by Aboriginality
Denominator source	QIDS Maternity Intelligence System (QIDS MatIQ)
Denominator availability	Three-monthly, data lag one month after the end of three-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, disaggregated by Aboriginality.
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. • Women giving birth in any private hospital in NSW or Northern Beaches Hospital. • Women who did not report their Aboriginality
Targets	**For both cohorts:** Target 4%-point 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 associated with poor health outcomes for the fetus such as increased risk of perinatal mortality, low birth weight, and prematurity.
Related Policies/ Programs	• 2022-24 NSW Implementation Plan for Closing the Gap • NSW Aboriginal Health Plan 2013-23 • Aboriginal Maternal and Infant Health Strategy • NSW Tobacco Strategy 2012-2021
Useable data available from	1 July 2022
Frequency of Reporting	Quarterly reporting of rolling 12-month period
Time lag to available data	Three monthly data is available with one month lag after the end of three-month period based on date of birth of the baby.
Business owners	Office of the Chief Health Officer
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 2025
Related National Indicator	COAG National Indigenous Reform Agreement: National Core Maternity Indicators: PI 01-Tobacco smoking in pregnancy for all females giving birth https://meteor.aihw.gov.au/content/index.phtml/itemId/742381

INDICATOR: KPI21-02	**NSW Health First 2000 Days Implementation Strategy** - Delivery of the 1-4 week health check (%)
Shortened Title	First 2000 Days Strategy 1-4 week health check
Service Agreement Type	Key Performance Indicator
NSW Health Strategic Outcome	3: People are healthy and well
Status	Final
Version number	1.1
Scope	Families with a new baby.
Goal	Universal Child Health Engagement: Early engagement with families in the postnatal period to maximise ongoing child and family health service uptake, participation in child health checks from birth to 4 years, and to support improved child development outcomes.
Desired outcome	All families are engaged in ongoing child and family health care by 1-4 weeks post birth and continue to engage with their child and family health service through attendance at the 6-8 week health check.
Primary point of collection	Child and Family Health Services (child and family health nurses)
Data Collection Source/System	Cerner eMR, CHIME, and other Community Health systems.
Primary data source for analysis	Enterprise Data Warehouse (EDWARD) - Local Reporting Solution (LRS) or interim summary report from source system
Indicator definition	The percentage of families with a new baby who receive a 1-4 week health check by a Child and Family Health Nurse within 2 weeks of the baby's birth.
Numerator	
Numerator definition	Number of families* receive a 1-4 week health check by a Child and Family Health Nurse within 2 weeks of the baby's birth. *Families are defined as residents in NSW with a newborn who, in principle, are eligible for a child and family health service within two weeks of the birth of the child.
Numerator source	EDWARD or interim summary report from source system
Numerator availability	Available monthly
Denominator	
Denominator definition	Families with a newborn, who are resident in NSW and who, in principle, are eligible for child and family health services.

Denominator source	Perinatal Data Collection/Admitted Patient Data Collection (EDWARD and PHISCO).
Denominator availability	Admitted Patient Data Collection available monthly. Perinatal Data Collection available quarterly.
Inclusions	All infants to NSW residents
Exclusion	Stillbirths, neonatal deaths occurring before the infant's discharge, babies who were not discharged within the timeframe of the 1-4 week check, neonatal deaths occurring after discharge and before the check. The following births are not included in the calculation of the Indicator: 1. Ineligible births (child health check eligibility flag = n). Ineligible births include: • Stillbirth • Neonatal death prior to discharge • Neonatal death post discharge • Resides out of catchment area 2. Births where an offer was made but it was declined by the patient (child health check offer outcome code is 3 declined). Declined reasons include: • Will go/has gone to GP, • Attending other provider (specify) • Is moving/has moved out of catchment area • Out of catchment area during child health check period • Does not want the service • Cannot travel to clinic • Does not respond to offer contact attempts
Reporting	
Reporting required by	NSW Health
Indicators reported to	Chief Executives Performance Review, Local Health District Performance Agreements, NSW Health Annual Report,
Next report due	TBC
Targets	Target 85% • Performing: ≥85 and <100 • Underperforming: ≥75 and <85 • Not performing: <75
Time frame for target	Yearly
Lower /upper age limit	N/A

Sex	N/A
Geographical area interest	Whole State/Local Health District
Comments	Note that an outcomes framework for the whole of government Brighter Beginnings: the first 2000 days of life initiative is being developed. The likely indicator is an increase in the proportion of children starting school developmentally on track by 2027.
Context	A key goal of the First 2000 Days Implementation Strategy 2020-25 for the First 2000 Days Framework PD2019_008 is attendance at the recommended schedule of health checks to support optimal childhood health and development so that children enter school developmentally on track. Success depends on engaging families into services as early as possible through the 1-4 week child health check, and continuing engagement throughout the full schedule of health and development checks with the next Indicator point to measured at the 6-8 week check. Attendance at the full schedule of checks will assist families to engage effectively in their children's health and wellbeing, and support parents to develop greater confidence in making evidence-based decisions for building brains. Early engagement with families and attendance at the schedule of health checks will ensure that developmental vulnerabilities are identified and addressed early, before children start school (the First 2000 Days Implementation Strategy 2020-25 program logic). This KPI will indicate: • Whether families have effectively transitioned from antenatal and postnatal care into child and family health care. • effective engagement into services to support children's development and delivery of well child health care. Additional indicators may be added over time to monitor the effectiveness of ongoing engagement in the full schedule of health checks.
Related Policies/ Programs	• First 2000 Days Framework (PD2019_008); First 2000 Days Implementation Strategy 2020-25
Major existing uses	• Results and Services Plan • Local Health District Performance Agreements/ Reviews • NSW dashboard indicators • Annual Report • Families NSW Area Health Service Annual Reports • First 2000 Days Implementation Strategy reporting
Useable data available from	TBC

Frequency of Reporting	Quarterly
Time lag to available data	TBC
Business owners	Health and Social Policy Branch
Contact - Policy	Director, Maternity, Child and Family Unit (Deborah Matha)
Contact - Data	Director, Maternity, Child and Family Unit (Deborah Matha)
Representation	
Data type	Numeric
Form	Number, presented as a percentage (%)
Representational layout	NNN.NN
Minimum size	1
Maximum size	6
Data domain	

INDICATOR: MS1102	**Childhood Obesity** - Children with height/length and weight recorded in inpatient settings (%) Proportion of children with an overnight admission/stay, aged greater than 2 days, up to but not including the 16th birthday with their both their height/length and weight recorded within the inpatient encounter during the relevant quarterly reporting period (%).
Service Agreement Type	Key Performance Indicator
Framework Strategy	Strategy 3: People are healthy and well
Framework Objective	The NSW Health - Nutrition Care Policy Growth Assessment in Children and Weight Status Assessment in Adults GL2017_021), Growth Assessment and Dietary Advice in Public Oral Health Services GL2019_001.
Status	Final
Version number	2.1
Scope	All children admitted to NSW health public inpatient facility for overnight stay, aged greater than 2 days and up to but not including the 16th birthday
Goal	Improve the routine recording of children's height/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.
Primary point of collection	All LHD/SHNs via Electronic Medical Record (eMR)
Data Collection Source/System	Local eMR systems.
Primary data source for analysis	Routine recoding of height and weight data extracts will be generated from Local Health District/Specialty Health Network. eMR
Indicator definition	Percentage of unique children admitted to NSW health public inpatient facility for overnight stay, aged greater than 2 days and up to but not including the 16th birthday who have their height/length and weight measured, within the current reporting period.
Numerator	
Numerator definition	Number of unique children admitted to NSW health public inpatient facility for overnight stay aged greater than 2 days and up to but not including the 16th birthday who are admitted to any NSW Health facility (excluding Emergency Department presentations that were not admitted) and had height/length and weight measured and entered at least once

	into the electronic medical record system, on or within the dates of the hospital admission/stay within the current reporting period.
Numerator source	Local eMRs, CHOC/CHIME/Titanium systems
Numerator availability	Quarterly
Denominator	
Denominator definition	Number of unique children admitted to NSW health public inpatient facility for overnight stay, aged greater than 2 days and up to but not including the 16th birthday who are admitted to any NSW Health facility (excluding Emergency Department presentations that were not admitted) within the current reporting period.
Denominator source	Local eMRs systems, and CHOC/CHIME/Titanium systems
Denominator availability	Quarterly
Inclusions	All children admitted to NSW health public inpatient facility for overnight stay, aged greater than 2 days and up to but not including the 16th birthday who have contact with NSW Health.
Exclusions	• Children below the age of 2 days and above 16 years of age. • Any child who presented to an Emergency Department and was not admitted below the aged of 2 days and up to but not including the 16th birthday. • Clinical services where measuring weight and height/length may not be appropriate, or else does not enhance patient care, such as trauma, life-threatening illness and end of life care. • Services identified as COVID-19 related (as identified by the LHD/SHN to CPH)
Targets	
Target	Target 70% • Performing ≥70% • Underperforming ≥65% and <70% • Not performing < 65%
Context	Local Health Districts/Specialty Health Networks are responsible for ensuring all children aged greater than 2 days and up to but not including the 16th 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 Strategic Priority that People are healthy and well. To support NSW Health staff within each Local Health District/Specialty Health Network to monitor and achieve compliance with the Policy.
Related Policies/ Programs	NSW Health Nutrition Care Policy PD2017_041,

	Growth Assessment in Children and Weight Status Assessment in Adults GL2017_021), Growth Assessment and Dietary Advice in Public Oral Health Services GL2019_001.
Useable data available from	July 2018
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	**Office of the Chief Health Officer**
Contact - Policy	Executive Director, Centre for Population Health / Health, and Social Policy
Contact - Data	Executive Director, Centre for Population Health / eHealth NSW
Representation	
Data type	Numeric
Form	Percentage, including numerator and denominator
Representational layout	NNN.N% (percentage), including nn/NN (corresponding numerator and denominator)
Minimum size	3
Maximum size	5
Data domain	N/A
Date effective	The date when the use of the particular version of the health indicator commenced.
Related National Indicator	N/A

INDICATOR: KF-005	**Domestic Violence Routine Screening** – Routine Screens conducted (%)
Shortened Title	Domestic Violence Routine Screening
Service Agreement Type	Key Performance Indicator
NSW Health Strategic Outcome	3: People are healthy and well
Status	Final
Version number	2.0
Scope	All women attending Maternity services, 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	Clinicians in Maternity, Child and Family Health, Drug and Alcohol, and Mental Health services
Data Collection Source/System	eMaternity, Cerner/eMR, CHIME
Primary data source for analysis	Domestic Violence Routine Screening Summary Report
Indicator definition	The percentage of Domestic Violence Routine Screens completed for women attending Maternity services, 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 women attending Maternity services, Child and Family Health services, and women aged 16 years and over in Drug and Alcohol and Mental Health Services who have a Domestic Violence Routine Screen completed.
Numerator source	eMaternity, Cerner/eMR, CHIME
Numerator availability	Quarterly
Denominator	
Denominator definition	Number of eligible women presenting to Maternity services, Child and Family Health services, and eligible women aged 16 years and over attending Drug and Alcohol and Mental Health services
Denominator source	eMaternity, Cerner/eMR, CHIME
Denominator availability	Quarterly

Inclusions

- All women attending Maternity services, 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 + 12 week offset period after the reporting period.
- For summary reports from eMaternity: If the same woman is screened multiple times across different bookings within the same reporting period, or across different reporting periods, each screen will be counted in the numerator, and each attendance will be counted in the denominator.
- For summary reports from Cerner/eMR: Each encounter is only counted in the summary report totals once.
    - If there are multiple screens attempted during the same encounter for the same service stream, the completed screen will be prioritised, or otherwise the latest screen attempted. If Inpatient Encounters for Drug and Alcohol and Mental Health specialties are to be included, then 'All streams' needs to be selected.
    - When Inpatient and Community Encounters are combined for the derived specialty of Mental Health or Drug and Alcohol, this will produce a summary count of unique encounters per derived specialty

Exclusions

- Children of women attending Maternity services, Child and Family Health services, Drug and Alcohol and Mental Health Services.
- For summary reports from Cerner/eMR: Women who did not have a new registration in Child and Family Health, Drug and Alcohol and Mental Health services within the reporting period.

Targets

Target 70%

- Performing: ≥ 70%
- Under Performing: ≥ 60% and < 70%
- Not Performing: < 60%

Context

NSW Health is committed to supporting the early identification and response to domestic violence. Since 2004, NSW Health has been undertaking Domestic Violence Routine Screening (DVRS) for women accessing maternity, child and family services and women, 16 years and over, accessing mental health and alcohol and other drug services. DVRS provides a critical opportunity for the disclosure of domestic violence, early identification and intervention, including initial risk assessment and providing women with information, support and referrals.

A 100% target is not feasible for the Domestic Violence Routine Screening program as this would likely detract from the quality of screening and ensuing outcomes. Nor would it take into account situations where it would be reasonable not to screen including:

- Where the client is not well enough to be screened (i.e. client may be presenting to a Mental Health service for first time and is psychotic)
- Where it is not 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	• Cerner/eMR, CHIME: July 2018 • eMaternity: July 2021 (to start reporting January to March 2021 data retrospectively with 12 week offset)
Frequency of Reporting	Quarterly
Time lag to available data	12 weeks
Business owners	
Contact - Policy	Director, Prevention and Response to Violence, Abuse and Neglect Unit, Government Relations Branch.
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 Indicator	

INDICATOR: KF-0061, -0062	**Sustaining NSW Families Programs**: • Families completing the program when child reached 2 years of age (%) *(KF-0061)* • Families enrolled and continuing in the program (%) *(KF-0062)*
Shortened Title(s)	Sustaining NSW Families Programs (Completed) Sustaining NSW Families Programs (Enrolled)
Service Agreement Type	Key Performance Indicator
NSW Health Strategic Outcome	3: People are healthy and well
Status	Final
Version number	1.2
Scope	Families enrolled in the Sustaining NSW Families Program
Goal	The Sustaining NSW Families Program operates at ≥ 80% of funded capacity. Families complete the full course of structured home visits
Desired outcome	Children have better health and development outcomes. Parents have improved parenting capacity.
Primary point of collection	Funded Sustaining NSW Families services
Data Collection Source/System	Excel spreadsheet
Primary data source for analysis	Excel spreadsheet
Indicator definition	**KF-0061**: The proportion of families with a child born in 2022/23 who enrolled in the program, that completed the program when their child reached two years of age in the reporting period. **KF-0062**: The proportion of families with a child born in 2023/24 who enrolled in the program, and who remained in the program until the child turned one year of age in FY 2024/25 and continued in the program.
Numerator	
Numerator definition	**KF-0061**: The number of families with a child born in 2022/23 who enrolled in the program, that completed the program when their child reached two years of age in the reporting period. **KF-0062**: The number of families with a child born in 2023/24 who enrolled in the program, and who remained in the program until the child turned one year of age in FY 2024/25 and continued in the program.
Numerator source	Excel spreadsheet (point of service provision)
Numerator availability	Monthly
Denominator	

Denominator definition	**KF-0061*:*** The number of families enrolled in the program whose child was born in the 2022/23 financial year and turned two years of age in the reporting period. **KF-0062**: The number of families enrolled in the program whose child was born in the 2023/24 financial year, who were still enrolled when their child turned one year of age and remained engaged in the program in the reporting period.
Denominator source	Excel spreadsheet (point of service provision)
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 with a child born in 2022/23 who enrolled in the program, completed the program (ie remained in the program until the child turned two years of age in FY 2024/25). • Performing: ≥50% • Under Performing: ≥45% and <50% • Not Performing: <45% NOTE: Indicator KF-0061 applies to: CCLHD, HNELHD (Site 1), ISLD, NNSWLHD, SESLHD, SWSLHD (Site 1 and Site 2), SLHD, WSLHD. **KF-0062*:*** At least 65% of families with a child born in 2022/23 who enrolled in the program, remained in the program until the child turned one year of age in FY 2024/25 and continued in the program. • Performing: ≥65% • Under Performing: ≥55% and <65% • Not Performing: <55% NOTE: Indicator KF-0062 applies to sites during establishment once they have commenced taking clients.
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 50 per 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	Quarterly
Time lag to available data	12 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
Form	Number, presented as a percentage (%)
Representational layout	NNN.N
Minimum size	3
Maximum size	5
Data domain	
Date effective	1 July 2015
Related National Indicator	

INDICATOR: KMH202	**Mental Health Peer Workforce Employment** – Full time equivalents (FTEs) (Number)
Shortened Title	Mental Health Peer Workforce Employment
Service Agreement Type	Key Performance Indicator
NSW Health Strategic Outcome	3: People are healthy and well
Status	Final
Version number	1.7
Scope	Staff employed by the Local Health District/Specialty Health Networks
Goal	• Identify opportunities to expand the scope and size of the Peer Consumer 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 Consumer 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	Administrative and peer workforce managers in NSW mental health facilities.
Data Collection Source/System	Local roster/or human resource management systems.
Primary data source for analysis	Manual collection - 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), where the total number of hours is divided by 40 to obtain an FTE number.
Numerator	
Numerator definition	The total number of ordinary hours worked by all mental health staff employed in a peer worker capacity (consumer or carer workers) using the following definitions: *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 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: The total ordinary working hours worked by a full time peer worker.

Denominator source:

Denominator availability:

Inclusions: All persons specifically employed for the expertise developed from their lived experience of mental illness or as a mental health carer.

Exclusions

Targets

LHD/SHN	Performing	Not performing
CC	≥8.6	<8.6
FW	≥7.0	<7.0
HNE	≥22.2	<22.2
IS	≥12.8	<12.8
JHFMHN	≥3.6	<3.6
MNCLHD	≥10.5	<10.5
MLHD	≥15.9	<15.9
NBM	≥10.2	<10.2
NNSW	≥9.5	<9.5
NS	≥22.4	<22.4
SES	≥29.2	<29.2
SWSLHD	≥25.6	<25.6
SNSWLHD	≥8.2	<8.2
SVHN	≥6.8	<6.8
SLHD	≥16.9	<16.9
SCHN	≥6.0	<6.0
WNSW	≥22.6	<22.6
WS	≥17.3	<17.3
NSW Total	**≥255.3**	**<255.3**

	• Performing: Equal to or greater than a specified target (count) for each LHD • Underperforming: N/A • Not performing: Less than the target.
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	Submission of data may take up to one month after the end of the reporting period.
Business owners	Mental Health Branch
Contact - Policy	Executive Director, Mental Health Branch
Contact - Data	Director, InforMH, System Information and Analytics Branch
Representation	
Data type	Numeric
Form	Number
Representational layout	NN.N
Minimum size	2
Maximum size	4
Data domain	
Date effective	01/07/2016
Related National Indicator	N/A

INDICATOR: SSA140	**Breast Screen Participation Rates**: All women aged 50-74 (%)
Previous IDs: 8A1, 0037 SSA126, SSA127, SSA128, SSA129, SSA130, SSA131	
Shortened Title	Breast Screen Participation Rates – All 50-74
Service Agreement Type	Key Performance Indicator
NSW Health Strategic Outcome	3: People are healthy and well
Status	Final
Version number	1.0
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.
Goal	≥50% of women aged 50-74 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	<u>All women</u> Number of individual women residing in the Service catchment areas (LHD) in NSW aged 50-74 who had one or more breast screening episode with any Service in the Program during the 24-month reporting period.
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

Denominator source	Projected population data for the designated years from the Epidemiology and Surveillance Branch, NSW Ministry of Health.
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.)
Targetsz	Target = 50 Women aged 50-74 years: • Performing ≥50% • Underperforming ≥45% and <50% • Not performing <45%
Context	Participation is a major indicator of the performance of BreastScreen Australia, which aims to maximise the early detection of breast cancer in the target population aged 50–74. High attendance for screening in this age group maximises the reduction in mortality from breast cancer (BreastScreen Australia 2004).
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	
Data type	Numeric
Form	Number, presented as a percentage (%)
Representational layout	NNN.N
Minimum size	3
Maximum size	4

Data domain	Percentage
Date effective	1 July 2013
Related National Indicator	BreastScreen Australia 2019, Data Dictionary (1.2) BreastScreen Australia 2008, National Accreditation Standards

HEALTH STRATEGIC OUTCOME 4: Our staff are engaged and well supported

INDICATOR: SPC111	**Workplace Culture**: People Matter Survey Culture Index- (% variation from previous survey)
Shortened Title	Workplace Culture
Service Agreement Type	Key Performance Indicator
NSW Health Strategic Outcome	4: Our staff are engaged and well supported
Status	Final
Version number	1.0
Scope	All LHD staff who respond to the survey.
Goal	Improved response rates, and workplace culture
Desired outcome	To achieve a higher response rate and higher workplace culture 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 Culture 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 for the previous survey.
Numerator source	Survey data from external provider
Numerator availability	External provider.
Denominator	
Denominator definition	Percentage 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: ≥ -1% on previous year

	• Performing: or ≥ -1% • Under Performing: > -5% and < -1% • Not Performing: ≤ -5%
Related Policies/Programs	NSW Health Workplace Culture Framework
Useable data available from	August 2018 from external provider
Frequency of Reporting	Annual-ongoing
Time lag to available data	
Business owners	Workforce Planning and Talent Development
Contact-Policy	Director, Workforce Strategy & Culture, Workforce Planning and Talent Development.
Contact-Data	Director, Workforce Strategy & Culture, Workforce Planning and Talent Development.
Representation	
Datatype	Numeric
Form	Percentage
Representational lay out	NNN
Minimum size	1
Maximum size	3
Data domain	External provider
Date effective	2011
Related National Indicator	N/A

INDICATOR: SPC115	**Take Action**: People Matter Survey take action as a result of the survey -Variation from previous survey (%)
Shortened Title	Take Action
Service Agreement Type	Key Performance Indicator
NSW Health Strategic Outcome	4: Our staff are engaged and well supported
Status	Final
Version number	2.0
Scope	All LHD staff who respond to the survey.
Goal	Improved response rates, and workplace culture
Desired outcome	To achieve a higher response rate and higher take action score 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 take action score in the current survey against last year's survey.
Numerator	
Numerator definition	Current % survey score from a question in survey determined by external provider for the previous survey.
Numerator source	Survey data from external provider
Numerator availability	External provider.
Denominator	
Denominator definition	Percentage survey score from a question 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: ≥ -1% on previous year • Performing: ≥ -1%

	• Under Performing: > -5% and < -1% • Not Performing: ≤ -5%
Related Policies/Programs	NSW Health Workplace Culture Framework
Useable data available from	August 2018 from external provider
Frequency of Reporting	Annual-ongoing
Time lag to available data	
Business owners	Workforce Planning and Talent Development
Contact-Policy	Director, Workforce Strategy & Culture, Workforce Planning and Talent Development.
Contact-Data	Director, Workforce Strategy & Culture, Workforce Planning and Talent Development.
Representation	
Datatype	Numeric
Form	Percentage
Representational lay out	NNN
Minimum size	1
Maximum size	3
Data domain	External provider
Date effective	2011
Related National Indicator	N/A

INDICATOR: SPC110	**Staff Engagement**: People Matter Survey Engagement Index - Variation from previous year (%)
Shortened Title	Staff Engagement
Service Agreement Type	Key Performance Indicator
NSW Health Strategic Outcome	4: Our staff are engaged and well supported
Status	Final
Version number	2.5
Scope	All LHD staff who respond to the survey.
Goal	Improved response rates, and staff engagement
Desired outcome	To achieve a higher response rate 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: ≥ -1% on previous year Performing: or ≥ -1%

	Under Performing: > -5% and < -1% Not Performing: ≤ -5%
Related Policies/ Programs	NSW Health Workplace Culture Framework
Useable data available from	August 2017 from external provider
Frequency of Reporting	Annual- ongoing
Time lag to available data	
Business owners	Workforce Planning and Talent Development
Contact - Policy	Director, Workforce Strategy and Culture, Workforce Planning and Talent Development Branch.
Contact - Data	Director, Workforce Strategy and Culture, Workforce Planning and Talent Development Branch.
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: KPI21-01	**Staff Engagement and Experience – People Matter Survey -** Racism experienced by staff - Variation from previous survey (%)
Shortened Title	Staff experience: Racism
Service Agreement Type	Key Performance Indicator
NSW Health Strategic Outcome	4: Our staff are engaged and well supported
Status	Final
Version number	1.1
Scope	All NSW Health Staff who completed the People Matter Employment Survey.
Goal	Decrease NSW Health Staffs' experience of racism at work.
Desired outcome	To reduce the incidence of racist experiences for Aboriginal staff and staff who speak a language other than English at home (LOESH).
Primary point of collection	People Matter Employment (PME) Survey.
Data Collection Source/System	External Service Provider: The Public Service Commission.
Primary data source for analysis	External Service Provider: The Public Service Commission.
Indicator definition	Percentage of Aboriginal staff and staff who speak a language other than English at home (LOESH) experiencing racism at work in the current PME Survey compared to the previous PME Survey.
Numerator	
Numerator definition	Percentage of Aboriginal staff or staff who speak a language other than English at home (LOESH) in the current survey who answered "yes" to PME Survey question H10: In the past 12 months have you experienced racism in the workplace.
Numerator source	PME Survey
Numerator availability	External provider: The Public Service Commission.
Denominator	
Denominator definition	Percentage of Aboriginal staff or staff who speak a language other than English at home (LOESH) in the previous survey who answered "yes" to PME Survey question H10: In the past 12 months have you experienced racism in the workplace.
Denominator source	PME Survey
Denominator availability	External provider: The Public Service Commission.
Inclusions	All Aboriginal staff or staff who speak a language other than English at home (LOESH) who complete the survey.
Exclusions	As per inclusions above.

Targets	Target: ≥ 5 % points decrease on previous survey • Performing: ≥ 5 % points decrease on previous survey • Under Performing: > 0 and < 5 % points decrease on previous survey • Not performing: No change or increase from previous survey
Context	Aboriginal staff and people who speak a language other than English at home (LOESH) may experience racism at work, which is inconsistent with NSW Health's CORE Values. It also impacts staff wellbeing, retention and performance at work.
Related Policies/ Programs	NSW Health Workplace Culture Framework 2022-24 NSW Implementation Plan for Closing the Gap NSW Aboriginal Health Plan 2013-23
Useable data available from	August 2019 from external provider. No data were collected for this question in 2020, so comparison between 2019 and 2021 will be undertaken for the 2021/2022 Service Agreements.
Frequency of Reporting	Annual (August)
Time lag to available data	Four months.
Business owners	Workforce Planning and Talent Development
Contact - Policy	Director, Workforce Strategy and Culture, Workforce Planning and Talent Development Branch.
Contact - Data	Director, Workforce Strategy and Culture, Workforce Planning and Talent Development Branch.
Representation	
Data type	Numeric.
Form	Percentage.
Representational layout	NNN.NN
Minimum size	3
Maximum size	6
Data domain	External provider.
Date effective	2021
Related National Indicator	NA

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.
Shortened Title	Staff Performance Reviews
Service Agreement Type	Key Performance Indicator
NSW Health Strategic Outcome	4: Our staff are engaged and well supported
Status	Final
Version number	1.41
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	HCM: PAT via Corporate Analytics –- Workforce
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	
Numerator definition	Total number of eligible staff who have had a performance review within the last 12 months.
Numerator source	HCM: PAT via Corporate Analytics –- Workforce
Numerator availability	Available
Denominator	
Denominator definition	Total number of eligible staff
Denominator source	HCM: PAT via Corporate Analytics –- Workforce
Denominator availability	Available
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. • 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	100% of eligible staff have a formal performance review at least annually. • Not performing: <85% • Under performing: ≥85% and <90% • Performing: ≥90%
Related Policies/ Programs	NSW Public Sector Performance Development Framework and PD2016_040 *Managing for Performance*.
Useable data available from	Corporate Analytics - Workforce
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	Director, Workplace Relations Branch
Contact - Data	Director, Workforce Planning and Performance Unit, Workforce Planning and Talent Development Branch
Representation	
Data type	Numeric
Form	Percentage
Representational layout	NNN.NN
Minimum size	3
Maximum size	6

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 StaffLink and reported from Corporate Analytics - Workforce (CAWF).
Date effective	01/07/2014
Related National Indicator	Nil

INDICATOR: SPC107	**Recruitment:** Average time taken from request to recruit to decision to approve/decline/defer recruitment (business days)
Shortened Title	Recruitment Decision Timeliness Improvement
Service Agreement Type	Key Performance Measure
NSW Health Strategic Outcome	4: Our staff are engaged and well supported
Status	Final
Version number	3.11
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	HCM: ROB via Corporate Analytics - Workforce
Data Collection Source/System	HCM: ROB via Corporate Analytics - Workforce
Primary data source for analysis	HCM: ROB via Corporate Analytics - Workforce
Indicator definition	Average business days for completion of recruitment approvals from submission of Approval to Fill (ATF) 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 ATFs submitted and completed each calendar month, YTD.
Numerator source	HCM: ROB via Corporate Analytics - Workforce
Numerator availability	Total number of business days for the completion of decisions from the date the Approval to Fill (ATF) sent to first approver to the date of final decision to approve, decline or defer the ATF in HCM: ROB for all submitted ATFs YTD
Denominator	
Denominator definition	Total number of ATFs submitted and completed YTD.
Denominator source	Recruitment and Onboarding system
Denominator availability	
Inclusions	All ATFs processed through the Recruitment and Onboarding system.
Exclusions	Rolling ads, casual ads, ATRs incomplete at the end of the month

Targets	Target: 10 business days • Performing: =< 10 days • Under Performing: No change from previous year and >10 days • Not Performing: >10 days
Comments	Achievement of appropriate recruitment times ensures that vacancies are not left unfilled, adversely affecting service provision and workplace culture.
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.
Business owners	**Workplace Relations**
Contact - Policy	Executive Director, Workplace Relations
Contact - Data	Director, Workforce Planning and Performance Unit, Workforce Planning and Talent Development Branch.
Representation	
Data type	Numeric
Form	Number/graphic
Representational layout	NNN.NN
Minimum size	N.N
Maximum size	NNNNN.NN
Data domain	Recruitment and Onboarding system
Related National Indicator	NA

INDICATOR: SPC108	**Aboriginal Workforce Participation:** Aboriginal Workforce as a proportion of total workforce at all salary levels (bands) and occupations: (%)
Shortened Title	Aboriginal Workforce Participation
Service Agreement Type	Key Performance Indicator
NSW Health Strategic Outcome	4: Our staff are engaged and well supported
Status	Final
Version number	2.22
Scope	Staff employed within NSW Health Workforce
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 Corporate Analytics - Workforce
Primary data source for analysis	Public Service Commission Workforce Profile via Corporate Analytics - Workforce

Indicator definition	The percentage of Aboriginal staff employed in health workforce (i) within all salary bands and (ii) within all occupations The June 2022 salary bands are as follows: • < $51,585 • $51,586 - $67,751 • $67,752 - $75,741 • $75,742 - $95,847 • $95,848 - $123,947 • $123,948 - $154,933 • ≥$154,934 Occupation 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 or employed under the Aboriginal Health Workers State Award
Numerator source	Public Service Commission Workforce Profile via Corporate Analytics – Workforce.
Numerator availability	Annually
Denominator	
Denominator definition	Total number of eligible staff employed in health workforce
Denominator source	Public Service Commission Workforce Profile via Corporate Analytics – Workforce.
Denominator availability	Annually
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.

Exclusions	Staff that do not provide a response to the EEO question regarding aboriginal status
Reporting	
Reporting required by	NSW Ministry of Health
Indicators reported to	
Next report due	Annual
Targets	Target: 3.43% representation of Aboriginal staff across all salary levels (bands) and occupational groups in the NSW Health workforce by 2022 • Performing: ≥ 3.43% • Under Performing: ≥2.0% to <3.43% • Not Performing: <2.0% **Note:** Where total workforce headcount in a particular salary band is less than 16 people, the percentage target will not contribute to the salary band portion of the KPI. However, unique headcount will contribute to overall agency representation target.
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 • PD2022_028 Respecting the Difference Aboriginal Cultural Training • 2022-24 NSW Implementation Plan for Closing the Gap • 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 and Implementation Plan 2021-2031 • The Government Sector Employment Rule 26, Employment of eligible persons
Related Policies/ Programs	PD2016_053 / IB2020_029 / PD2022_028 Stepping Up online recruitment resource Documentation of indicator: Public Service Commission Workforce Profile via Corporate Analytics – Workforce.

Useable data available from	Public Service Commission Workforce Profile via Corporate Analytics – Workforce.
Frequency of Reporting	Annually
Time lag to available data	3 months from end of quarter
Business owners	Workforce Planning and Talent Development Branch
Contact - Policy	Executive Director, Workforce Planning and Talent Development Branch
Contact - Data	Director, Workforce Planning and Performance Unit, Workforce Planning and Talent Development Branch
Representation	
Data type	Numeric
Form	Number, as a percentage
Representational layout	NNN.NN
Minimum size	3
Maximum size	6
Related National Indicator	N/A

INDICATOR: KS4401	**Compensable Workplace Injury** - Claims (% of change over rolling 12-month period) Reduction in the number of compensable injury claims.
Shortened Title	Compensable Workplace Injury Claims
Service Agreement Type	Key Performance Indicator
NSW Health Strategic Outcome	4: Our staff are engaged and well supported
Status	Final
Version number	4.0
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	Insurance for NSW portal – TMF Dashboard
Data Collection Source/System	Insurance for NSW portal – TMF Dashboard
Primary data source for analysis	Insurance for NSW portal – TMF Dashboard
Indicator definition	Number of NSW Health employees who have lodged a claim as a result of a workplace injury over the past 12 months compared to the previous 12 months, expressed as a percentage.
Numerator	
Numerator definition	The number of Reportable claims reported in the current 12 months
Numerator source	Insurance for NSW portal – TMF Dashboard
Numerator availability	Available
Denominator	
Denominator definition	The number of Reportable claims reported in the previous 12 months
Denominator source	Insurance for NSW portal – TMF Dashboard
Denominator availability	Available
Inclusions	Reportable Claims only and Data Claim Reported Definitions: Reportable Claims

Reportable Claims are incidents where payments were made or estimates established.

Claims with Latest Liability Status code of

- 01 – Notification of Work-Related Injury OR;
- 02 – Liability Accepted 03 – Liability Disputed OR;
- 04 – Further Liability Denied OR;
- 05 – Liability Not Yet Determined OR;
- 07 – Liability Denied OR;
- 08 – Provisional Liability Accepted – Weekly and Medial Payments OR;
- 09 – Reasonable Excuse OR;
- 10 – Provisional Liability Discontinued OR;
- 11 – Provisional Liability Accepted – Medical Only. Weekly Payments Not Applicable AND Net Incurred Amount is not equal to zero (0)

OR

Total Number of Payments is not equal to zero (0)
AND Net Incurred $ is not equal to zero (0)

Date Claim Reported

The date the accident was reported to the Agency.

Sequence of dates (example):

*Date Injury Occurred 3/01/2015
*Date Claim Reported 20/09/2016
*Date Claim Notified 21/09/2016
*Date Claim Entered 22/09/2016

Exclusions

Excludes null and Non-Reportable claims

Definition:
Non-Reportable Claims

Non-Reportable Claims are incidents with no payments and nil estimates that are not or not yet classified as a 'claim' as it does not meet the Reportable Claim business definition.
Latest Liability Status Code is equal to '06 – Administrative Error' or '12 – No Action after Notification.'
AND Net Incurred Amount is equal to zero (0)

OR

Total Number of Payments is equal to zero (0)

	AND Net Incurred $ is equal to zero (0)
Targets	Target: 5% decrease • Performing: ≥5% decrease or maintain at 0 claims • Under performing: ≥0% and <5% decrease • Not performing: increase
Context	To monitor whether overall levels of active claims are changing over time.
Related Policies/ Programs	NSW Health PD Rehabilitation, Recovery and Return to Work
Useable data available from	Baseline data for the 2016/17 financial year by month, quarter and annual.
Frequency of Reporting	Monthly
Time lag to available data	The TMF Dashboard is refreshed monthly following the monthly data update of the Insurance for NSW data warehouse (usually 1 week after the conclusion of the month).
Business owners	
Contact - Policy	Safety and Security Improvement, Workplace Relations Branch
Contact - Data	Safety and Security Improvement, Workplace Relations Branch
Representation	
Data type	Numeric
Form	Number, presented as a percentage (%)
Representational layout	NNN.N
Minimum size	3
Maximum size	5
Date Effective	1 July 2016
Related National Indicator	

HEALTH STRATEGIC OUTCOME 5: Research and innovation, and digital advances inform service delivery

INDICATOR: KPI21-04	**Research Governance Application Authorisations** – Site specific within 60 calendar days - Involving greater than low risk to participants (%)
Shortened Title	Research Governance Application Authorisations in 60 Days
Service Agreement Type	Key Performance Indicator
NSW Health Strategic Outcome	5: Research and innovation, and digital advances inform service delivery
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	REGIS
Primary data source for analysis	REGIS
Indicator definition	The proportion of Greater than Low Risk site specific assessment (SSA) applications authorised by the RGO within 60 calendar days, authorised within the reporting period.
Numerator	
Numerator definition	Total number of Greater than Low Risk SSA applications authorised by the RGO within 60 calendar days, authorised (final SSA decision letter provided) within the reporting period.
Numerator source	REGIS
Numerator availability	
Denominator	
Denominator definition	Total number of Greater than Low Risk SSA applications authorised (final SSA decision letter provided) by the RGO within the reporting period.
Denominator source	REGIS
Denominator availability	

Inclusions	• Application Type = Site Specific Assessment • LNR = No • Current Decision = Authorised; Authorised with Conditions
Exclusions	• Application Type = Ethics • LNR = Yes • Current Decision = In Progress, Completed pending HOD, HOD not supported, Submitted, Ineligible, Valid, Eligible, Information Requested, Pending CE, Authorised pending further information, Information Provided, Authorised with conditions (pending decision email), Authorised (pending decision email), Not Authorised (pending decision email), Withdrawn, Abandoned, Not Authorised.
Targets	Target: 75% • Performing: ≥ 75% • Under Performing: ≥ 55% and < 75% • Not Performing: < 55%
Context	The Key Performance Indicator will not account for clock stops. The SSA application received date is the date the RGO or designee either: 1. receives an SSA application from a researcher regardless of whether or not it is complete and/or deemed valid. 2. Receives ethics approval for a submitted SSA application 3. Uploads ethics approval documentation into REGIS from an interjurisdictional HREC The clock is stopped when the final SSA decision letter is provided to the site principal investigator.
Related Policies/ Programs	https://www.medicalresearch.nsw.gov.au/ethics-governance-metrics-2/
Useable data available from	
Frequency of Reporting	Quarterly
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 Indicator

INDICATOR: KPI2410	**Concordance of Trials in:** Clinical Trial Management System (CTMS) Vs Research Ethics and Governance Information System (REGIS) (%)
Shortened Title	Concordance between CTMS and REGIS
Service Agreement Type	Key Performance Measure
Framework Strategy	Strategic Outcome 5: Research and innovation, and digital advances inform service delivery.
Framework Objective	Key objective • 5.1: Advance and translate research and innovation with institutions, industry partners and patients • 5.2 Ensure health data and information is high quality, integrated, accessible and utilised
Status	Final
Version number	1.0
Scope	New clinical trials involving public hospital patients conducted at NSW public hospitals and health services. Clinical trials as per World Health Organisation (WHO) definition.
Goal	Increased availability of more detailed clinical trial data essential for hospital accreditation under the national clinical trials governance framework
Desired outcome	The concordance indicator assesses percentage of clinical trials entered in the CTMS against newly authorised clinical trials for the specified reporting period. Any trials which are entered in the CTMS must complete a minimum data set, which is used to support hospitals for accreditation under the national clinical trials governance framework. Higher concordance represents greater data available to districts and Ministry which supports hospital accreditation requirements, reduces revenue leakage, improves workforce stability, and increases clinical trial quality and quantity.

Primary point of collection	The NSW Health Statewide Clinical Trial Management System (CTMS) and Research Ethics and Governance Information System (REGIS). Office for Health and Medical Research (OHMR) manages both platforms.
Data Collection Source/System	CTMS and REGIS.
Primary data source for analysis	Data fields common to both CTMS and REGIS, with linkage point as STE ID.
Indicator definition	Percentage concordance of trials between REGIS and CTMS as measured by comparison of clinical trials receiving Site Specific Assessment (SSA) authorisation against trials entered into the CTMS. For each trial record in REGIS there will be a binary judgement (i.e. yes/no) of whether the matching study has been entered in CTMS. The percent concordance will be an average of the total concordance of all the individual clinical trial SSA authorisations for that district and reporting period. For example, if 10 clinical trials have been authorised in a district, and 8 have matched entries in CTMS then the percentage concordance will be 80% for that reporting period.
Numerator	
Numerator definition	Number of clinical trials entered into the CTMS by an LHD with an STE ID that matches a new SSA in REGIS for that LHD during the reporting period.
Numerator source	CTMS
Numerator availability	The CTMS has been mandatory since September 2023. All newly authorised clinical trials are expected to be entered into the system. The CTMS has full report capability at Ministry, Local Health District, and trial site level.
Denominator	
Denominator definition	Number of SSA authorised clinical trials in REGIS for that LHD during the reporting period.
Denominator source	REGIS.
Denominator availability	REGIS has dashboards and reporting functionality accessible at Ministry, Local Health District, and trial site level.

Inclusions	• Studies which meet the WHO definition of a clinical trial (i.e. prospective, interventional health research) • Clinical trials receiving SSA authorisation within the reporting period. • Clinical trials conducted at a NSW public hospital or health service AND involving individual public hospital patients.
Exclusions	• Trials which received SSA authorisation outside of the reporting period • Trials conducted outside of a NSW public hospital or health service • Trials that enrol non-patient participants e.g. school children, health workers, community members • Cluster randomised trials, where the trial intervention is targeting a hospital, ward, health worker, or other, and individual patients are not the participant.

Targets

Target	60% concordance for first year • Performing: ≥60% • Under performing: ≥ 50% and < 60% • Not performing: <50%
Context	High concordance indicates more accurate clinical trial reporting in both CTMS and REGIS. The CTMS is a new system and districts will require time to adjust to changed workflows and requirements, while 100% concordance would achieve the greatest amount of data availability and system value, this would likely not be achievable for multiple reasons including challenges in definitions for some clinical trials, dates of SSA authorisation, and staff resource availability to enter the information in CTMS. A target of 60% for this reporting period is reasonable and accommodates resource limited trial units and investigators and takes into consideration that system wide, high levels of concordance will require step changes over time. A low concordance could indicate either the clinical trial has not been registered in CTMS yet or the information entered into the specified common data fields are not accurate or consistent between the platforms.
Related Policies/ Programs	The decision for mandatory use of the Statewide CTMS for all Districts was made by the Secretary of NSW Health.

	District Chief Executives were informed of and agreed to mandatory use of the CTMS commencing from 1st September 2023.
Useable data available from	The CTMS was first implemented in November 2022 and has been mandatory at almost all districts from September 2023.
Frequency of Reporting	Annually. Data will be captured quarterly on a cumulative basis and reported annually.
Time lag to available data	Data pushes to the reporting tool overnight, so is available within 24hrs of entry. Data will need to be cleaned and checked prior to reporting. Estimated lag of 4-6weeks.
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	
Date effective	1 July 2024

Related National Indicator

HEALTH STRATEGIC OUTCOME 6: The health system is managed sustainably

INDICATOR: KPI2408 **Previous IDs:**	**Purchased Activity Volumes – Variance: Total NWAU (%)**
Shortened Title	Purchased Activity Variance: Total
Service Agreement Type	Key Performance Indicator
Framework Strategy	6 The health system is managed sustainably
Status	Final
Version number	1.0
Scope	All facilities in scope of ABF
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	Enterprise Data Warehouse (EDWARD) - Local Reporting Solution (LRS)
Indicator definition	Variation of year-to-date total weighted activity (NWAU) from the year-to-date total activity target.
Numerator	
Numerator definition	The total sum of weighted activity for all activity streams: • Acute Admitted • Emergency Department • Mental Health-Acute • Sub-Acute Admitted • Non-Admitted • Non-Admitted - Dental • Non-Admitted - Mental Health NOTE: Uncoded episodes are estimated at average NWAU from previous year's activity, with a 10% NWAU loading for current month uncoded episodes.
Numerator source	EDWARD

Numerator availability	Available 2 months after the end of the period of measurement

Denominator

Denominator definition	Total Activity Based Funding target for the year to date in NWAU separations
Denominator source	LHD Activity Targets
Denominator availability	Available when targets finalised

Inclusions

- Episode end date within the period
- Facilities in scope of ABF in 2024-25
- For Non-Admitted, only the following Funding Source National Standard Codes (FUNDING_SOURCE_NHDD_CODEs: '01''02' '03' '04' '06' '08' '10' '11' '12' '99')

Exclusions

- 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 Tier 2 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

Target

Target: ≥ 0% and ≤ +2.5% of the negotiated activity target.

- Performing ≥ 0% and ≤ +2.5%
- Not performing: < -1.5% or > +2.5%
- Under performing: Between ≥ -1.5% and <0

LHD/SHN	Individual Targets
Central Coast	159,603
Far West	15,515
Hunter New England	410,295
Illawarra Shoalhaven	188,386
Mid North Coast	128,941
Murrumbidgee	110,607
Nepean Blue Mountains	170,000
Northern NSW	158,532
Northern Sydney	268,137
South Eastern Sydney	315,715
South Western Sydney	396,036
Southern NSW	74,335
St Vincent's Health Network	80,408
Sydney Childrens Network	125,676
Sydney	307,646
Western NSW	152,720
Western Sydney	317,906

Context	Nil
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	System Purchasing Branch
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
Data domain	
Date effective	July 2024
Related National Indicator	National Efficient Price Determination 2024-25 https://www.ihacpa.gov.au/resources/national-efficient-price-determination-2024-25

INDICATOR: KPI2409	**Purchased Activity Volumes – Variance: Activity Reportable Under NHRA Clause A95(B) Notice: NWAU (%)**
Shortened Title	Purchased Activity Variance: NHRA Activity
Service Agreement Type	Key Performance Indicator
Framework Strategy	6 The health system is managed sustainably
Framework Objective	Nil specific
Status	Final
Version number	1.0
Scope	All facilities in scope of ABF
Goal	Greater certainty concerning the amount of activity to be performed in a year that is provided by the Ministry of Health as a system manager to the National Health Funding Body (NHFB) to enable the calculation and payment of the Commonwealth contribution under the National Health Reform Agreement.
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	Enterprise Data Warehouse (EDWARD) - Local Reporting Solution (LRS)
Indicator definition	Variation of year-to-date total weighted activity (NWAU) from the year to date total activity target.
Numerator	
Numerator definition	The total sum of weighted activity for all activity streams: • Acute Admitted • Emergency Department • Mental Health-Acute • Sub-Acute Admitted

- Non-Admitted
- Non-Admitted - Dental
- Non-Admitted - Mental Health

NOTE: Uncoded episodes are estimated at average NWAU from previous year's activity, with a 10% NWAU loading for current month uncoded episodes.

Numerator source	EDW
Numerator availability	Available 2 months after the end of the period of measurement

Denominator

Denominator definition	Total Activity Based Funding target for the year to date in NWAU separations
Denominator source	LHD Activity Targets
Denominator availability	Available when targets finalised

Inclusions

- Episode end date within the period
- Facilities in scope of ABF in 2024-25
- For Non-Admitted, only the following Non-Admitted Patient Funding Source National Standard Codes (FUNDING_SOURCE_NHDD_CODEs: '01''02' '03' '04' '06' '08' '10' '11' '12' '99')

Exclusions

- 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 Tier 2 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)
- In addition to the above the following Non-Admitted Tier 2 clinic activity is out of scope for Commonwealth funding: (10.21, 20.06, 40.08, 40.27, 40.33)

Targets

Target: Individual targets

- Performing ≥ 0% and ≤ +2.5% of the negotiated activity target.
- Not performing: < -1.5% or > +2.5% of the negotiated activity target.
- Under performing: Between ≥ -1.5% and <0 of the negotiated activity target.

Context	Nil
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	System Purchasing Branch
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
Data domain	
Date effective	July 2024
Related National Indicator	National Efficient Price Determination 2024-25 https://www.ihacpa.gov.au/resources/national-efficient-price-determination-2024-25

INDICATOR: PD-001	**Purchased Activity Volumes – Variance**: Public Dental Clinical Service - DWAU (%)
Shortened Title	Purchased Activity Variance: Dental
Service Agreement Type	Key Performance Indicator
NSW Health Strategic Outcome	6: The health system is managed sustainably
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	Titanium
Primary data source for analysis	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. Note: Actual activity includes an estimate for unclaimed vouchers.
Numerator source	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.

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.
Targets	Target: Individual targets of the negotiated activity target. • Performing ≥ 0% and ≤ +2.5% • Under performing: ≥ -1.5% and <0 • Not performing: < -1.5% or > +2.5%
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	5
Data domain	
Date effective	July 2014
Related National Indicator	Indicator sets and related indicators Part 4 – Performance, Monitoring and Reporting.

INDICATOR: KFA101	**Expenditure Matched to Budget**: Year to date variance – General Fund (%)
Shortened Title	Expenditure Matched to Budget YTD
Service Agreement Type	Key Performance Indicator
NSW Health Strategic Outcome	6: The health system is managed sustainably
Status	Final
Version number	1.3
Scope	Financial Management
Goal	Health Entities to operate within approved allocation
Desired outcome	Health Entities achieve an on budget or favorable result
Primary point of collection	Health Entities
Data Collection Source/System	Oracle Accounting System
Primary data source for analysis	Health Entity monthly financial narrative/SMRS
Indicator definition	General Fund expenditure matched to budget is the YTD expenditure compared to YTD budget.
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 Restricted Financial Assets
Targets	Target: On budget or favourable • Performing: On budget or favourable. • Not performing: >0.5 unfavourable • Under performing: > 0 and ≤ 0.5 unfavourable
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	
Contact - Policy	Chief Financial Officer
Contact - Data	Director, Financial Performance & Reporting
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	

INDICATOR: KFA103	**Own Source Revenue Matched to Budget**: Year to date variance – General Fund (%)
Shortened Title	Revenue Matched to Budget YTD
Service Agreement Type	Key Performance Indicator
NSW Health Strategic Outcome	6: The health system is managed sustainably
Status	Final
Version number	1.2
Scope	Financial Management
Goal	Health Entities achieve approved own source revenue budget
Desired outcome	Health Entities achieve an on budget or favourable result
Primary point of collection	Health Entities
Data Collection Source/System	Oracle
Primary data source for analysis	Health Entity Monthly Financial Narrative/SMRS
Indicator definition	General Fund own source revenue matched to budget is the comparison of YTD actual own source revenue compared to YTD budget.
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 Restricted Financial Assets. The Own Source revenue excludes Government grant contributions (subsidy)
Targets	Target: On budget or favourable • Performing: On budget or favourable • Not performing: >0.5 unfavourable • Under performing: > 0 and ≤ 0.5 unfavourable
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	Finance
Contact - Policy	Chief Financial Officer
Contact - Data	Director, Financial Performance & Reporting
Representation	
Data type	Numeric
Form	Number, presented as a percentage (%)
Representational layout	NNN.NN
Minimum size	1
Maximum size	6
Related National Indicator	

INDICATOR: KPI22-04	**Net Cost of Service Matched to Budget**: Year to date variance – General Fund (%)
Shortened Title	NCOS Matched to Budget
Service Agreement Type	Key Performance Indicator
NSW Health Strategic Outcome	6: The health system is managed sustainably
Status	Final
Version number	1.0
Scope	Financial Management
Goal	Health Entities to operate within approved allocation
Desired outcome	Health Entities achieve an on budget or favorable result
Primary point of collection	Health Entities
Data Collection Source/System	Oracle Accounting System
Primary data source for analysis	Oracle Accounting System SMRS - NSW Health monthly financial narrative report
Indicator definition	The General Fund net cost of service result is the variance between the actual net cost of services and the approved net cost of services budget expressed as a percentage (%) for both the year to date result and full year forecast. **Formula:** $\frac{\text{NCoS General Fund Budget - NCoS General Fund Actual}}{\text{NCoS General Fund Budget}}$
Numerator	
Numerator definition	Year to date and Full Year Actual General Fund NCOS
Numerator source	SMRS
Numerator availability	Available
Denominator	
Denominator definition	Year to date and Full Year Budget General Fund NCOS
Denominator source	SMRS
Denominator availability	Available
Inclusions	NCOS is defined as Net variance of GF Expense and GF Own Source Revenue (OSR)
Exclusions	Other items
Targets	Target: On budget or favourable

	• Performing: On budget or favourable. • Not performing: >0.5 unfavourable • Under performing: > 0 and ≤ 0.5 unfavourable
Context	Health Entities are expected to operate within approved NCOS budget
Related Policies/ Programs	Annual - Financial year (available from Finance on a monthly basis)
Useable data available from	Current Financial Year
Time lag to available data	Monthly
Business owners	Finance
Contact - Policy	Chief Financial Officer
Contact - Data	Director, Funds Management and Reporting Systems
Representation	
Data type	Numeric
Form	Number, presented as a percentage (%)
Representational layout	NNN.NN
Minimum size	1
Maximum size	6
Date effective	01/07/2022
Related National Indicator	

INDICATOR: KPI22-02	**Annual Procurement Savings**: Percentage Achieved Against Target (%)
Shortened Title	Annual Procurement Savings
Service Agreement Type	Key Performance Indicator
NSW Health Strategic Outcome	6: The health system is managed sustainably
Status	Final
Version number	1.0
Scope	Financial Management
Goal	Health Entities to identify and implement savings opportunities.
Desired outcome	Health Entities to achieve annual procurement savings target
Primary point of collection	Health Entities
Data Collection Source/System	Health Entity monthly financial narrative
Primary data source for analysis	Health Entity monthly financial narrative
Indicator definition	The percentage variance of actual procurement savings against target, year to date.
Numerator	
Numerator definition	Actual YTD dollar ($) procurement savings achieved.
Numerator source	Oracle Accounting System
Numerator availability	Oracle Accounting System
Denominator	
Denominator definition	Target dollar ($) procurement savings target
Denominator source	To be advised by CFO
Denominator availability	Available from Q1 FY22/23
Inclusions	
Exclusions	
Targets	Entity Directors of Finance will be advised of the targets following release of the State Budget. • Performing: >= 95% of Annual Procurement Savings Target. • Under Performing: >= 90% and < 95% of Annual Procurement Savings Target • Not Performing – Achieving < 90% of Annual Procurement Savings Target

Context	Health Entities are expected to identify, implement and deliver savings opportunities.
Related Policies/ Programs	Savings Leadership Program
Useable data available from	TBD Q1 FY22/23
Frequency of Reporting	Monthly
Time lag to available data	Available at month end
Business owners	Finance
Contact - Policy	Chief Financial Officer
Contact - Data	Chief Procurement Officer
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	

INDICATOR: KPI23-011	**Reducing Free Text Orders Catalogue Compliance -Reduce free text orders in the catalogue**
Shortened Title	Reduce Free Text Orders
Service Agreement Type	Key Performance Indicator
NSW Health Strategic Outcome	6: The health system is managed sustainably
Status	Final
Version number	1.0
Scope	Financial Management.
Goal	Health Entities to identify, monitor and reduce free text catalogue orders.
Desired outcome	Health Entities to reduce free text catalogue orders
Primary point of collection	Health Entities
Data Collection Source/System	Health Entity monthly financial narrative
Primary data source for analysis	Health Entity monthly financial narrative
Indicator definition	Reduction of free text orders.
Numerator	
Numerator definition	Dollar of free text spend.
Numerator source	Oracle Contract Spend Analysis Dashboard
Numerator availability	Oracle Contract Spend Analysis Dashboard
Denominator	
Denominator definition	Dollar of total spend.
Denominator source	Oracle Contract Spend Analysis Dashboard
Denominator availability	Oracle Contract Spend Analysis Dashboard from Q1 FY23/24
Inclusions	
Exclusions	
Targets	Target: <=25% free text orders in catalogue • Performing <=25% • Under Performing ≤ 60% and > 25% • Not Performing >60%
Context	Health Entities are expected to identify, monitor and reduce free text orders in catalogue.
Related Policies/ Programs	Procurement Reform

Useable data available from	Q1 FY23/24
Frequency of Reporting	Monthly
Time lag to available data	Available at Month End
Business owners	Finance
Contact - Policy	Chief Financial Officer
Contact - Data	Chief Procurement Officer
Representation	
Data type	Numeric
Form	Number, presented as a percentage (%)
Representational layout	NN.NN
Minimum size	4
Maximum size	6
Data domain	
Date effective	July 2023
Related National Indicator	

INDICATOR: KPI23-005	**Sustainability Towards 2030: Nitrous Oxide Reduction: Emissions Per Admitted Patient Service Event**
Shortened Title	Sustainability Towards 2030: N_2O
Service Agreement Type	Key Performance Indicator
NSW Health Strategic Outcome	6: The health system is managed sustainably.
Status	Final
Version number	1.0
Scope	Ordering details by LHD and admitted patients in public hospitals, except where indicated in Exclusions.
Goal	NSW hospitals reduce direct greenhouse gas emissions by reducing nitrous oxide wastage.
Desired outcome	To reduce direct emissions attributed to nitrous oxide use in ED, ICU, Oral Health, Pediatrics, Theatres and Birthing units (CO_2e reduced 5%).
Primary point of collection	The required data will be generated by the Senior Data Analyst, Climate Risk & Net Zero Unit, calculated from: • Nitrous oxide gas refill datasets from HealthShare NSW's Strategic Procurement Services' procurement records; and • Admitted patient records from EDWARD Data reports will be provided quarterly to System Information & Analytics for inclusion in the Health System Performance Reports.
Data Collection Source/System	Nitrous oxide gas refill datasets; Admitted Patient data collection
Primary data source for analysis	Enterprise Data Warehouse (EDWARD) - Local Reporting Solution (LRS) Pharmalytix / iPharmacyPROD database
Indicator definition	Decreased nitrous oxide greenhouse gas emissions (kg CO_2e) per admitted patient service event.
Numerator	
Numerator definition	YTD kg CO_2e emissions attributed to N_2O and Entonox® (Equanox® / Nitronox®) gas cylinder procurement
Numerator source	HealthShare datasets on cylinders by site (suppliers: Coregas, Air Liquide and BOC)
Numerator availability	Reliance on third parties for adequate record keeping and timely data provision
Denominator	
Denominator definition	YTD Number of admitted patient service events (SE_TYPE_CD = '2')
Denominator source	EDWARD
Denominator availability	N/A

Inclusions	All LHDs, SCHN and SVHN
Exclusions	Patient Transport/Ambulance excluded. Hospital in the Home service events excluded.
Targets	Target: 5% reduction in the rate of emissions per admitted patient service event (YTD) compared to the baseline rate as at 30 June the previous year • Performing: >=5% • Under Performing: >=1% and <5% • Not Performing: <1%
Context	Nitrous oxide has an environmental impact 273 times that of carbon dioxide. Reducing the volume of nitrous oxide procured across LHDs can be achieved in the first instance by investigating and addressing leaking infrastructure at facilities. Evidence from around the world has consistently shown a substantial proportion of nitrous oxide is wasted due to leaks in the manifolds, pipes, wall outlets and pendants. Five percent is a modest target compared to what has been achieved elsewhere by addressing leaks, decommissioning sections of piping, and/or converting to mobile nitrous cylinders (where appropriate rather than older manifolds and piping).
Related Policies/ Programs	This indicator aligns with the NSW Government's Net Zero Plan Stage 1:2020-2030 and goal to reach net zero emissions by 2050. Related plan can be sourced from: Net Zero Plan | NSW Climate and Energy Action
Useable data available from	1 July 2023
Frequency of Reporting	Quarterly
Time lag to available data	6 weeks
Business owners	
Contact - Policy	Executive Director, System Purchasing Branch
Contact - Data	Executive Director, System Purchasing Branch
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 2023
Related National Indicator	N/A

INDICATOR: KPI23-008	**Passenger Vehicle Fleet Optimisation (% Cost Reduction)**
Shortened Title	Passenger Vehicle Fleet Optimisation
Service Agreement Type	Key Performance Indicator
NSW Health Strategic Outcome	6: The health system is managed sustainably.
Status	Final
Version number	1.0
Scope	Local Health Districts, Specialty Networks, Health Organisations excluding Health Protection NSW and NSW Ambulance, NSW Pathology NSW Ministry of Health and Education and Training Institute (HETI).
Goal	Reduce the financial burden/impact of the passenger fleet on the Health network.
Desired outcome	Cost savings and reduced fleet operational burden through global fleet size reduction.
Primary point of collection	Asset Managers, Fleet Managers, Sustainability Managers.
Data Collection Source/System	AFM Online as the primary asset data central register for NSWH, fleet management systems, financial reports, internal data management systems.
Primary data source for analysis	Fleet management software programs, vehicle use logs, telematics systems.
Indicator definition	The percentage change (decrease) in the total net passenger fleet operational costs from the previous reporting period (FY).
Numerator	
Numerator definition	The net total passenger fleet operational costs incurred through the reporting year.
Numerator source	Fleet management systems, annual reports, AFM Online.
Numerator availability	Available.
Denominator	
Denominator definition	NA.
Denominator source	NA.
Denominator availability	NA
Inclusions	• Annual leasing or equivalent purchase costs where for purchased vehicles the cost of purchase will be dispersed over the lifespan of the vehicle (e.g. cost of purchase ÷ 4 year lifespan) • Annual fuel costs • Annual servicing costs • Annual registration costs • Annual insurance costs

Exclusions	Non-passenger fleet vehicles not limited to trucks, vans, heavy vehicle buses, tractors and other non-car vehicles such as golf buggies or tugs.
Targets	Target: 3.0% decrease. • Performing: ≥3.0 % • Under Performing: ≥1 and <3% • Not Performing: <1 % Implement fleet optimization strategies to reduce the sum total passenger fleet operational costs by 3% compared to the baseline of total fleet operational costs of the previous financial year.
Context	The NSW Government's NSW Electric Vehicle Strategy has a target of electrifying NSW Government passenger vehicle fleet procurement by 2030, with an interim target of 50% EV procurement by 2026. Achievement of this target will have financial, environmental and public health benefits. The NSW Government Fleet Transition plan for Health aligns with the Government's NSW Electric Vehicle Strategy.
Related Policies/ Programs	NSW Government Electric Vehicle Strategy; The NSW Government Fleet Transition Plan for Health; NSW Health Fleet Electrification Roadmap; NSW Government Net Zero Plan Stage 1 2020 to 2030 and the Net Zero Plan Implementation Update; NSW Government Resource Efficiency Policy.
Useable data available from	FY 2022/23.
Frequency of Reporting	Quarterly
Time lag to available data	Nil
Business owners	Asset Information and Sustainability Team, Financial Services and Asset Management, NSW Ministry of Health
Contact - Policy	Asset Management Financial Services and Asset Management, NSW Ministry of Health moh-assetmanagement@health.nsw.gov.au
Contact - Data	Asset Management Financial Services and Asset Management, NSW Ministry of Health moh-assetmanagement@health.nsw.gov.au
Representation	
Data type	Numeric
Form	Number. Presented as a percentage (%)
Representational layout	NNN.NN
Minimum size	4
Maximum size	6

Data domain	
Date effective	NA

Related National Indicator

INDICATOR: KPI23-006	**Waste Streams - Resource Recovery and Diversion from Landfill (%)**
Shortened Title	Diversion of Waste from Landfill
Service Agreement Type	Key Performance Indicator
NSW Health Strategic Outcome	6: The health system is managed sustainably.
Status	Final
Version number	1.0
Scope	Local Health Districts and Health entities.
Goal	Meet or exceed the National Waste Policy Action Plan target of 80% average resource recovery rate from all waste streams (excluding hazardous waste) by 2030. Reduce the amount of waste disposed to landfill by increasing the amount of waste diverted to non-landfill disposal by a minimum of 5% per annum compared to the previous reporting period.
Desired outcome	Cost savings and increased percentages in diversion from landfill by 2030 in line with National Waste Policy Action Plan's 80% target.
Primary point of collection	NSW Treasury Power BI reports under Whole of Government 9698 contract, monthly data reports from suppliers.
Data Collection Source/System	NSW Treasury Power BI System, Suppliers monthly Microsoft Excel reports, Annual Business Review reporting.
Primary data source for analysis	Waste Management volumes and percentages from supplier reports as set out in the Whole of Government C9698 Waste Management Contract.
Indicator definition	The change (% increase) in the amount of waste diverted from landfill under the C9698 Whole of Government Contract in the reporting year, when compared to the previous reporting year. **Calculation Methodology:** For the reporting year (FY) and the previous reporting year (FY) calculate: The amount of waste diverted from disposal to landfill including waste diverted: a) by waste contractors using downstream methods as reported in the Annual Business Review; AND, b) through the implementation of services, strategies and projects at Health facilities. represented as a percentage of the total waste generated under the C9698 Whole of Government Contract. NB: Total waste excludes hazardous/clinical waste as unrecyclable and potentially harmful to human health. **Determine the level of change (%) between the current reporting year and the previous reporting year.** Notes: Includes landfill diversion by downstream methods as reported in the Annual Business Review and the total volume of recycled waste (source

	separated) as a percentage of the total waste generated. NB: Total waste excludes hazardous/clinical waste as unrecyclable and potentially harmful to human health. Calculating baseline requires landfill diversion percentages of waste at landfill and resource recovery facilities. This is provided in a report at each annual business review based on the Whole of Government Contract. The percentage includes a combination of Government Agencies based on the recovery facility. The HealthShare Corporate Services - Strategic Procurement Team is available to assist in determining performance against this KPI.
Numerator	
Numerator definition	The total amount of waste diverted from disposal to landfill under the C9698 Whole of Government Contract.
Numerator source	Information about the resource recovery rates can be determined by direct measurement, or by reference to contractually agreed percentage levels of diversion from landfill, or recycled volumes that are guaranteed by the supplier(s).
Numerator availability	Direct measurement must be based on a minimum of 6 months of data. Supplier determined figures must be agreed and not based on estimates unless those estimates have been reviewed and confirmed by an independent third party such as NSW Treasury WofG Contract Management Team. The HSNSW Corporate Procurement team is available to assist in verifying.
Denominator	
Denominator definition	The total waste generated under the C9698 Whole of Government Contract. NB: Total waste excludes hazardous/clinical waste as unrecyclable and potentially harmful to human health.
Denominator source	C9698 Waste Management Reporting, NSW Treasury Power BI Waste Reporting, Supplier Annual Business Reviews.
Denominator availability	Available
Inclusions	General Waste, Recyclable Waste.
Exclusions	Hazardous waste or other waste types that may be harmful to human health.
Targets	Target: 5% increase on previous year. • Performing: ≥5 % • Under Performing: ≥3 and <5 % • Not Performing: <3 %
Context	National Waste Action Plan requires Government Agencies to achieve 80% diversion by 2030. The achievement of this KPI will contribute to NSW Health's efforts to achieve the 2030 goal.

Related Policies/ Programs	National Waste Management Action Plan; NSW Government Resource Efficiency Policy. The National Waste Policy Action Plan Target 3: 80% average resource recovery rate from all waste streams. Excludes Hazardous waste (Unrecyclable and potentially harmful to human health).
Useable data available from	FY 2022/23
Frequency of Reporting	Quarterly
Time lag to available data	Nil
Business owners	Asset Information and Sustainability Team, Financial Services and Asset Management, NSW Ministry of Health
Contact - Policy	Russell Burns, Program Manager Asset Information and Sustainability Team, Financial Services and Asset Management, moh-assetmanagement@health.nsw.gov.au. Stephen Ransom, Senior Project Officer Asset Information and Sustainability Team, Financial Services and Asset Management, moh-assetmanagement@health.nsw.gov.au
Contact - Data	Ciaran Doyle Senior Contract Manager, Strategic Procurement Services, Corporate, HealthShare NSW, [redacted] Simon Button, Senior Category Officer, Strategic Procurement Services, Corporate, HealthShare NSW. [redacted]
Representation	
Data type	Numeric
Form	Number. Presented as a percentage (%)
Representational layout	NNN.N%
Minimum size	3
Maximum size	5
Data domain	
Date effective	NA
Related National Indicator	NA