

2026–27

KPI AND
MONITORING
MEASURES
DATA SUPPLEMENT
PART 1 OF 2

KEY PERFORMANCE INDICATORS

Final – 1.0

June 2026

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			
Mar-2026 Apr-2026	KS2301	Overall Patient Experience Index – adult admitted patients (Number)	Update to: - Policy contact Chief Experience Officer, Strategic Planning Economics and Experience (SPEE), Ministry of Health - Not performing amended <8.7 Version Number updated to 2.1
Mar-2026	KS2302	Patient Engagement Index – adult admitted patients (Number)	Update to Policy contact: Chief Experience Officer, Strategic Planning Economics and Experience (SPEE), Ministry of Health Version Number updated to 1.4
Mar-2026	KS2303	Overall Patient Experience Index – ED patients (Number)	Update to Policy contact: Chief Experience Officer, Strategic Planning Economics and Experience (SPEE), Ministry of Health Version Number updated to 1.4
Mar-2026	KS2304	Patient Engagement Index – ED patients not admitted to hospital (Number)	Update to Policy contact: Chief Experience Officer, Strategic Planning Economics and Experience (SPEE), Ministry of Health Version Number updated to 1.4
Health Outcome 2:			
Safe care is delivered across all settings			
Mar-2026	SSQ106, SSQ107	Unplanned Hospital Readmissions: all unplanned admissions within 28 days of separation (%)	Numerator and Denominator Exclusion updated to added “Records where CL_ID is missing” “JHFMHN and NSWA” Version Number updated to 3.7
Mar-2026	KPI2503	Hospital in the Home: Direct Admissions (%)	Title and shortened title change from “Direct Referrals” to “Direct Admissions” Scope change to “all admitted patients” Inclusions added wording around “with a bed type 25” Exclusions added “76 Transit Lounge” Target updated to Performing ≥ 60% and Underperforming ≥ 50% and Not Performing < 50% Multiple comments and updates added for clarification. Version Number updated to 1.1

2026-27 KPI Service Agreements

Date	Indicator No.	Measure	Version Control Change
Mar-2026 Jun-2026	KPI2525	Hospital in the Home: Activity Growth (%)	Updated from Monitoring Measure to KPI for 26/27 Update to targets
Mar-2026	PI-03	Hospital in the Home: Admitted Activity (%)	Changed from KPI to Monitoring Measure
Mar-2026	IM21-006	Inpatient Discharge Performance: Inpatient Discharges from ED Accessible and Rehabilitation Beds by Midday (%)	Update to targets Target: ≥35% - Performing: ≥35% - Under Performing: ≥30% and <35% - Not Performing: <30% Version Number updated to 3.1
Mar-2026	SSQ127	Mental health: Involuntary Patients Absconded from an Inpatient Mental Health Unit – Incident Types 1 and 2 (rate per 1,000 bed days)	Reinstated as KPI
Mar-2026	SSQ124	Mental Health: Frequency of Seclusion (%)	Reinstated as KPI
Mar-2026	KS2142	Potentially Preventable Hospital Services (%)	Remove KPI
Apr-2026	KPI2411, KPI2412	Incomplete ED Aboriginal Patient Attendances	Update to Exclusion, remove “03” Dead on Arrival and i.e. DoA. Indicator definition note removed. Version number updated to 4.1
Apr-2026	SSA108, SSA109 & SSA110	Overdue Planned Surgeries	Update to Inclusions and Exclusions. Removed reference to IPC In-Scope file. Exclusion added IPC = 026 Reference to IPC In-Scope list is in context. Version number updated to 8.1
Jun-2026	KS2128 - KS2141	Hospital Acquired Complications	Update Time lag to available data changed to “1 - 2 months” Addition of clinical codes for KS2130 Update to wording around development of using risk adjusted models. Update to targets Version numbers 4.0
Apr-2026	KQS203 & KQS203a	Mental Health: Acute Readmission - within 28 days (%)	Update to business owners to include Executive Director, Centre for Aboriginal Health Version number updated to 4.2
Apr-2026	KQS204 & KQS204a	Mental Health Acute Post-Discharge Community Care - Follow up by Community Care within seven days of discharge (%)	Update to business owners to include Executive Director, Centre for Aboriginal Health Version number updated to 3.3
May-2026	KPI2407	ED Extended stays – 12 hours – Mental Health	Denominator definition expanded to reference HIRD. Version number updated to 1.3

2026-27 KPI Service Agreements

Date	Indicator No.	Measure	Version Control Change
Jun-2026	SSA105b SSA105c	Emergency Department Presentations Treated within Benchmark Times – Triage 2 and 3 (%)	Indicator definition updated to include SUB_EVNT_FIRST_PHYSIO_SEEN_D TTM under Commencement of clinical care Note revised. Version Number updated to 2.2
May-2026	KPI2506	Average Length of Stay of Overnight Acute Episodes of Care	Remove reference to 2025/26 targets
Jun-2026	MS2213	Virtual Care Access: Non-Admitted Services Provided through Virtual Care (%)	Changed from KPI to Monitoring Measure
Health Outcome 3: People are healthy and well			
Mar-2026	KMH202	Mental Health Peer Workforce Employment – Full time equivalents (FTEs) (Number)	Changed from KPI to Monitoring Measure
Mar-2026	KPI21-02	NSW Health First 2000 Days Implementation Strategy - Delivery of the 1-4 week health and development check (%)	Split KPI between All babies and All Aboriginal babies who receive a 1-4 week health check (%) Update Goal, Desired outcome, Indicator definition, Numerator definition and context to include “health and development” check. Update to: - Denominator definition - Business owners
Mar-2026	KPI2508	Health Outcomes Action Plan – developed on time	KPI Removed
Mar-2026	KPI2509	Health Outcomes Action Plan – Achievement of Actions (%)	Update to Scope to include JHFMHN Removal of reference to “Prevalence of e-cigarette (vaping) use in adults” combined with “smoking” dot point in Goal and context. Date in Denominator definition updated to 2026/27 Version Number updated to 1.1
Mar-2026	KPI2606	Prescription, Recreational And Illicit Substance Evaluation (Prise) - Final Results for all Biological Samples Reported within 35 Business Days of Sample Receipt (%)	New KPI
Health Outcome 4: Our Staff are engaged and well supported			
Mar-2026	SPC111	Workplace Culture: People Matter Survey Culture Index- (% variation from previous survey)	Changed from KPI to Monitoring Measure
Mar-2026	SPC115	Take Action: People Matter Survey take action as a result of the survey -Variation from previous survey (%)	Changed from KPI to Monitoring Measure
Mar-2026	SPC110	Staff Engagement	Changed from KPI to Monitoring Measure

2026-27 KPI Service Agreements

Date	Indicator No.	Measure	Version Control Change
Mar-2026	KPI21-01	Staff experience: Racism	Changed from KPI to Monitoring Measure
Mar-2026	KPC201	Staff Performance Reviews	Changed from KPI to Monitoring Measure
Mar-2026	SPC107	Recruitment Decision Timeliness Improvement	Changed from KPI to Monitoring Measure
Mar-2026	SPC108	Aboriginal Workforce Participation	Changed from KPI to Monitoring Measure
Mar-2026	KF-0061	Families completing the program when child reached 2 years of age (%)	KPI Removed
Mar-2026	KF-0062	Families enrolled and continuing in the program when child is one year of age (%)	KPI Removed
Mar-2026	KF-0063	Families enrolled in the program compared to funded places (%)	KPI Removed
Mar-2026 Jun-2026	KPI2601	Agreed Composite Diversity Targets (Aboriginal participation, Women in leadership, Disability, CALD) - Increase in Overall Score for Diversity Index (Number) - Diversity rate	New KPI Title updated
Mar-2026	KPI2602	People Matter Employee Survey (PMES): Increase in Overall Engagement Index Score (Number)	New KPI
Mar-2026	KPI2603	Sick Leave Per FTE Amount of Sick Leave (Hours) Taken Per Full Time Equivalent Per Quarter Relative to Same Quarter Last Year	New KPI
Mar-2026	KPI2604	Nursing Hours Per Patient Day (NHPPD): Hours under compliance target (% reduction)	New KPI
Health Outcome 5:			
Research and innovation, and digital advances inform service delivery			
Mar-2026	KPI2410	Concordance of Trials in: Clinical Trial Management System (CTMS) Vs Research Ethics and Governance Information System (REGIS) (%)	Targets updated: Not performing <75% Underperforming ≥ 75% and < 85% Performing ≥ 85% Exclusions updated to include JHFMHN & NSW Version Number updated to 1.1
Health Outcome 6:			
The health system is managed sustainably			
Mar-2026 Apr-2026 Jun-2026	KPI2507	Same Day Surgery	Update to AR-DRG inclusion List: Update to targets with addition of targets for ISLHD and SWSLHD. Update to inclusions for SCHN Update to Exclusions, removed "Emergency Admissions, Service Event and Admitted (Formal Admission Urgency Code = 1 Emergency)" Added SE_TYPE_CD = '2' and Formal Admission Urgency Code = 2 and 5 to Inclusions.

2026-27 KPI Service Agreements

Date	Indicator No.	Measure	Version Control Change
			Update to policy name "Planned Surgery Access Policy" Version Number updated to 2.1
Mar-2026 Jun-2026	KPI2408	Purchased Activity Volumes - Variance (%): Total activity (NWAU)	Scope updated to 'All facilities in scope of ABF and small hospitals' Numerator definition updated: Exclusions updated "All facilities that fall outside the scope of ABF, as described in Service Agreements Context updated: "Official ABF and block funded facility list managed by Service Utilisation and Activity Modelling Unit, Systems Information and Analytics" Inclusions – removed SE_TYP_CD = 2 Exclusions: - for ED updated and sequenced. - Addition of unqualified neonates - Addition of ED only service events Targets updated for performing, not performing and underperforming and individual LHD/Ns. Version Number updated to 2.2
Mar-2026 Jun-2026	KPI2409	Purchased Activity Volumes - Variance (%): Total activity (NWAU) reportable under NHRA clause A95(b)	Context updated. "All facilities that fall in the scope of the NHRA reporting, are described in National Efficient Price/Cost documentation. Official ABF and block funded facility list managed by Service Utilisation and Activity Modelling Unit, Systems Information and Analytics" Numerator definition added and separate out Non-Admitted Mental Health Inclusions: added Service Category 1 and 5. Dates updated to 2026/27 Exclusions for ED updated and sequenced. Exclusions reviewed for Acute Admitted. Financial classes updated and Tier 2 - 20.52 and 40.30 removed. Exclusions updated, addition of: - Unqualified neonates - ED only service events - Medicare Ineligibility Targets updated for performing, not performing and underperforming and individual LHD/Ns. Version Number updated to 2.2
Jun-2026	PD-001	Purchased Activity Volumes – Variance: Public Dental Clinical Service - DWAU (%)	Update to Targets Version Number updated to 4.0

2026-27 KPI Service Agreements

Date	Indicator No.	Measure	Version Control Change
May-2026	KFA101	Expenditure Matched to Budget YTD	Update to Title Version Number updated to 1.5
May-2026	KPI22-04	NCOS Matched to Budget YTD	Update to Title Version Number updated to 1.3
May-2026	KFA103	Revenue Matched to Budget YTD	Update to Title Version Number updated to 1.4
May-2026	KFA109	Net Result Matched to Budget YTD	Update to Title. Version Number updated to 2.1
Jun-2026	KPI22-02	Annual Procurement Savings: Percentage Achieved Against Target (%)	Changed from KPI to Monitoring Measure

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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 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 2026-27. 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 2026-27 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 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 a general principle KPIs and Monitoring Measures that refer to Admitted Patients exclude Residential Care Residents (Service Event Type Code = 3)

As in previous years, the 2026-27 KPI and Improvement Measures data supplement is also located on the NSW Health Information Resource Directory and accessible via the following link:

[View Data Resource](#)

KEY PERFORMANCE INDICATORS FOR 2026-27

2026-27 Service Performance Agreements

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

2026-27 Service Performance Agreements

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

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	2.1
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?

2026-27 Service Performance Agreements

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

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

2026-27 Service Performance Agreements

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

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/intervention 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 8.9 out of 10.0

- Performing - organisational score ≥ 8.9
- Underperforming ≥ 8.7 to < 8.9
- Not performing < 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

Chief Experience Officer, Strategic Planning Economics and Experience (SPEE), 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>

2026-27 Service Performance Agreements

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

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	1.4
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)

2026-27 Service Performance Agreements

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

- **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

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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

- Performing - organisational score ≥ 8.7
- Underperforming ≥ 8.5 to < 8.7 (non-exclusive)
- Not performing < 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 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

Chief Experience Officer, Strategic Planning Economics and Experience (SPEE), 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>

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

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	1.4
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)

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	- 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 <i>Technical Supplement: Emergency Department Patient Survey</i> at: http://www.bhi.nsw.gov.au/nsw_patient_survey_program
Targets	Target score of 8.6 out of 10.0 - Performing - organisational score ≥ 8.6 - Underperforming ≥ 8.4 to < 8.6 - Not performing < 8.4
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

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Business owners

Contact – Policy	Chief Experience Officer, Strategic Planning Economics and Experience (SPEE), 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>

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

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	1.4
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)

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- **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

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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 <i>Technical Supplement: Emergency Department Patient Survey</i> at: • http://www.bhi.nsw.gov.au/nsw_patient_survey_program
Targets	Target score of 8.5 out of 10.0 • Performing - organisational score ≥ 8.5 • Underperforming ≥ 8.2 to < 8.5 • Not performing < 8.2
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	Chief Experience Officer, Strategic Planning Economics and Experience (SPEE), 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

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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

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

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	

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

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

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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 <i>Technical Supplement: Adult Admitted Patient Survey</i> at: http://www.bhi.nsw.gov.au/nsw_patient_survey_program
Targets	
Target	Target score of 8.0 out of 10.0 • Performing ≥ 8.0 • Underperforming ≥ 7.8 to < 8.0 • Not performing < 7.8
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

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

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>

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

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	1.3
Scope	NSW public specialised inpatient and community mental health services.
Goal	Measure and improvement of experience and outcomes in mental health care
Desired outcome	80% or more of mental health consumers report a Very Good or Excellent overall experience.
Primary point of collection	Your Experience of Service (YES) questionnaire (digital and paper versions)
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 maintained within the InforMH database
Indicator definition	NSW or LHD/SHN percentage is the average of percentages calculated separately for inpatient and community settings. Within each setting, the score is the Percent of valid YES questionnaires with overall Experience score in the Very Good to Excellent range. Calculation method is: $100 * (\text{Numerator 1} / \text{Denominator 1} + \text{Numerator 2} / \text{Denominator 2}) / 2$.
Numerator	
Numerator definition	1. The number of valid YES questionnaires with overall Experience score in the Very Good to Excellent range ($\geq 8/10$) in inpatient settings 2. The number of valid YES questionnaires with overall Experience score in the Very Good to Excellent range ($\geq 8/10$) in community settings Overall Experience score is the average score of validly completed YES questions 1-22, expressed as a score out of 10.
Numerator source	NSW YES Collection
Numerator availability	Monthly. Delays may occur if there are issues with the process that supports the collection of paper YES questionnaires as this requires additional processing by a 3 rd party scanning company.
Denominator	

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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	NSW YES Collection
Denominator availability	Monthly. Delays may occur if there are issues with the process that supports the collection of paper YES questionnaires as this requires additional processing by a 3 rd party scanning company.
Inclusions	All YES questionnaires (digital and paper versions) 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 month. • JHFMHN services
Targets	• Performing: $\geq 80\%$ • Underperforming: $\geq 70\%$ and $<80\%$ • Not performing: $<70\%$
Context	YES data is provided to AIHW annually for national reporting alongside participating jurisdictions
Related Policies/ Programs	Fifth National Mental Health and Suicide Prevention Plan, NSW Health Strategy Elevating the Human Experience
Useable data available from	July 2015
Frequency of Reporting	Monthly
Time lag to available data	One-two months (to support paper collection)
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%
Minimum size	1
Maximum size	3
Data domain	
Date effective	1 July 2018 (reporting changed from quarterly to monthly from 1 July 2025)

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

Related National Indicator

Your Experience of Service NBEDS 2019-: Your Experience of Service Database, 2023 (METEOR ID: 801350)
<https://meteor.aihw.gov.au/content/801350>

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HEALTH OUTCOME 2: Safe care is delivered across all settings

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

NSW Health Strategic Outcome

2: Safe care is delivered across all settings

Status

Final

Version number

1.1

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

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HEALTH OUTCOME 2: Safe care is delivered across all settings

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 records with same facility code, AUID (if AUID missing – use MRN), arrival date, arrival time and birth date (EDW: HEALTH_ORG, CL_ID, CL_ARRIVAL_DTTM and CL_DOB). Retain single row with the latest SOURCE_MODIFIED_DTTM. - Records where CL_ID (AUID and MRN) are missing - Duplicate records with same facility and SRV_ENC_REC_ID. Retain single row by selecting the record with the latest SOURCE_MODIFIED_DTTM
Targets	Target 80%

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HEALTH OUTCOME 2: Safe care is delivered across all settings

- Performing: $\geq 80\%$
- Under Performing: $\geq 70\%$ 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

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HEALTH OUTCOME 2: Safe care is delivered across all settings

INDICATOR: KPI2403	Hospital Access Target – Admitted/transferred from ED within 6 hours (%)
Shortened Title	Hospital access target - Admitted
Service Agreement Type	Key Performance Indicator
NSW Health Strategic Outcome	2: Safe care is delivered across all settings.
Status	Final
Version number	1.1
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:

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HEALTH OUTCOME 2: Safe care is delivered across all settings

- 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

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	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 records with same facility code, AUID (if AUID missing – use MRN), arrival date, arrival time and birth date (EDW: HEALTH_ORG, CL_ID, CL_ARRIVAL_DTTM and CL_DOB). Retain single row with the latest SOURCE_MODIFIED_DTTM. - Records where CL_ID (AUID and MRN) are missing - Duplicate records with same facility and SRV_ENC_REC_ID. Retain single row by selecting the record with the latest SOURCE_MODIFIED_DTTM - ED presentations admitted to EDSSU identified using their linked AP sub service event with a bed type '59'
Targets	Target 80% - Performing: $\geq 80\%$ - Under Performing: $\geq 70\%$ 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 (%)

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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

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HEALTH OUTCOME 2: Safe care is delivered across all settings

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
NSW Health Strategic Outcome	2: Safe care is delivered across all settings
Status	Final
Version number	1.1
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 admitted to this hospital (either short-stay unit, hospital-in-

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HEALTH OUTCOME 2: Safe care is delivered across all settings

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 Emergency Department Separation Mode Code (Master List) '01' and '01.03' 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 linked EDSSU record (due to data quality), then use START 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 records with same facility code, AUID (if AUID missing – use MRN), arrival date, arrival time and birth date (EDW:

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HEALTH_ORG, CL_ID, CL_ARRIVAL_DTTM and CL_DOB). Retain single row with the latest SOURCE_MODIFIED_DTTM.

- Records where CL_ID (AUID and MRN) are missing
- Duplicate records with same facility and SRV_ENC_REC_ID. Retain single row by selecting the record with the latest SOURCE_MODIFIED_DTTM
- FWLHD

Targets

Target 60%

- Performing: $\geq 60\%$
- Under Performing: $\geq 55\%$ 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 emergenc

LHD	Not Performing	Under Performing	Performing
CCLHD	>4.5	>3.8 and ≤ 4.5	≤ 3.8

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FWLHD	>7.7	>4.9 and ≤7.7	≤4.9
HNELHD	>3.9	>3.6 and ≤3.9	≤3.6
ISLHD	>4.7	>4.1 and ≤4.7	≤4.1
JH&FMHN	NA	NA	NA
MLHD	>3.9	>3.2 and ≤3.9	≤3.2
MNCLHD	>3.7	>3.1 and ≤3.7	≤3.1
NBMLHD	>4.2	>3.6 and ≤4.2	≤3.6
NNSWLHD	>4.0	>3.4 and ≤4.0	≤3.4
NSLHD	>4.2	>3.7 and ≤4.2	≤3.7
SCHN	>2.0	>1.5 and ≤2.0	≤1.5
SESLHD	>3.9	>3.5 and ≤3.9	≤3.5
SLHD	>4.2	>3.7 and ≤4.2	≤3.7
SNSWLHD	>4.3	>3.4 and ≤4.3	≤3.4
SVHN	>4.9	>3.9 and ≤4.9	≤3.9
SWSLHD	>3.5	>3.2 and ≤3.5	≤3.2
WNSWLHD	>3.7	>3.1 and ≤3.7	≤3.1
WSLHD	>3.9	>3.5 and ≤3.9	≤3.5
NSW	>3.2	>3.1 and ≤3.2	≤3.1

cy 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>

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HEALTH OUTCOME 2: Safe care is delivered across all settings

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	1.1
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, CERTIFIED.FACT_AP_EDSSU (or equivalent data sources)
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;

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It is the earliest of EDSSU start date/time (SE_LOC_START_DTTM) or actual departure date/time (CL_DEPART_DTTM) for EDSSU patients
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 records with same facility code, AUID (if AUID missing – use MRN), arrival date, arrival time and birth date (EDW: HEALTH_ORG, CL_ID, CL_ARRIVAL_DTTM and CL_DOB). Retain single row with the latest SOURCE_MODIFIED_DTTM.
- Records where CL_ID (AUID and MRN) are missing
- Duplicate records with same facility and SRV_ENC_REC_ID. Retain single row by selecting the record with the latest SOURCE_MODIFIED_DTTM

Targets

Target 95%

- Performing: ≥95%
- Under Performing: ≥85% and <95%
- Not Performing: <85%

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HEALTH OUTCOME 2: Safe care is delivered across all settings

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

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HEALTH OUTCOME 2: Safe care is delivered across all settings

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: Safe care is delivered across all settings
Status	Final
Version number	1.3
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	Enterprise Data Warehouse (EDWARD) - Local Reporting Solution (LRS) CERTIFIED.FACT_ED_SE (or equivalent data source)
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 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 and SUB_EVNT_FIRST_TRIAGE_DTTM) and • Departure date/time is the earlier of departure ready date/time (SUB_EVNT_FIRST_PT_DEPART_READY_DTTM) and the actual departure date/time (CL_DEPART_DTTM) for non-admitted patients with ED mode of separation codes (ED_SEPARATION_MODE_CD) of either: - o 01.01 – Expired: formally admitted and discharged within emergency department - o 02- Departed, not further defined - o 02.01 – Departed, treatment completed - o 02.02 – Departed, transferred to another hospital

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HEALTH OUTCOME 2: Safe care is delivered across all settings

- o 02.03 – Departed, did not wait
 - o 02.04 – Departed, left at own risk
 - o 02.05 – Departed, for other clinical service location
 - o 03 – Dead on both arrival and departure
 - o 04 – Dead in emergency department
- Otherwise**, it is the actual departure date/time (CL_DEPART_DTTM)

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.
Numerator source	EDWARD (Emergency Department Data Collection)
Numerator availability	Availability is determined by the EDWARD load and refresh schedule

Denominator

Denominator definition	All mental health and self-harm related ED presentations 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 • ICD-10 diagnosis codes for a primary or additional mental health condition • ICD-10 diagnosis codes for self-harm or suicidal ideation • Derived Presenting problem text indicating self-harm or suicidal ideation See more details on HIRD • Mental health or self-harm related presentations: http://hird.health.nsw.gov.au/hird/view_data_element_definition.cfm?ItemID=50474 • Self-harm presenting problem: http://hird.health.nsw.gov.au/hird/view_data_element_definition.cfm?ItemID=50559
Denominator source	EDWARD (Emergency Department Data Collection)
Denominator availability	Availability is determined by the EDWARD load and refresh schedule
Inclusions	All mental health and self-harm related 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 records with same facility code, AUID (if AUID missing – use MRN), arrival date, arrival time and birth date (EDW: HEALTH_ORG, CL_ID, CL_ARRIVAL_DTTM and CL_DOB). Retain single row with the latest SOURCE_MODIFIED DTTM. • Records where CL_ID (AUID and MRN) are missing

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	• Duplicate records with same facility and SRV_ENC_REC_ID. Retain single row by selecting the record with the latest SOURCE_MODIFIED_DTTM • Records where client age at arrival is less than 10 years old for self-harm (EDW: CL_ARRIVAL_DTTM and CL_DOB)
Targets	• Performing: $\geq 95\%$ • Under Performing: $\geq 85\%$ and $< 95\%$ • Not Performing: $< 85\%$
Context	This indicator is specific to mental health and aligns with the broader Hospital Access Target for ED Extended Stays of no greater than 12 hours. Details of the testing and validation of the enhanced self-harm identification method are available at https://doi.org/10.17061/phrp33012303
Related Policies/ Programs	Whole of Health Program
Useable data available from	1 January 2023
Frequency of Reporting	Monthly
Time lag to available data	Time lags are determined by data loading schedules which can vary by LHD/SHN.
Business owners	Executive Director, System Information and Analytics Branch
Contact - Policy	Executive Director, System Performance Support and Mental Health Branch.
Contact - Data	Director, InforMH, System Information and Analytics Branch
Representation	
Data type	Numeric
Form	Percentage (%)
Representational layout	NN%
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

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HEALTH OUTCOME 2: Safe care is delivered across all settings

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	3.1
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	Patient Administration System (PAS)
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', '48', '69', '87', '93' 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 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)

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HEALTH OUTCOME 2: Safe care is delivered across all settings

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', '48', '69', '87', '93'. 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. When a patient's last and second last bed types are '76' and '25' exclude both '76' and '25'. 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 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%

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HEALTH OUTCOME 2: Safe care is delivered across all settings

- 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

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HEALTH OUTCOME 2: Safe care is delivered across all settings

INDICATOR: KPI2406

Mental Health Inpatient Discharge Performance:
Discharges from ED accessible Mental Health inpatient beds by midday (%)

Shortened Title	Discharges by midday - Mental Health
Service Agreement Type	Key Performance Indicator
NSW Health Strategic Outcome	2: Safe care is delivered across all settings
Status	Final
Version number	1.1
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 within the Emergency Department • Improved safety and efficiency of transfer of care for patients in the Emergency Department awaiting access to inpatient treatment. • Improve the access to inpatient services for patients admitted via the Emergency Department
Primary point of collection	Patient Medical Record
Data Collection Source/System	Patient Administration System (PAS)
Primary data source for analysis	Enterprise Data Warehouse (EDWARD) – Local Reporting Solution (LRS)
Indicator definition	The percentage of overnight admitted patient discharges from mental health inpatient care The method for defining Mental Health inpatient care is based on separation from a designated mental health inpatient unit, with these units being defined by a ward reference list and mental health bed types 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	Availability is determined by the EDWARD load and refresh schedule

2026-27 Service Performance Agreements

HEALTH OUTCOME 2: Safe care is delivered across all settings

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	Availability is determined by the EDWARD load and refresh schedule

Inclusions

- Admitted patient episodes separating from mental health units in hospitals. The method for defining Mental Health inpatient care is based on separation from a designated mental health inpatient unit with these units being defined by a ward reference list and mental health bed types maintained by InforMH.

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 indicator is specific to mental health and aligns with the broader Mental Health Inpatient Discharge Performance indicator.

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

July 2022

Frequency of Reporting

Monthly

Time lag to available data

Time lags are determined by data loading schedules which can vary by LHD/SHN

Business owners

Executive Director, System Information and Analytics Branch

Contact - Policy

Executive Directors, Mental Health Branch and System Performance Support

Contact - Data

Director, InforMH, System Information and Analytics Branch

Representation

Data type

Numeric

2026-27 Service Performance Agreements

HEALTH OUTCOME 2: Safe care is delivered across all settings

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

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HEALTH OUTCOME 2: Safe care is delivered across all settings

INDICATOR: KPI2411, KPI2412	Incomplete Emergency Department Attendances for Aboriginal Patients: Patients who departed from an ED with a “Did not wait” or “Left at own risk” status (%)
Previous ID: IM22-004b	• 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	4.1
Scope	All Aboriginal patients presenting to public facility Emergency Departments
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.
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)

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HEALTH OUTCOME 2: Safe care is delivered across all settings

Denominator availability	Available
Exclusions	• ED_VIS_TYPE_CD of '06', '12' or '13', (ED presentation without ED workup, Telehealth presentation, current admitted patient) • Separation mode (ED_SEPR_MODE_CD) = '98' Registered in error • Duplicate records with same facility code, AUID (if AUID missing – use MRN), arrival date, arrival time and birth date (EDW: HEALTH_ORG, CL_ID, CL_ARRIVAL_DTTM and CL_DOB) Retain single row with the latest SOURCE_MODIFIED DTTM • Records where CL_ID (AUID and MRN) are missing • Duplicate records with same facility and SRV_ENC_REC_ID. Retain single row by selecting the record with the latest SOURCE_MODIFIED_DTTM
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 • <u>NSW Aboriginal Health Plan 2013-2023</u> • <u>NSQHS Standards User guide for Aboriginal and Torres Strait Islander health Australian Commission on Safety and Quality in Health Care</u> • <u>NSW Health Policy Directive <i>Aboriginal and Torres Strait Islander Origin - Recording of Information of Patients</i></u>
Useable data available from	2010
Frequency of Reporting	Monthly
Time lag to available data	Reporting required by the 10 th day of each month, data available for previous month

2026-27 Service Performance Agreements
HEALTH OUTCOME 2: Safe care is delivered across all settings

Business owners

Contact - Policy	Executive Director, Centre for Aboriginal Health and Executive Director System Purchasing Branch
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Contact - Data	Executive Director, System Information and Analytics
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Representation

Data type	Numeric
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Form	Number, presented as a percentage (%)
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Representational layout	NNN.N
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Minimum size	3
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Maximum size	5
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Data domain	
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Date effective	July 2022
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Related National Indicator

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HEALTH OUTCOME 2: Safe care is delivered across all settings

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	4.1
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. <i>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.</i> Ambulance Zone = ambulance bay where ambulance vehicle arrives outside Hospital doors

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HEALTH OUTCOME 2: Safe care is delivered across all settings

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).

Ambulance Clinical Response Grid = defines the ambulance response categories. The definitions can be found in NSW Ambulance Clinical Response Standards Policy Directive PD2025_002

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 $\leq$ 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:

C1 - Category 1	C3V - Category 3V
C2 - Category 2	C3VE - Category 3VE
C2E - Category 2E	C4 - Category 4
C2V - Category 2V	C4E - Category 4E
C2VE - Category 2VE	C4H - Category 4H
C3 - Category 3	C4HE - Category 4HE
C3E - Category 3E	C5 - Category 5

Response Category		Dispatch Guidelines
Category 1		Closest available (lights & sirens)
Category 2		Closest available (lights & sirens)
Category 3		30 min response
Category 4		60 min response
Category 5		Time Critical
Suffixes		
E	ECP	Extended Care Paramedic
H	Healthdirect	Healthdirect Secondary Triage
V	VCCC	Virtual Clinical Care Centre

Numerator Exclusions

Patients where the Ambulance Priority is either:

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HEALTH OUTCOME 2: Safe care is delivered across all settings

Response Category	Dispatch Guidelines
Category 6	Aeromedical
Category 7	Treatments
Category 8	After Treatment Routine Transport
Category 9	Sports / Special Events
Category 10	Major Incident
Other	
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:

C1 - Category 1	C3V - Category 3V
C2 - Category 2	C3VE - Category 3VE
C2E - Category 2E	C4 - Category 4
C2V - Category 2V	C4E - Category 4E
C2VE - Category 2VE	C4H - Category 4H
C3 - Category 3	C4HE - Category 4HE
C3E - Category 3E	C5 - Category 5

Response Category	Dispatch Guidelines
Category 1	Closest available (lights & sirens)
Category 2	Closest available (lights & sirens)
Category 3	30 min response
Category 4	60 min response
Category 5	Time Critical
Suffixes	
E	ECP Extended Care Paramedic
H	Healthdirect Healthdirect Secondary Triage

2026-27 Service Performance Agreements

HEALTH OUTCOME 2: Safe care is delivered across all settings

V	VCCC	Virtual Clinical Care Centre
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Exclusions

Patients where the Ambulance Priority is either:

- C6 - Category 6
- C7 - Category 7
- C8 - Category 8
- C9 - Category 9
- C10 - Category 10

Response Category	Dispatch Guidelines
Category 6	Aeromedical
Category 7	Treatments
Category 8	After Treatment Routine Transport
Category 9	Sports / Special Events
Category 10	Major Incident
Other	
Priority Error	
Ambulance records 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

February 5, 2025

Frequency of Reporting

Monthly/Weekly

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HEALTH OUTCOME 2: Safe care is delivered across all settings

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

NNN.NN

Minimum size

4

Maximum size

6

Data domain

N/A

Date effective

5 February 2025

2026-27 Service Performance Agreements

HEALTH OUTCOME 2: Safe care is delivered across all settings

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	4.0
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 V3.2 downloadable from https://www.safetyandquality.gov.au/publications-and-resources/resource-library/hospital-acquired-complications-hacs-list-specifications-version-32-13th-edn for the numerator for hospital acquired pressure injuries (HAC 1). The 13th Edition of ICD-10-AM coding should be used, which includes the following additional diagnosis codes: - Any of the listed ICD-10-AM 13th 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.

2026-27 Service Performance Agreements

HEALTH OUTCOME 2: Safe care is delivered across all settings

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'. • Any uncoded records.
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 V3.2).
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:

LHD	Not Performing	Under Performing	Performing
CCLHD	>4.5	>3.8 and <=4.5	<=3.8
FWLHD	>7.7	>4.9 and <=7.7	<=4.9
HNELHD	>3.9	>3.6 and <=3.9	<=3.6

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HEALTH OUTCOME 2: Safe care is delivered across all settings

ISLHD	>4.7	>4.1 and <=4.7	<=4.1
JH&FMHN	NA	NA	NA
MLHD	>3.9	>3.2 and <=3.9	<=3.2
MNCLHD	>3.7	>3.1 and <=3.7	<=3.1
NBMLHD	>4.2	>3.6 and <=4.2	<=3.6
NNSWLHD	>4.0	>3.4 and <=4.0	<=3.4
NSLHD	>4.2	>3.7 and <=4.2	<=3.7
SCHN	>2.0	>1.5 and <=2.0	<=1.5
SESLHD	>3.9	>3.5 and <=3.9	<=3.5
SLHD	>4.2	>3.7 and <=4.2	<=3.7
SNSWLHD	>4.3	>3.4 and <=4.3	<=3.4
SVHN	>4.9	>3.9 and <=4.9	<=3.9
SWSLHD	>3.5	>3.2 and <=3.5	<=3.2
WNSWLHD	>3.7	>3.1 and <=3.7	<=3.1
WSLHD	>3.9	>3.5 and <=3.9	<=3.5
NSW	>3.2	>3.1 and <=3.2	<=3.1

The HAC targets have been developed using risk adjusted models on the 2024 NSW APDC data. The risk adjusters used are largely in the same dimensions as those used for IHACPA's service activity adjusters. In calculating the HAC targets for SCHN, the 2025/26 risk adjusted modelling was conducted with more refined age groups, while other risk factors remain the same.

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 - 2 months

2026-27 Service Performance Agreements
HEALTH OUTCOME 2: Safe care is delivered across all settings

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's (ACSQHC)
HACs specification file for HACs V3.2 downloadable from
<https://www.safetyandquality.gov.au/publications-and-resources/resource-library/hospital-acquired-complications-hacs-list-specifications-version-32-13th-edn>

2026-27 Service Performance Agreements

HEALTH OUTCOME 2: Safe care is delivered across all settings

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	4.0
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 V3.2 downloadable from https://www.safetyandquality.gov.au/publications-and-resources/resource-library/hospital-acquired-complications-hacs-list-specifications-version-32-13th-edn for the numerator for fall related injuries in hospitals (HAC 2). The 13th Edition of ICD-10-AM coding should be used, which includes the following additional diagnosis codes: • Any of the listed ICD-10-AM 13th Edition codes recorded as an additional diagnosis, • AND any external cause code of (falls): W01x, W03, W04, W05, W06.1, W06.2, W06.3, W06.4, W06.6, W06.8, W06.9, W07.x, W08.x, W10.x, W13.0, W13.1, W13.2, W13.5, W13.8, W13.9, W18.x, 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

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HEALTH OUTCOME 2: Safe care is delivered across all settings

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 V3.2).
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:

LHD	Not Performing	Under Performing	Performing
CCLHD	>10.3	>9.3 and <=10.3	<=9.3
FWLHD	>14.8	>10.9 and <=14.8	<=10.9
HNELHD	>8.1	>7.6 and <=8.1	<=7.6
ISLHD	>10.3	>9.4 and <=10.3	<=9.4

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HEALTH OUTCOME 2: Safe care is delivered across all settings

JH&FMHN	NA	NA	NA
MLHD	>9.3	>8.2 and <=9.3	<=8.2
MNCLHD	>8.1	>7.3 and <=8.1	<=7.3
NBMLHD	>8.0	>7.1 and <=8.0	<=7.1
NNSWLHD	>9.0	>8.1 and <=9.0	<=8.1
NSLHD	>9.0	>8.3 and <=9.0	<=8.3
SCHN	NA	NA	NA
SESLHD	>8.1	>7.5 and <=8.1	<=7.5
SLHD	>7.9	>7.2 and <=7.9	<=7.2
SNSWLHD	>10.1	>8.8 and <=10.1	<=8.8
SVHN	>9.0	>7.7 and <=9.0	<=7.7
SWSLHD	>7.1	>6.6 and <=7.1	<=6.6
WNSWLHD	>8.3	>7.5 and <=8.3	<=7.5
WSLHD	>7.2	>6.6 and <=7.2	<=6.6
NSW	>7.0	>6.8 and <=7.0	<=6.8

The HAC targets have been developed using risk adjusted models on the 2024 NSW APDC data. The risk adjusters used are largely in the same dimensions as those used for IHACPA's service activity adjusters. In calculating the HAC targets for SCHN, the 2025/26 risk adjusted modelling was conducted with more refined age groups, while other risk factors remain the same.

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 - 2 months

Business owners

Contact - Policy Chief Executive, Clinical Excellence Commission

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

2026-27 Service Performance Agreements
HEALTH OUTCOME 2: Safe care is delivered across all settings

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's (ACSQHC) HACs specification file for HACs V3.2 downloadable from
<https://www.safetyandquality.gov.au/publications-and-resources/resource-library/hospital-acquired-complications-hacs-list-specifications-version-32-13th-edn>

2026-27 Service Performance Agreements

HEALTH OUTCOME 2: Safe care is delivered across all settings

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	4.0
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 Health Care's (ACSQHC) HACs specification file for HACs V3.2 downloadable from https://www.safetyandquality.gov.au/publications-and-resources/resource-library/hospital-acquired-complications-hacs-list-specifications-version-32-13th-edn for the numerator for healthcare associated infections (HAC 3). The 13th Edition of ICD-10-AM coding should be used, which includes the following additional diagnosis codes: - Any of the listed ICD-10-AM 13th Edition codes recorded as an additional diagnosis: - Urinary Tract Infection: N39.0, N30.0, O86.2, T83.5 - Surgical Site Infection: T81.4, T87.4, O86.0 - Pneumonia: J10.0, J11.0, J12.0, J12.1, J12.2, J12.3, J12.8, J12.9, J13, J14, J15.0, J15.1, J15.2, J15.3, J15.4, J15.5, J15.6, J15.7, J15.8, J15.9, J16.0, J16.8, J17.0, J17.1, J17.2, J17.3, J17.8, J18.0, J18.1, J18.2, J18.8, J18.9, J22 - Bloodstream Infection: A40.0, A40.1, A40.21, A40.22, A41.0, A41.51, A41.52, A41.58, B37.7, U92 - Catheter-Associated Infection: T82.74, T82.75

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Multi-Resistant Organisms: Z14.9, Z14.01, Z14.02, Z14.11, Z14.12, Z14.13, Z14.02, U93, Z14.8, Z14.31, Z14.21, Z14.22, Z14.23, Z14.24, Z14.25, Z14.33, Z15.9, Z15.41, Z15.89, Z15.49, Z15.30, Z15.31, Z15.39, Z15.7, Z15.0, Z15.1, Z15.2, Z15.82, Z15.83, Z15.89, Z16.9, Z16.30, Z16.31, Z16.32, Z16.39, Z16.0, Z16.2, Z16.1, Z16.7, Z16.8

Prosthetic / Implant Infection: T82.6, T82.71, T82.72, T82.73, T82.76, T82.77, T82.79, T83.61, T83.62, T84.5, T84.6, T84.7, T85.71, T85.72, T85.73, T85.74, T85.75, T85.76, T85.77, T85.78

Gastrointestinal Infections: A02.0, A02.2, A02.8, A02.9, A04.0, A04.1, A04.2, A04.3, A04.4, A04.5, A04.6, A04.7, A04.8, A04.9, A05.0, A05.1, A05.2, A05.3, A05.4, A05.8, A05.9, A06.0, A06.2, A06.3, A06.9, A07.0, A07.1, A07.2, A07.3, A07.8, A07.9, A08.0, A08.1, A08.2, A08.3, A08.4, A08.5

Other High Impact Infections: A41.1, A41.2, A41.3, A41.4, A41.50, A40.3, A40.8, A40.9, A41.8, A41.9, A48.0, A02.1, A32.7, A48.8, A49.00, A49.01, A49.11, A49.12, A49.89, A49.81, A49.82, A49.83, A49.84, A49.85, A49.86, A49.87, A49.9, R65.1, R57.2, O85

Postoperative Haemorrhage / Haematoma: T81.0, T82.81, T83.81, T84.81, I97.84

Surgical Wound Dehiscence: T81.3, O90.0, O90.1

Anastomotic Leak: K91.83, K91.84, N99.83, T83.2, T85.5

Vascular Graft Failure: T82.2, T82.3

Other Surgical Complications: T81.81, T81.82, T81.84, T81.89, T82.85, T82.89, T83.89, T84.85, T84.89, T85.81, T85.88, T88.8

- **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')

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HEALTH OUTCOME 2: Safe care is delivered across all settings

	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 V3.2).
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:

LHD	Not Performing	Under Performing	Performing
CCLHD	>115.5	>112.3 and <=115.5	<=112.3
FWLHD	>122.3	>111.0 and <=122.3	<=111.0
HNELHD	>109.3	>107.4 and <=109.3	<=107.4
ISLHD	>117.3	>114.3 and <=117.3	<=114.3
JH&FMHN	>131.7	>100.9 and <=131.7	<=100.9
MLHD	>104.8	>101.4 and <=104.8	<=101.4
MNCLHD	>90.2	>87.3 and <=90.2	<=87.3
NBMLHD	>107.1	>104.1 and <=107.1	<=104.1
NNSWLHD	>101.2	>98.4 and <=101.2	<=98.4
NSLHD	>120.2	>117.7 and <=120.2	<=117.7
SCHN	>40.5	>38.4 and <=40.5	<=38.4
SESLHD	>107.2	>105.0 and <=107.2	<=105.0
SLHD	>124.1	>121.6 and <=124.1	<=121.6
SNSWLHD	>93.9	>89.9 and <=93.9	<=89.9
SVHN	>116.3	>111.7 and <=116.3	<=111.7
SWSLHD	>100.0	>98.1 and <=100.0	<=98.1
WNSWLHD	>93.5	>90.6 and <=93.5	<=90.6
WSLHD	>106.8	>104.6 and <=106.8	<=104.6
NSW	>101.2	>100.6 and <=101.2	<=100.6

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HEALTH OUTCOME 2: Safe care is delivered across all settings

The HAC targets have been developed using risk adjusted models on the 2024 NSW APDC data. The risk adjusters used are largely in the same dimensions as those used for IHACPA's service activity adjusters. In calculating the HAC targets for SCHN, the 2025/26 risk adjusted modelling was conducted with more refined age groups, while other risk factors remain the same.

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 - 2 months

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's (ACSQHC) HACs specification file for HACs V3.2 downloadable from

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HEALTH OUTCOME 2: Safe care is delivered across all settings

<https://www.safetyandquality.gov.au/publications-and-resources/resource-library/hospital-acquired-complications-hacs-list-specifications-version-32-13th-edn>

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HEALTH OUTCOME 2: Safe care is delivered across all settings

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	4.0
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	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 V3.2 downloadable from https://www.safetyandquality.gov.au/publications-and-resources/resource-library/hospital-acquired-complications-hacs-list-specifications-version-32-13th-edn for the numerator for hospital acquired respiratory complications (HAC 6). The 13th 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 intervention 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:

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HEALTH OUTCOME 2: Safe care is delivered across all settings

- 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 V3.2)

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

LHD	Not Performing	Under Performing	Performing
CCLHD	>30.3	>28.7 and <=30.3	<=28.7
FWLHD	>41.3	>34.7 and <=41.3	<=34.7
HNELHD	>30.2	>29.1 and <=30.2	<=29.1
ISLHD	>30.5	>29.0 and <=30.5	<=29.0
JH&FMHN	NA	NA	NA
MLHD	>21.8	>20.2 and <=21.8	<=20.2
MNCLHD	>23.1	>21.7 and <=23.1	<=21.7
NBMLHD	>30.5	>28.9 and <=30.5	<=28.9
NNSWLHD	>25.8	>24.4 and <=25.8	<=24.4
NSLHD	>36.9	>35.5 and <=36.9	<=35.5
SCHN	>21.4	>19.9 and <=21.4	<=19.9
SESLHD	>32.4	>31.2 and <=32.4	<=31.2
SLHD	>40.5	>39.1 and <=40.5	<=39.1
SNSWLHD	>19.8	>18.0 and <=19.8	<=18.0
SVHN	>41.9	>39.1 and <=41.9	<=39.1

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SWSLHD	>30.6	>29.6 and <=30.6	<=29.6
WNSWLHD	>21.9	>20.5 and <=21.9	<=20.5
WSLHD	>33.6	>32.3 and <=33.6	<=32.3
NSW	>28.4	>28.0 and <=28.4	<=28.0

The HAC targets have been developed using risk adjusted models on the 2024 NSW APDC data. The risk adjusters used are largely in the same dimensions as those used for IHACPA's service activity adjusters. In calculating the HAC targets for SCHN, the 2025/26 risk adjusted modelling was conducted with more refined age groups, while other risk factors remain the same.

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 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 - 2 months

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's (ACSQHC) HACs specification file for HACs V3.2 downloadable from

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HEALTH OUTCOME 2: Safe care is delivered across all settings

<https://www.safetyandquality.gov.au/publications-and-resources/resource-library/hospital-acquired-complications-hacs-list-specifications-version-32-13th-edn>

2026-27 Service Performance Agreements

HEALTH OUTCOME 2: Safe care is delivered across all settings

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	4.0
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 V3.2 downloadable from https://www.safetyandquality.gov.au/publications-and-resources/resource-library/hospital-acquired-complications-hacs-list-specifications-version-32-13th-edn for the numerator for Hospital Acquired VTE (HAC 7). The 13th Edition of ICD-10-AM coding should be used, which includes the following additional diagnosis codes: - Any of ICD-10-AM 13th 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.

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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 3.2).
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:

LHD	Not Performing	Under Performing	Performing
CCLHD	>8.7	>7.8 and <=8.7	<=7.8
FWLHD	>12.6	>8.9 and <=12.6	<=8.9
HNELHD	>9.2	>8.6 and <=9.2	<=8.6
ISLHD	>9.1	>8.3 and <=9.1	<=8.3

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JH&FMHN	NA	NA	NA
MLHD	>7.9	>6.9 and <=7.9	<=6.9
MNCLHD	>7.3	>6.5 and <=7.3	<=6.5
NBMLHD	>9.8	>8.9 and <=9.8	<=8.9
NNSWLHD	>7.9	>7.1 and <=7.9	<=7.1
NSLHD	>10.3	>9.6 and <=10.3	<=9.6
SCHN	>3.5	>2.9 and <=3.5	<=2.9
SESLHD	>9.0	>8.4 and <=9.0	<=8.4
SLHD	>11.3	>10.5 and <=11.3	<=10.5
SNSWLHD	>6.9	>5.8 and <=6.9	<=5.8
SVHN	>11.3	>9.9 and <=11.3	<=9.9
SWSLHD	>8.1	>7.6 and <=8.1	<=7.6
WNSWLHD	>7.7	>6.9 and <=7.7	<=6.9
WSLHD	>9.3	>8.6 and <=9.3	<=8.6
NSW	>7.7	>7.5 and <=7.7	<=7.5

The HAC targets have been developed using risk adjusted models on the 2024 NSW APDC data. The risk adjustors used are largely in the same dimensions as those used for IHACPA's service activity adjustors. In calculating the HAC targets for SCHN, the 2025/26 risk adjusted modelling was conducted with more refined age groups, while other risk factors remain the same.

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.

Context

The HAC information kit contains more contextual information:
[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 - 2 months

Business owners

Contact - Policy

Chief Executive, Clinical Excellence Commission

Contact - Data

Executive Director, System Information and Analytics Branch

2026-27 Service Performance Agreements
HEALTH OUTCOME 2: Safe care is delivered across all settings

(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's (ACSQHC)
HACs specification file for HACs V3.2 downloadable from
<https://www.safetyandquality.gov.au/publications-and-resources/resource-library/hospital-acquired-complications-hacs-list-specifications-version-32-13th-edn>

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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	4.0
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 V3.2 downloadable from https://www.safetyandquality.gov.au/publications-and-resources/resource-library/hospital-acquired-complications-hacs-list-specifications-version-32-13th-edn for the numerator for hospital acquired renal failure (HAC 8). The 13th Edition of ICD-10-AM coding should be used, which includes the following additional diagnosis codes: • Any of ICD-10-AM 13th Edition codes: N17.0, N17.1, N17.2, N17.8, N17.9, N19, O90.4, O08.4 • AND any of intervention 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	

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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 3.2)
Exclusions	Numerator and denominator exclusions: • DRG E03Z Lung or Heart-Lung Transplant • DRG F23Z Heart Transplant • 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. Additional exclusions for Numerator: • 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

Targets

LHD	Not Performing	Under Performing	Performing
CCLHD	>1.2	>0.9 and <=1.2	<=0.9
FWLHD	NA	NA	NA
HNELHD	>1.2	>1.0 and <=1.2	<=1.0
ISLHD	>1.3	>1.0 and <=1.3	<=1.0
JH&FMHN	NA	NA	NA
MLHD	>0.8	>0.5 and <=0.8	<=0.5

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MNCLHD	>0.9	>0.6 and <=0.9	<=0.6
NBMLHD	>1.5	>1.2 and <=1.5	<=1.2
NNSWLHD	>0.9	>0.7 and <=0.9	<=0.7
NSLHD	>1.9	>1.6 and <=1.9	<=1.6
SCHN	>1.3	>0.9 and <=1.3	<=0.9
SESLHD	>1.6	>1.3 and <=1.6	<=1.3
SLHD	>2.4	>2.0 and <=2.4	<=2.0
SNSWLHD	NA	NA	NA
SVHN	>3.4	>2.6 and <=3.4	<=2.6
SWSLHD	>1.3	>1.1 and <=1.3	<=1.1
WNSWLHD	>0.9	>0.6 and <=0.9	<=0.6
WSLHD	>1.8	>1.5 and <=1.8	<=1.5
NSW	>1.0	>0.9 and <=1.0	<=0.9

The HAC targets have been developed using risk adjusted models on the 2024 NSW APDC data. The risk adjusters used are largely in the same dimensions as those used for IHACPA's service activity adjusters. In calculating the HAC targets for SCHN, the 2025/26 risk adjusted modelling was conducted with more refined age groups, while other risk factors remain the same.

For renal failure (HAC 08), NSW Health has applied additional exclusion of heart transplant DRG E03Z and heart and lung transplant DRG F23Z. This exclusion was based on suggestions by CEC, prompted by SVHN raising the concern that these patients having unusually high rate of renal failure.

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

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 - 2 months

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HEALTH OUTCOME 2: Safe care is delivered across all settings

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:
A Australian Commission on Safety and Quality in Health Care's (ACSQHC) HACs specification file for HACs V3.2 downloadable from
<https://www.safetyandquality.gov.au/publications-and-resources/resource-library/hospital-acquired-complications-hacs-list-specifications-version-32-13th-edn>

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HEALTH OUTCOME 2: Safe care is delivered across all settings

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	4.0
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 V3.2 downloadable from https://www.safetyandquality.gov.au/publications-and-resources/resource-library/hospital-acquired-complications-hacs-list-specifications-version-32-13th-edn for the numerator for hospital acquired gastrointestinal bleeding (HAC 9). The 13th Edition of ICD-10-AM coding should be used, which includes the following additional diagnosis codes: - Any of ICD-10-AM 13th 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	

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HEALTH OUTCOME 2: Safe care is delivered across all settings

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 3.2)

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:

LHD	Not Performing	Under Performing	Performing
CCLHD	>10.9	>9.9 and <=10.9	<=9.9
FWLHD	>14.8	>10.9 and <=14.8	<=10.9
HNELHD	>9.7	>9.1 and <=9.7	<=9.1
ISLHD	>11.1	>10.2 and <=11.1	<=10.2
JH&FMHN	NA	NA	NA
MLHD	>9.3	>8.2 and <=9.3	<=8.2
MNCLHD	>8.8	>7.9 and <=8.8	<=7.9
NBMLHD	>9.8	>8.9 and <=9.8	<=8.9

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NNSWLHD	>9.5	>8.6 and <=9.5	<=8.6
NSLHD	>10.3	>9.6 and <=10.3	<=9.6
SCHN	>5.8	>5.0 and <=5.8	<=5.0
SESLHD	>9.7	>9.0 and <=9.7	<=9.0
SLHD	>10.6	>9.9 and <=10.6	<=9.9
SNSWLHD	>9.5	>8.2 and <=9.5	<=8.2
SVHN	>11.0	>9.6 and <=11.0	<=9.6
SWSLHD	>8.8	>8.3 and <=8.8	<=8.3
WNSWLHD	>8.8	>7.9 and <=8.8	<=7.9
WSLHD	>9.5	>8.9 and <=9.5	<=8.9
NSW	>8.4	>8.2 and <=8.4	<=8.2

The HAC targets have been developed using risk adjusted models on the 2024 NSW APDC data. The risk adjustors used are largely in the same dimensions as those used for IHACPA's service activity adjustors. In calculating the HAC targets for SCHN, the 2025/26 risk adjusted modelling was conducted with more refined age groups, while other risk factors remain the same.

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 - 2 months

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

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HEALTH OUTCOME 2: Safe care is delivered across all settings

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's (ACSQHC) HACs specification file for HACs V3.2 downloadable from

<https://www.safetyandquality.gov.au/publications-and-resources/resource-library/hospital-acquired-complications-hacs-list-specifications-version-32-13th-edn>

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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	4.0
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 V3.2 downloadable from https://www.safetyandquality.gov.au/publications-and-resources/resource-library/hospital-acquired-complications-hacs-list-specifications-version-32-13th-edn for the numerator for Hospital Acquired Medication Complications (HAC 10). The 13th Edition of ICD-10-AM coding should be used, which includes the following additional diagnosis codes: • ICD-10-AM codes J96.00, J96.01, J96.09, J96.90, J96.91, 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, R26.0, R26.3, R27.0, R29.2, R40.0, R40.1, R40.2, R45.1, R55, S06.01, S06.02 as an additional diagnosis AND a condition onset flag (COF) code of 1 (Condition

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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 3.2).

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.

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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:

LHD	Not Performing	Under Performing	Performing
CCLHD	>7.9	>7.1 and <=7.9	<=7.1
FWLHD	>14.8	>10.9 and <=14.8	<=10.9
HNELHD	>7.3	>6.8 and <=7.3	<=6.8
ISLHD	>8.3	>7.5 and <=8.3	<=7.5
JH&FMHN	>70.0	>47.6 and <=70.0	<=47.6
MLHD	>7.4	>6.5 and <=7.4	<=6.5
MNCLHD	>6.8	>6.0 and <=6.8	<=6.0
NBMLHD	>7.5	>6.7 and <=7.5	<=6.7
NNSWLHD	>7.2	>6.4 and <=7.2	<=6.4
NSLHD	>8.3	>7.7 and <=8.3	<=7.7
SCHN	>2.0	>1.5 and <=2.0	<=1.5
SESLHD	>7.1	>6.6 and <=7.1	<=6.6
SLHD	>8.0	>7.3 and <=8.0	<=7.3
SNSWLHD	>7.5	>6.4 and <=7.5	<=6.4
SVHN	>9.7	>8.3 and <=9.7	<=8.3
SWSLHD	>7.0	>6.5 and <=7.0	<=6.5
WNSWLHD	>7.1	>6.3 and <=7.1	<=6.3
WSLHD	>7.4	>6.8 and <=7.4	<=6.8
NSW	>6.3	>6.2 and <=6.3	<=6.2

The HAC targets have been developed using risk adjusted models on the 2024 NSW APDC data. The risk adjusters used are largely in the same dimensions as those used for IHACPA's service activity adjusters. In calculating the HAC targets for SCHN, the 2025/26 risk adjusted modelling was conducted with more refined age groups, while other risk factors remain the same.

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

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HEALTH OUTCOME 2: Safe care is delivered across all settings

Time lag to available data 1 - 2 months

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's (ACSQHC)
HACs specification file for HACs V3.2 downloadable from
<https://www.safetyandquality.gov.au/publications-and-resources/resource-library/hospital-acquired-complications-hacs-list-specifications-version-32-13th-edn>

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HEALTH OUTCOME 2: Safe care is delivered across all settings

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	4.0
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 V3.2 downloadable from https://www.safetyandquality.gov.au/publications-and-resources/resource-library/hospital-acquired-complications-hacs-list-specifications-version-32-13th-edn for the numerator for hospital acquired Delirium (HAC 11). The 13th Edition of ICD-10-AM coding should be used, which includes the following additional diagnosis codes: - Any of ICD-10-AM 13th 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

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- 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 V3.2).

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:

LHD	Not Performing	Under Performing	Performing
CCLHD	>43.7	>41.7 and <=43.7	<=41.7
FWLHD	>47.1	>40.1 and <=47.1	<=40.1
HNELHD	>41.7	>40.5 and <=41.7	<=40.5
ISLHD	>44.8	>42.9 and <=44.8	<=42.9
JH&FMHN	>52.8	>33.3 and <=52.8	<=33.3
MLHD	>34.9	>32.9 and <=34.9	<=32.9
MNCLHD	>35.3	>33.5 and <=35.3	<=33.5
NBMLHD	>40.4	>38.6 and <=40.4	<=38.6
NNSWLHD	>39.6	>37.9 and <=39.6	<=37.9
NSLHD	>48.4	>46.8 and <=48.4	<=46.8
SCHN	>11.0	>9.9 and <=11.0	<=9.9
SESLHD	>43.3	>42.0 and <=43.3	<=42.0

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HEALTH OUTCOME 2: Safe care is delivered across all settings

SLHD	>48.0	>46.5 and <=48.0	<=46.5
SNSWLHD	>34.6	>32.1 and <=34.6	<=32.1
SVHN	>46.9	>43.9 and <=46.9	<=43.9
SWSLHD	>37.0	>35.8 and <=37.0	<=35.8
WNSWLHD	>34.3	>32.6 and <=34.3	<=32.6
WSLHD	>39.7	>38.3 and <=39.7	<=38.3
NSW	>37.6	>37.2 and <=37.6	<=37.2

The HAC targets have been developed using risk adjusted models on the 2024 NSW APDC data. The risk adjusters used are largely in the same dimensions as those used for IHACPA's service activity adjusters. In calculating the HAC targets for SCHN, the 2025/26 risk adjusted modelling was conducted with more refined age groups, while other risk factors remain the same.

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 - 2 months

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

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HEALTH OUTCOME 2: Safe care is delivered across all settings

Related National Indicator

This HAC indicator follows the ACSQHC's specification:

Australian Commission on Safety and Quality in Health Care's (ACSQHC) HACs specification file for HACs V3.2 downloadable from

<https://www.safetyandquality.gov.au/publications-and-resources/resource-library/hospital-acquired-complications-hacs-list-specifications-version-32-13th-edn>

2026-27 Service Performance Agreements

HEALTH OUTCOME 2: Safe care is delivered across all settings

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	4.0
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 V3.2 downloadable from https://www.safetyandquality.gov.au/publications-and-resources/resource-library/hospital-acquired-complications-hacs-list-specifications-version-32-13th-edn for the numerator for hospital acquired Persistent Incontinence (HAC 12). The 13th Edition of ICD-10-AM coding should be used, which includes the following additional diagnosis codes: - Any of ICD-10-AM 13th Edition codes: N39.30, N39.31, N39.4, R15 or R32. 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:

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HEALTH OUTCOME 2: Safe care is delivered across all settings

- 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 3.2).

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:

LHD	Not Performing	Under Performing	Performing
CCLHD	>2.6	>2.1 and <=2.6	<=2.1
FWLHD	NA	NA	NA
HNELHD	>2.2	>1.9 and <=2.2	<=1.9
ISLHD	>2.5	>2.1 and <=2.5	<=2.1
JH&FMHN	NA	NA	NA
MLHD	>2.8	>2.2 and <=2.8	<=2.2
MNCLHD	>2.3	>1.8 and <=2.3	<=1.8
NBMLHD	>2.7	>2.2 and <=2.7	<=2.2
NNSWLHD	>2.2	>1.8 and <=2.2	<=1.8
NSLHD	>2.4	>2.1 and <=2.4	<=2.1

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HEALTH OUTCOME 2: Safe care is delivered across all settings

SCHN	NA	NA	NA
SESLHD	>2.3	>2.0 and <=2.3	<=2.0
SLHD	>2.4	>2.0 and <=2.4	<=2.0
SNSWLHD	>2.8	>2.1 and <=2.8	<=2.1
SVHN	>1.8	>1.2 and <=1.8	<=1.2
SWSLHD	>2.4	>2.1 and <=2.4	<=2.1
WNSWLHD	>2.4	>1.9 and <=2.4	<=1.9
WSLHD	>2.7	>2.3 and <=2.7	<=2.3
NSW	>1.8	>1.7 and <=1.8	<=1.7

The HAC targets have been developed using risk adjusted models on the 2024 NSW APDC data. The risk adjusters used are largely in the same dimensions as those used for IHACPA's service activity adjusters. In calculating the HAC targets for SCHN, the 2025/26 risk adjusted modelling was conducted with more refined age groups, while other risk factors remain the same.

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 - 2 months

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

2026-27 Service Performance Agreements

HEALTH OUTCOME 2: Safe care is delivered across all settings

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's (ACSQHC) HACs specification file for HACs V3.2 downloadable from

<https://www.safetyandquality.gov.au/publications-and-resources/resource-library/hospital-acquired-complications-hacs-list-specifications-version-32-13th-edn>

2026-27 Service Performance Agreements

HEALTH OUTCOME 2: Safe care is delivered across all settings

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	4.0
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 V3.2 downloadable from https://www.safetyandquality.gov.au/publications-and-resources/resource-library/hospital-acquired-complications-hacs-list-specifications-version-32-13th-edn for the numerator for hospital acquired endocrine complications (HAC 13). The 13th Edition of ICD-10-AM coding should be used, which includes the following additional diagnosis codes: • Any of ICD-10-AM 13th Edition codes: E10.64, E11.64, E13.64, E14.64, E16.0, E16.1, E16.2, E43, E44.0, E44.1, E46. • 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:

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HEALTH OUTCOME 2: Safe care is delivered across all settings

- 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 3.2).

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:

LHD	Not Performing	Under Performing	Performing
CCLHD	>34.6	>32.9 and <=34.6	<=32.9
FWLHD	>45.2	>38.3 and <=45.2	<=38.3
HNELHD	>32.3	>31.2 and <=32.3	<=31.2
ISLHD	>35.5	>33.8 and <=35.5	<=33.8
JH&FMHN	>52.8	>33.3 and <=52.8	<=33.3
MLHD	>28.3	>26.5 and <=28.3	<=26.5
MNCLHD	>27.4	>25.8 and <=27.4	<=25.8
NBMLHD	>33.4	>31.7 and <=33.4	<=31.7
NNSWLHD	>30.0	>28.4 and <=30.0	<=28.4
NSLHD	>31.4	>30.1 and <=31.4	<=30.1
SCHN	>7.3	>6.4 and <=7.3	<=6.4
SESLHD	>30.6	>29.4 and <=30.6	<=29.4

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HEALTH OUTCOME 2: Safe care is delivered across all settings

SLHD	>31.1	>29.9 and <=31.1	<=29.9
SNSWLHD	>28.2	>25.9 and <=28.2	<=25.9
SVHN	>32.0	>29.6 and <=32.0	<=29.6
SWSLHD	>29.3	>28.3 and <=29.3	<=28.3
WNSWLHD	>29.0	>27.4 and <=29.0	<=27.4
WSLHD	>32.0	>30.8 and <=32.0	<=30.8
NSW	>28.2	>27.8 and <=28.2	<=27.8

The HAC targets have been developed using risk adjusted models on the 2024 NSW APDC data. The risk adjusters used are largely in the same dimensions as those used for IHACPA's service activity adjusters. In calculating the HAC targets for SCHN, the 2025/26 risk adjusted modelling was conducted with more refined age groups, while other risk factors remain the same.

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 - 2 months

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

2026-27 Service Performance Agreements

HEALTH OUTCOME 2: Safe care is delivered across all settings

Related National Indicator

This HAC indicator follows the ACSQHC's specification:

Australian Commission on Safety and Quality in Health Care's (ACSQHC) HACs specification file for HACs V3.2 downloadable from

<https://www.safetyandquality.gov.au/publications-and-resources/resource-library/hospital-acquired-complications-hacs-list-specifications-version-32-13th-edn>

2026-27 Service Performance Agreements

HEALTH OUTCOME 2: Safe care is delivered across all settings

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	4.0
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 V3.2 downloadable from https://www.safetyandquality.gov.au/publications-and-resources/resource-library/hospital-acquired-complications-hacs-list-specifications-version-32-13th-edn for the numerator for hospital acquired Cardiac complications (HAC 14). The 13th Edition of ICD-10-AM coding should be used, which includes the following additional diagnosis codes: - Any of ICD-10-AM 13th Edition codes: I47.0, I47.1, I48.9, I49.0, I49.8, I49.9, I50.0, I50.1, I50.9 OR - Diagnosis code R00.1, AND with any of the intervention 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 I20.0, I21.0, I21.1, I21.2, I21.3, I21.4, I21.9, I22.0, I22.1, I22.8, I22.9, I33.0, I46.0, I46.1, I46.9; 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

2026-27 Service Performance Agreements

HEALTH OUTCOME 2: Safe care is delivered across all settings

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 3.2).
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:

LHD	Not Performing	Under Performing	Performing
CCLHD	>30.3	>28.7 and <=30.3	<=28.7
FWLHD	>45.2	>38.3 and <=45.2	<=38.3
HNELHD	>30.9	>29.8 and <=30.9	<=29.8
ISLHD	>31.1	>29.5 and <=31.1	<=29.5
JH&FMHN	NA	NA	NA
MLHD	>24.3	>22.6 and <=24.3	<=22.6

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HEALTH OUTCOME 2: Safe care is delivered across all settings

MNCLHD	>23.6	>22.1 and <=23.6	<=22.1
NBMLHD	>31.1	>29.5 and <=31.1	<=29.5
NNSWLHD	>27.0	>25.6 and <=27.0	<=25.6
NSLHD	>36.0	>34.6 and <=36.0	<=34.6
SCHN	>12.9	>11.7 and <=12.9	<=11.7
SESLHD	>33.2	>32.0 and <=33.2	<=32.0
SLHD	>40.2	>38.7 and <=40.2	<=38.7
SNSWLHD	>20.4	>18.6 and <=20.4	<=18.6
SVHN	>45.3	>42.4 and <=45.3	<=42.4
SWSLHD	>30.4	>29.4 and <=30.4	<=29.4
WNSWLHD	>23.0	>21.5 and <=23.0	<=21.5
WSLHD	>35.9	>34.6 and <=35.9	<=34.6
NSW	>28.7	>28.4 and <=28.7	<=28.4

The HAC targets have been developed using risk adjusted models on the 2024 NSW APDC data. The risk adjusters used are largely in the same dimensions as those used for IHACPA's service activity adjusters. In calculating the HAC targets for SCHN, the 2025/26 risk adjusted modelling was conducted with more refined age groups, while other risk factors remain the same.

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 - 2 months

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

2026-27 Service Performance Agreements

HEALTH OUTCOME 2: Safe care is delivered across all settings

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's (ACSQHC) HACs specification file for HACs V3.2 downloadable from https://www.safetyandquality.gov.au/publications-and-resources/resource-library/hospital-acquired-complications-hacs-list-specifications-version-32-13th-edn

2026-27 Service Performance Agreements

HEALTH OUTCOME 2: Safe care is delivered across all settings

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	4.0
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 V3.2 downloadable from https://www.safetyandquality.gov.au/publications-and-resources/resource-library/hospital-acquired-complications-hacs-list-specifications-version-32-13th-edn for the numerator for 3rd or 4th Degree Perineal Lacerations (HAC 15). The 13th Edition of ICD-10-AM coding should be used, which includes the following additional diagnosis codes: • O70.2 or 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 13th Edition codes: Z37.0, Z37.1, Z37.2, Z37.3, Z37.4, Z37.5, Z37.6, Z37.7, Z37.9, any onset flag

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- AND a caesarean birth was NOT recorded (No ACHI intervention 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 3.2).

Exclusions

Numerator exclusions:

- Admitted patient service events where an O70.2 or O70.3 ICD-10-AM 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:

LHD	Not Performing	Under Performing	Performing
CCLHD	>374.2	>339.3 and <=374.2	<=339.3
FWLHD	>745.5	>530.3 and <=745.5	<=530.3
HNELHD	>342.5	>322.2 and <=342.5	<=322.2
ISLHD	>371.0	>336.4 and <=371.0	<=336.4
MLHD	>399.0	>351.9 and <=399.0	<=351.9
MNCLHD	>383.8	>341.5 and <=383.8	<=341.5
NBMLHD	>359.5	>330.1 and <=359.5	<=330.1

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NNSWLHD	>373.1	>337.3 and <=373.1	<=337.3
NSLHD	>362.2	>332.7 and <=362.2	<=332.7
SESLHD	>349.5	>325.9 and <=349.5	<=325.9
SLHD	>357.9	>329.8 and <=357.9	<=329.8
SNSWLHD	>405.0	>354.7 and <=405.0	<=354.7
SWSLHD	>337.8	>320.0 and <=337.8	<=320.0
WNSWLHD	>369.7	>335.0 and <=369.7	<=335.0
WSLHD	>339.7	>321.1 and <=339.7	<=321.1
NSW	>316.1	>309.2 and <=316.1	<=309.2

The HAC targets have been developed using risk adjusted models on the 2024 NSW APDC data. The risk adjustors used are largely in the same dimensions as those used for IHACPA's service activity adjustors.

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](https://www.health.nsw.gov.au/Commission/Pages/default.aspx)

Related Policies/ Programs

Useable data available from

1 September 2015

Frequency of Reporting

Monthly

Time lag to available data

1 - 2 months

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:

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Australian Commission on Safety and Quality in Health Care's (ACSQHC)
HACs specification file for HACs V3.2 downloadable from
<https://www.safetyandquality.gov.au/publications-and-resources/resource-library/hospital-acquired-complications-hacs-list-specifications-version-32-13th-edn>

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HEALTH OUTCOME 2: Safe care is delivered across all settings

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	4.0
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 V3.2 downloadable from https://www.safetyandquality.gov.au/publications-and-resources/resource-library/hospital-acquired-complications-hacs-list-specifications-version-32-13th-edn for the numerator Neonatal Birth Trauma (HAC 16). The 13th Edition of ICD-10-AM coding should be used, which includes the following additional diagnosis codes: - Any of the listed ICD-10-AM 13th 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	

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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 13th 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 13th 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:

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LHD	Not Performing	Under Performing	Performing
CCLHD	>93.8	>80.1 and <=93.8	<=80.1
FWLHD	>306.1	>193.2 and <=306.1	<=193.2
HNELHD	>82.5	>74.7 and <=82.5	<=74.7
ISLHD	>95.1	>81.4 and <=95.1	<=81.4
MLHD	>100.1	>82.4 and <=100.1	<=82.4
MNCLHD	>102.8	>85.1 and <=102.8	<=85.1
NBMLHD	>89.4	>77.8 and <=89.4	<=77.8
NNSWLHD	>95.0	>80.2 and <=95.0	<=80.2
NSLHD	>90.1	>78.8 and <=90.1	<=78.8
SESLHD	>85.9	>76.5 and <=85.9	<=76.5
SLHD	>89.7	>78.5 and <=89.7	<=78.5
SNSWLHD	>104.8	>84.4 and <=104.8	<=84.4
SWSLHD	>81.4	>74.3 and <=81.4	<=74.3
WNSWLHD	>93.2	>79.6 and <=93.2	<=79.6
WSLHD	>81.5	>74.1 and <=81.5	<=74.1
NSW	>72.4	>69.7 and <=72.4	<=69.7

The HAC targets have been developed using risk adjusted models on the 2024 NSW APDC data. The risk adjustors used are largely in the same dimensions as those used for IHACPA's service activity adjustors.

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 - 2 months

Business owners

Contact - Policy

Chief Executive, Clinical Excellence Commission

Contact - Data

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

Representation

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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's (ACSQHC) HACs specification file for HACs V3.2 downloadable from https://www.safetyandquality.gov.au/publications-and-resources/resource-library/hospital-acquired-complications-hacs-list-specifications-version-32-13th-edn

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HEALTH OUTCOME 2: Safe care is delivered across all settings

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)
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	

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HEALTH OUTCOME 2: Safe care is delivered across all settings

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 - $\geq 1\%$ 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 <i>Aboriginal and Torres Strait Islander Origin - Recording of Information of Patients</i>.
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	

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HEALTH OUTCOME 2: Safe care is delivered across all settings

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

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HEALTH OUTCOME 2: Safe care is delivered across all settings

INDICATOR: SSA108, SSA109, SSA110

Overdue Planned (Elective) Surgery Patients (Number)

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

Shortened Title	Overdue Planned Surgeries
Service Agreement Type	Key Performance Indicator
NSW Health Strategic Outcome	2: Safe care is delivered across all settings
Status	Final
Version number	8.1
Scope	All ready-for-care cases currently on the NSW Health Waiting Times Collection for planned (elective) surgery.
Goal	To reduce waiting time for planned (elective) surgery in public hospitals.
Desired outcome	Better management of waiting lists to minimise waiting time for planned (elective) surgery.
Primary point of collection	Waiting List/Booking Clerk: Receipt of 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 planned (elective) surgical cases on the NSW Health Waiting Times Data Collection whose waiting time has exceeded the time recommended in the clinical urgency/priority category to which they have been assigned, where waiting time is measured from listing date to census date then subtract any waiting time, in which the clinical urgency/priority category is lower than the category at the census date, minus any days when the patient was Not Ready for Care (NRFC) (Noting: 1 is the highest priority, 3 is the lowest priority)
Numerator	
Numerator definition	• Number of Category 1 cases waiting >30 days Number of Category 1 planned (elective) surgical cases that have been waiting for admission greater than 30 days. • Number of Category 2 cases waiting >90 days Number of Category 2 planned (elective) surgical cases that have been waiting for admission greater than 90 days. • Number of Category 3 cases waiting >365 days Number of Category 3 planned (elective) surgical cases that have been waiting for admission greater than 365 days.

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HEALTH OUTCOME 2: Safe care is delivered across all settings

Numerator source	EDWARD
Numerator availability	Available Monthly
Denominator	Not applicable
Inclusions	Ready for Care cases (clinical urgency/priority categories 1, 2 and 3) on the planned (elective) surgical waiting list. For EDW, WL_BKG_PRIORITY_CLIN_PRIORITY_CD = '1', '2' and '3'. • Waitlist Service Event type 2 (Intended Admitted) or • Waitlist Service Event type 4 (non-admitted) and have a valid IPC.
Exclusions	• Not Ready for Care (NRFC) cases are excluded. For EDW, the NRFC status is identified through the presence of a current NRFC_REC_ID record. • Duplicate records (records with the same facility code, MRN, listing date, specialty, Indicator Procedure Code and census date). • IPC = '026'
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. 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.
Context	Planned (elective)surgery: The numbers of overdue cases represent a measure of the hospital's performance of planned (elective) surgical care. National Elective Surgery Targets Valid Indicator Procedure Codes are uploaded to HIRD with the current year's Data Supplement.
Related Policies/ Programs	• PD2022_001 Planned (elective)Surgery Access Policy • Agency for Clinical Innovation: Surgical Care Network and Anaesthesia and Perioperative Care Network • Operating Theatre Efficiency Guidelines: A guide to the efficient management of operating theatres in New South Wales hospitals

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<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 10 th 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 Elective surgery waiting list episode—waiting time at a census date, total days N[NNN] <u>Elective surgery waiting list episode—waiting time at a census date, total days N[NNN]</u>

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HEALTH OUTCOME 2: Safe care is delivered across all settings

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	3.7
Scope	All patient admissions to public facilities in peer groups A1 – D1
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, Patient Administration 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 (Discharge Mode Codes = '6','7' & '12')
Exclusions	Transfers in from other hospitals.

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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

Numerator and Denominator Inclusions

- Each index/initial admission can have at most one readmission
- Readmission can be an index/initial admission to another readmission.

Numerator and Denominator 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 D1.
- CL_ID is missing
- JHFMHN and NSW

Targets

Reduction from previous year

- Performing: Reduction on previous year
- Underperforming: No change on 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 disaggregation, inclusion in the numerator and denominator depends on the status recorded at the end of each admission (SE_END_DTTM). 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.

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- 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>

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HEALTH OUTCOME 2: Safe care is delivered across all settings

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	1.5
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 (dependent on source system)
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 EX057 extract and aggregate collection (dependent on source systems)
Numerator availability	Availability is determined by the EDWARD load and refresh schedule. Quarterly historical data available since the statewide collection commenced in January 2008. Monthly data available from 1 July 2025.
Denominator	
Denominator definition	Number of bed days in acute mental health units within the reporting period
Denominator source	EDWARD
Denominator availability	Availability is determined by the EDWARD load and refresh schedule. Quarterly historical data available since the statewide collection commenced in January 2008. Monthly data available from 1 July 2025.
Inclusions	All acute mental health units

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HEALTH OUTCOME 2: Safe care is delivered across all settings

Exclusions	Leave days are excluded from the denominator
Targets	Target: <5.1 - Performing: <5.1 - Not performing: ≥5.1 - Under performing: N/A
Context	NSW Health organisations must provide Official Visitors access to all records relating to seclusion and restraint, including monthly summary information. Each year state and territory governments supply data to the AIHW under the Mental health Seclusion and Restraint National Best Endeavours Data Set (SECREST NBEDS) agreement. BHI also report routinely on seclusion and restraint practices in NSW specialised acute mental health units
Related Policies/ Programs	- PD 2020_004 Seclusion and Restraint in NSW Health Settings - Review of seclusion, restraint and observation of consumers with a mental illness in NSW Health facilities (2017) - Mental Health Safety and Quality in NSW: A plan to implement recommendations of the Review of seclusion, restraint and observation of consumers with a mental illness in NSW Health facilities (2018) - Clinical Excellence Commission Mental Health Patient Safety Program
Useable data available from	Quarterly historical data available since the statewide collection commenced in January 2008. Monthly data available from 1 July 2025.
Frequency of Reporting	Monthly
Time lag to available data	Reporting is required by the 10th calendar day of each month for previous month. .
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

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Related National Indicator

METEOR ID 791461 KPIs for Australian Mental Health Services: PI 15J –
Seclusion rate, 2025

<https://meteor.aihw.gov.au/content/791461>

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HEALTH OUTCOME 2: Safe care is delivered across all settings

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	1.4
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 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 (dependent on source system)
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 EX057 extract and aggregate collection (dependent on source systems)
Numerator availability	Availability is determined by the EDWARD load and refresh schedule. Quarterly historical data available since the statewide collection commenced in January 2008. Monthly data available from 1 July 2025.
Denominator	
Denominator definition	Number of seclusion episodes in acute mental health units within the reporting period
Denominator source	Seclusion Collection EX057 extract and aggregate collection (dependent on source systems)
Denominator availability	Availability is determined by the EDWARD load and refresh schedule. Quarterly historical data available since the statewide collection commenced in January 2008. Monthly data available from 1 July 2025.
Inclusions	All acute mental health units

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HEALTH OUTCOME 2: Safe care is delivered across all settings

Exclusions	N/A
Targets	Target < 4.0 hours - Performing: < 4.0 hours - Under performing: ≥ 4.0 hours and ≤ 5.5 hours - Not performing: > 5.5 hours
Context	NSW Health organisations must provide Official Visitors access to all records relating to seclusion and restraint, including monthly summary information. Each year state and territory governments supply data to the AIHW under the Mental health Seclusion and Restraint National Best Endeavours Data Set (SECREST NBEDS) agreement. BHI also report routinely on seclusion and restraint practices in NSW specialised acute mental health units
Related Policies/ Programs	- PD 2020_004 Seclusion and Restraint in NSW Health Settings - Review of seclusion, restraint and observation of consumers with a mental illness in NSW Health facilities (2017) - Mental Health Safety and Quality in NSW: A plan to implement recommendations of the Review of seclusion, restraint and observation of consumers with a mental illness in NSW Health facilities (2018) - Clinical Excellence Commission Mental Health Patient Safety Program
Useable data available from	Quarterly historical data available since the statewide collection commenced in January 2008. Monthly data available from 1 July 2025.
Frequency of Reporting	Monthly
Time lag to available data	Reporting is required by the 10th calendar day of each month for previous month.
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 http://meteor.aihw.gov.au/content/index.phtml/itemId/573910

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HEALTH OUTCOME 2: Safe care is delivered across all settings

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	Monitoring Measure
NSW Health Strategic Outcome	2: Safe care is delivered across all settings
Status	Final
Version number	1.6
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. Local seclusion registers
Data Collection Source/System	Inpatient data; Patient Administration Systems, 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 <u>(dependent on source system)</u>
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 EX057 extract and aggregate collection (dependent on source systems)
Numerator availability	Availability is determined by the EDWARD load and refresh schedule. Quarterly historical data available since the statewide collection commenced in January 2008. Monthly data available from 1 July 2025.
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	Availability is determined by the EDWARD load and refresh schedule. Quarterly historical data available since the statewide collection commenced in January 2008. Monthly data available from 1 July 2025.

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HEALTH OUTCOME 2: Safe care is delivered across all settings

Inclusions	All acute mental health units
Exclusions	JHFMHN performance thresholds are managed by JHFMHN and are not included
Targets	Target: <4.1% - Performing: <4.1% - Not performing: >5.3% - Under performing: ≥4.1% and ≤5.3%
Context	NSW Health organisations must provide Official Visitors access to all records relating to seclusion and restraint, including monthly summary information. Each year state and territory governments supply data to the AIHW under the Mental health Seclusion and Restraint National Best Endeavours Data Set (SECREST NBEDS) agreement. BHI also report routinely on seclusion and restraint practices in NSW specialised acute mental health units
Related Policies/ Programs	- PD 2020_004 Seclusion and Restraint in NSW Health Settings - Review of seclusion, restraint and observation of consumers with a mental illness in NSW Health facilities (2017) - Mental Health Safety and Quality in NSW: A plan to implement recommendations of the Review of seclusion, restraint and observation of consumers with a mental illness in NSW Health facilities (2018) - Clinical Excellence Commission Mental Health Patient Safety Program
Useable data available from	Quarterly historical data available since the statewide collection commenced in January 2008. Monthly data available from 1 July 2025.
Frequency of Reporting	Monthly
Time lag to available data	Reporting is required by the 10th calendar day of each month for previous month
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

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HEALTH OUTCOME 2: Safe care is delivered across all settings

Data domain

Date effective

2015

Related National Indicator

Meteor ID 572980 Specialised mental health service—number of episodes with seclusion, total episodes
<http://meteor.aihw.gov.au/content/index.phtml/itemId/572980>

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HEALTH OUTCOME 2: Safe care is delivered across all settings

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 net cost Community Care
Service Agreement Type	Key Performance Indicator
NSW Health Strategic Outcome	2: Safe care is delivered across all settings
Status	Final
Version number	3.3
Scope	Mental Health Services
Goal	Improve the effectiveness of 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, eMR source systems.
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) Client Area Unique Patient Identifier (AUID) Client Identifier (CLIENT_ID)
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. Notes that • Aboriginal persons include people who identify as Aboriginal and/or Torres Strait Islander • A person needs to be accurately identified in both inpatient and ambulatory data collections to enable the EUID, AUID or client ID 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.
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

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HEALTH OUTCOME 2: Safe care is delivered across all settings

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 are linked using (i) EUID, when available (ii) AUID, if EUID is not available (iii) CLIENT_ID, if neither EUID nor AUID is available
Numerator availability	Availability is determined by the EDWARD load and refresh schedule

Denominator

Denominator definition	Number of overnight separations from a NSW acute psychiatric inpatient unit(s) occurring within the reference period.
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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	Availability is determined by the EDWARD load and refresh schedule.

Inclusions

Includes only overnight separations where the last ward is a designated acute mental health unit.

Uses only separations with EUID, AUID or CLIENT_ID to link the separation of inpatients from acute mental health units with contacts recorded in the community. 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 an intervention code for Electroconvulsive Therapy (ECT) or Trans-cranial Magnetic Stimulation (TMS) 14217-00, 14217-01, 14220-00, 14220-01 is recorded
- separations where the mode of separation is:
 - death;
 - transfer to another acute or psychiatric inpatient hospital;
 - service category change.
- 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
- Community contacts where the client does not directly participate

Targets

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

- Performing: $\geq 75\%$
- Under Performing: $\geq 60\%$ and $< 75\%$
- Not Performing: $< 60\%$

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HEALTH OUTCOME 2: Safe care is delivered across all settings

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. Some separations are appropriately followed up by GP, private psychiatrist or contracted NGO and will not be captured within this indicator. Post discharge community care is a national KPI and is routinely reported by AIHW.
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	July 2022
Frequency of Reporting	Monthly, annual/financial
Time lag to available data	Time lags are determined by data loading schedules which can vary by LHD/SHN Community mental health data can be lagged up to one month
Business owners	Executive Director, System Information and Analytics Branch
Contact - Policy	Executive Director, Mental Health Branch Executive Director, Centre for Aboriginal Health
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	
Date effective	2005/2006
Related National Indicator	METEOR ID 791397 KPIs for Australian Mental Health Services: PI 02J – Mental health readmissions to hospital, 2025 https://meteor.aihw.gov.au/content/791397

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HEALTH OUTCOME 2: Safe care is delivered across all settings

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	4.2
Scope	Mental health services
Goal	To reduce the number of acute public sector mental health readmissions to same or another public sector acute mental health unit within 28 days of discharge.
Desired outcome	Improved mental health and well-being through effective inpatient care and adequate and proper post-discharge follow up in the community.
Primary point of collection	Administrative and clinical staff at designated facilities (including stand-alone psychiatric hospitals) with mental health units/beds.
Data Collection Source/System	Inpatient data: Patient Administration System (PAS).
Primary data source for analysis	Enterprise Data Warehouse (EDWARD) - Local Reporting Solution (LRS) Admitted Patient Data Collection Enterprise Unique Person Identifier (EUID) Client Area Unique Patient Identifier (AUID) Client Identifier (CLIENT_ID)
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 Aboriginal 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 Aboriginal status, where SE_TYP_CD = '2'. Aboriginal status = CL_INDGNS_STUS_CD.
Numerator source	Admitted Patient Data Collection (EDWARD LRS). Readmission between facilities detected by (i) EUID, when available (ii) AUID, if EUID is not available (iii) CLIENT_ID, if neither EUID nor AUID is available

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HEALTH OUTCOME 2: Safe care is delivered across all settings

Numerator availability	Availability is determined by the EDWARD load and refresh schedule. 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	Availability is determined by the EDWARD load and refresh schedule.
Inclusions	Separations following overnight acute care 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.
Exclusions	• Separations where “mode of separation” = death, transfer or service category 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 Transcranial Magnetic Stimulation (TMS) 14217-00, 14217-01, 14220-00, 14220-01 is recorded. This exclusion applies to each separation in the denominator and any subsequent readmission. • JHFMHN services
Target	• Performing: $\leq 13\%$ • Under Performing: $> 13\%$ and $\leq 20\%$ • Not Performing: $> 20\%$
Context	The Australian national mental health KPI set includes the 28 Day Readmission indicator in the domains of effectiveness and continuity.
Related Policies/ Programs	The NSW Health Policy Directive <i>Discharge Planning and Transfer of Care for Consumers of NSW Health Mental Health Services</i> (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	July 2022
Frequency of Reporting	Monthly: Health System Performance (HSP) report.

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HEALTH OUTCOME 2: Safe care is delivered across all settings

Annual/Financial: NSW Health Annual Report, National Mental Health KPIs for Australian Public Mental Health Services.

Time lag to available data Time lags are determined by data loading schedules which can vary by LHD/SHN.

Business owners Executive Director, System Information and Analytics Branch

Contact – Policy Executive Director, Mental Health Branch

Executive Director, Centre for Aboriginal Health

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

Date effective 2002/2003

Related National Indicator KPIs for Australian Public Mental Health Services: PI 02J – Mental health readmissions to hospital, 2024
<https://meteor.aihw.gov.au/content/783639> Meteor ID: 783639

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HEALTH OUTCOME 2: Safe care is delivered across all settings

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	Monitoring Measure
NSW Health Strategic Outcome	2: Safe care is delivered across all settings
Status	Final
Version number	1.8
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 web platform) 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 web platform)
Numerator availability	Quarterly historical data available since the statewide collection commenced in July 2016. Monthly data available from 1 July 2025.
Denominator	
Denominator definition	Number of bed days in acute mental health units within the reporting period
Denominator source	EDWARD LRS
Denominator availability	Availability is determined by the EDWARD load and refresh schedule. Quarterly historical data available since the statewide collection commenced in July 2016. Monthly data available from 1 July 2025

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HEALTH OUTCOME 2: Safe care is delivered across all settings

Inclusions	All acute mental health inpatient units
Exclusions	Leave days are excluded from the denominator JHFMHN services
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	Quarterly historical data available since the statewide collection commenced in July 2016. Monthly data available from 1 July 2025.
Frequency of Reporting	Monthly
Time lag to available data	Reporting is required by the 10th calendar day of each month for previous month.
Business owners	Executive Direction, System Information and Analytics Branch
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

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HEALTH OUTCOME 2: Safe care is delivered across all settings

Related National Indicator

N/A

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HEALTH OUTCOME 2: Safe care is delivered across all settings

INDICATOR: KPI2503	Hospital in the Home: Direct Admissions (%)
Shortened Title	HITH Direct Admissions
Service Agreement Type	Key Performance Indicator
NSW Health Strategic Outcome	2: Safe care is delivered across all settings
Status	Final
Version number	1.1
Scope	All overnight acute care (Service Category = 1) admitted patient episodes involving HITH service
Goal	To increase the scope of clinical conditions that can be managed in HITH without requiring an admission to an overnight hospital bed.
Desired outcome	Increase the number of referrals to a HITH service, where the patient is not admitted to an overnight bed type prior to commencement of the HITH service.
Primary point of collection	Hospital in the Home services – Patient Administration System
Data Collection Source/System	Admitted patient data collection
Primary data source for analysis	Enterprise Data Warehouse (EDWARD) - Local Reporting Solution (LRS)
Indicator definition	The proportion of acute overnight separations from a HITH service where the patient has not been admitted to an overnight bed type prior to admission to the HITH service.
Numerator	
Numerator definition	All completed acute overnight episodes where bed type 25 is the first overnight bed type in episode sequence and Service Event Type Code = '2'.
Numerator source	EDWARD – Admitted Patient Data Collection
Numerator availability	Available
Denominator	
Denominator definition	All completed acute overnight episodes with bed type 25
Denominator source	EDWARD – Admitted Patient Data Collection
Denominator availability	Available
Inclusions	All facilities with admitted patient events (Service Event Type Code = '2') with a Bed Type '25' at any time during an admitted patient service event.
Exclusions	Justice Health and Forensic Mental Health Network Admitted patient services events segments or service location with ED beds, EDSSU, and sameday beds including bed types

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HEALTH OUTCOME 2: Safe care is delivered across all settings

17 ED - Level 3 and Above

58 – ED - Level 1 or 2

59 – EDSSU

68 - Mobile Service

71 - Same Day Chemotherapy

72 - Sleep Disorder (< 24 hour care)

73 - Same Day Mental Health

74 - Same Day Drug and Alcohol

75 - Same Day, not elsewhere classified

76 – Transit Lounge

80 - Same Day Medical

81 - Same Day Surgical

82 - Extended Short Stay Surgical (< 24 hrs)

If the bed type is blank or missing it will be classified as an overnight bed type.

Targets

Target $\geq 60\%$

- Performing $\geq 60\%$
- Under performing $\geq 50\%$ and $< 60\%$
- Not performing $< 50\%$

Note: 60% of all HITH admissions (virtual and face-to-face) should be direct referrals

Comment

A direct admission to HITH is defined as HITH being the first overnight bed type in the episode. Direct admissions include those referred from ED and EDSSU, primary care, aged care outreach services and other community-based healthcare services. Only those that have been admitted to another inpatient ward with an overnight bed type prior to coming to HITH would not count as a direct admission

- Prior episodes are identified on the same day or the day before, using the discharge and admission dates. Prior episodes are checked based on the Encounter identifier, EUID, and AUID.
- Where transfers are indicated from another facility (Admission Mode Code is 1) and when no prior episodes are found, the admission is considered the first.
- When multiple HITH Services occur within the same episode, including where ED is involved after initial admission, only the first HITH Service is considered.
- Overnight is defined based on the intention of a bed type, not based on duration or occupancy of a bed.
- All admissions coming (referred) from ED are considered direct admissions.
- Reporting occurs for the day when the episode has ended, not when the (last) HITH Service in the episode has ended

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HEALTH OUTCOME 2: Safe care is delivered across all settings

Context	As part of the 2024 NSW ED Relief Package \$31.4 million over four years will be invested to uplift HITH services. NSW has secured \$56.9 million from the Commonwealth over four years (2024-25 to 2027-28) to implement a Virtual Specialist Geriatric Care (VSGC) model. This model will be embedded within existing Hospital in the Home (HITH) services and enable older people access to specialist medical care.
Related Policies/ Programs	Hospital in the Home
Useable data available from	July 2022
Frequency of Reporting	Monthly
Time lag to available data	10 th day of each month for previous month
Business owners	
Contact - Policy	Director, Connected Care, System Performance Support
Contact - Data	Executive Director, System Information and Analytics 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	1 July 2025
Related National Indicator	
Components	Hospital in the home care Meteor ID: 327308 http://meteor.aihw.gov.au/content/index.phtml/itemId/327308

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HEALTH OUTCOME 2: Safe care is delivered across all settings

INDICATOR: KPI2525

Hospital in the Home: Activity Growth (%)

Shortened Title	HITH Growth
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	All admitted patients of overnight acute care involving HITH service.
Goal	To increase the scope of clinical conditions and that can be managed in HITH setting.
Desired outcome	Increase the number of episodes with HITH service from previous year.
Primary point of collection	Hospital in the Home services
Data Collection Source/System	Admitted Patient Data Collection
Primary data source for analysis	Enterprise Data Warehouse (EDWARD) - Local Reporting Solution (LRS)
Indicator definition	The percentage increase of acute overnight episodes of care with all or part of the admitted patient service in HITH (bed type 25) the current financial year to date (FYTD) compared to the same period in the previous FYTD.
Numerator	
Numerator definition	Growth in the FYTD number of acute overnight episodes of care with HITH (bed type 25) compared to the same period of FYTD
Numerator source	EDWARD – Admitted Patient Data Collection
Numerator availability	The availability of the data sources from which the numerator can be extracted and any issues that may exist in accessing the data. e.g. availability may be delayed; problems exist with data quality.
Denominator	
Denominator definition	The number of overnight episodes of care with HITH (bed type 25 in of FYTD of the previous financial year.
Denominator source	EDWARD – Admitted Patient Data Collection

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HEALTH OUTCOME 2: Safe care is delivered across all settings

Denominator availability	The availability of the data sources from which the numerator can be extracted (available, not available, available, do problems exist with data quality, comparability, available from which year onwards)
Inclusions	All Facilities with admitted patient service events (SE_TYPE_CD = '2') with a Bed Type '25' at any time during an admitted patient service event are included in both the numerator and denominator.
Exclusions	Justice and Forensic Mental Health Network
Targets	Target 15% - Performing $\geq 15\%$ - Under performing $\geq 5\%$ and $< 15\%$ - Not performing $< 5\%$
Context	As part of the 2024 NSW ED Relief Package \$31.4 million over four years will be invested to uplift HITH services. NSW has secured \$56.9 million from the Commonwealth over four years (2024-25 to 207-28) to implement a Virtual Specialist Geriatric Care (VSGC) model. This model will be embedded within existing Hospital in the Home (HITH) services and enable older people access to specialist medical care.
Related Policies/ Programs	Hospital in the Home
Useable data available from	The date since when data became available and can be reliably used for comparison purposes
Frequency of Reporting	Monthly
Time lag to available data	10th day of each month for the previous month
Business owners	
Contact - Policy	Director, Connected Care, System Performance Support
Contact - Data	Executive Director, System Information and Analytics
Representation	
Data type	Numeric
Form	Number, expressed as a percentage
Representational layout	NNN.NN
Minimum size	3
Maximum size	6
Data domain	
Date effective	1 July 2025

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HEALTH OUTCOME 2: Safe care is delivered across all settings

Related National Indicator

Components

Hospital in the home care

Meteor ID:327308

<https://meteor.aihw.gov.au/content/327308>

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HEALTH OUTCOME 2: Safe care is delivered across all settings

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 waiting lists for public dental services)
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	2.0
Scope	Patients on non-admitted dental 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 care.
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 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 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 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 waiting lists.
Exclusions	Patients waiting for specialist dental treatment Patients waiting for general anaesthetic dental treatment
Targets	Target 98% of patients within recommended waiting time for their urgency category.

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HEALTH OUTCOME 2: Safe care is delivered across all settings

- Performing: $\geq 98\%$
- Underperforming: $\geq 95\%$ and $< 98\%$
- Not performing: $< 95\%$.

Related Policies/ Programs	Priority Oral Health Program and Waiting List Management Policy
Useable data available from	2018-19
Frequency of Reporting	Weekly
Time lag to available data	1-2 days
Business owners	Centre for Oral Health Strategy
Contact - Policy	Manager, Oral Health Information Systems
Contact - Data	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

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HEALTH OUTCOME 2: Safe care is delivered across all settings

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

2.2

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 SUB_EVNT_FIRST_PHYSIO_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.

Numerator

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HEALTH OUTCOME 2: Safe care is delivered across all settings

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 records with same facility code, AUID (if AUID missing – use MRN), arrival date, arrival time and birth date (EDW: HEALTH_ORG, CL_ID, CL_ARRIVAL_DTTM and CL_DOB). Retain single row with the latest SOURCE_MODIFIED DTTM. • Records where CL_ID (AUID and MRN) are missing • Duplicate records with same facility and SRV_ENC_REC_ID. Retain single row by selecting the record with the latest SOURCE_MODIFIED_DTTM)
Targets	Performing: • Triage Category 2 $\geq 80\%$ • Triage Category 3 $\geq 75\%$ Underperforming: • Triage Category 2 $\geq 70\%$ - $<80\%$ • Triage Category 3 $\geq 65\%$ - $<75\%$ 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

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HEALTH OUTCOME 2: Safe care is delivered across all settings

	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 10 th 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

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HEALTH OUTCOME 2: Safe care is delivered across all settings

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>

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HEALTH OUTCOME 2: Safe care is delivered across all settings

INDICATOR: KPI2506

Average Length of Stay of Overnight Acute Episodes of Care

Shortened Title	Average Length of Stay
Service Agreement Type	Key Performance Indicator
NSW Health Strategic Outcome	2: Provide World-Class Clinical Care Where Patient Safety Is First
Status	Final
Version number	1.0
Scope	Acute overnight admitted patients, all public hospitals
Goal	Reduce acute average overnight length of stay
Desired outcome	Release inpatient bed capacity to facilitate improved patient access and relieve pressure on NSW emergency departments
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 average number of patient days for acute admitted patient episodes during the reporting period. Patients admitted and separated on the same day are excluded. Average Length of Stay (ALOS) = Sum of service events length of stay / Number of service events The Episode of care (Length of stay) is measured from the admitted service event start date to admitted service event end date excluding leave days.
Numerator	
Numerator definition	Sum of all acute patient's episode length of stay in the reporting period. Episode of care, length_of_stay is measured from the admitted service event start date to the admitted service event end date excluding leave days • Where length of stay of a patient is measured in days • Total collaborative/contracted days are included in the length of stay.
Numerator source	EDWARD

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HEALTH OUTCOME 2: Safe care is delivered across all settings

FACT_AP_SE, COUNT_TOTAL_SE_BED_DAY_COUNT

Numerator availability	Available Daily
Denominator	
Denominator definition	Total number of admitted patient service events (SE_TYPE_CD = '2' Admitted patient) with separation dates in the reporting period
Denominator source	EDWARD
Denominator availability	Available Daily
Inclusions	Acute Care Type (Admitted Patient) National Standard Code = 1
Exclusions	- Same Day episodes of care - Any other care type than acute - Leave days are not counted towards LOS - Ongoing episodes of care withing the reporting period (no service event end date)
Targets	- Target in the 26/27 financial year, reduce Acute Overnight ALOS by ≥ 0.4 days from 2023/24 baseline or reduce to January to June 2019 whichever is greater. 2026/2027 - Performing: ≥ 0.4 day reduction in Acute Overnight ALOS in 2026/27 or reduce to January to June 2019 with ever is greater. - Under Performing: N/A - Not Performing: $>0 - < 0.4$ reduction in Acute Overnight ALOS in 2026/27
Context	Average length of stay in hospital is one of the indicators of the health and long-term care strand of the Open Method of Coordination on Social Inclusion and Social Protection. Data are not age-standardized
Related Policies/ Programs	2025-26 ED Relief Package
Useable data available from	2021/22
Frequency of Reporting	Monthly
Time lag to available data	1-2 Days
Business owners	
Contact - Policy	Executive Director, System Performance Support Branch
Contact - Data	Executive Director, System Information and Analytics
Representation	

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HEALTH OUTCOME 2: Safe care is delivered across all settings

Data type	Numeric
Form	Numeric
Representational layout	NNN.NN
Minimum size	1
Maximum size	6
Data domain	
Date effective	01/07/2025
Related National Indicator	https://meteor.aihw.gov.au/content/329889

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HEALTH OUTCOME 2: Safe care is delivered across all settings

INDICATOR: KPI2504, KPI2505	Timely psychosocial and medical forensic responses to sexual assault or abuse - % of victims receiving a timely responses
Previous ID IM21-001	Timely responses - Metropolitan (KPI2504) Timely responses - Rural/Regional (KPI2505)
Shortened Title	Timely response to sexual assault or abuse
Service Agreement Type	Key Performance Indicator
Framework Strategy	Strategy 2: Safe care is delivered across all settings
Framework Objective	Objective 2.1: Deliver safe, high quality reliable care for patients in hospital and other settings
Status	Final
Version number	2.0
Scope	All victims of sexual assault or abuse receiving service responses from NSW Health Services
Goal	Ensure that NSW Health provide timely 24 hour psychosocial, medical and forensic crisis responses for both adults and children.
Desired outcome	Victims of sexual assault or abuse are provided a timely integrated psychosocial and medical and forensic crisis response.
Primary point of collection	NSW Health Sexual Assault or Violence Abuse & Neglect Services
Data Collection Source/System	Cerner/eMR, CHIME
Primary data source for analysis	- VAN Service Event Form Extract – Submission Version. - Aggregated report (HNELHD)
Indicator definition	The percentage of victims of sexual assault or abuse receiving a timely* crisis response. *Timely is defined as within 1 hour of request for a crisis response; and within 2 hours of request for a medical examination or a medical and forensic examination.
Numerator	

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HEALTH OUTCOME 2: Safe care is delivered across all settings

Numerator definition The number of victims of sexual assault or abuse receiving crisis management/support, or medical examinations, or medical and forensic examinations from an NSW Health Service in a timely* manner during the reporting period.

*Timely is defined as within 1 hour of request for a crisis response; and within 2 hours of request for a medical examination or a medical and forensic examination.

Numerator source Cerner/eMR, CHIME

Numerator availability Quarterly

Denominator

Denominator definition The number of victims of sexual assault or abuse receiving crisis management/support, or medical examinations, or medical and forensic examinations from a NSW Health Service during the reporting period.

Denominator source Cerner/eMR, CHIME

Denominator availability Quarterly

Inclusions

The following LHDs are expected to have the VAN Service Event Form Extract: Central Coast, Far West, Illawarra Shoalhaven, Mid North Coast, Murrumbidgee, Nepean Blue Mountains, Northern NSW, Northern Sydney, South Eastern Sydney, Southern NSW, Western NSW, Western Sydney, Sydney, South Western Sydney, Sydney Children's Hospitals Network.

The following LHDs/SCHN can report aggregated data where this is available from source systems, and the VAN Service Event Form Extract is unavailable: Hunter New England.

Exclusions

- St. Vincent's Health Network
- Justice Health and Forensic Mental Health Network
- Medical or medical and forensic examinations exclude those performed using early evidence kits.

Targets

Target

Rural/Regional	Metropolitan
Performing: $\geq 80\%$	Performing: $\geq 80\%$
Under performing: $>60\% < 80\%$	Under performing: $\geq 70\% < 80\%$
Not performing: $< 60\%$	Not performing: $< 70\%$
Far West - FWLHD	Central Coast - CCLHD
Hunter New England - HNELHD	Nepean Blue Mountains - NBMLHD
Illawarra Shoalhaven - ISLHD	Northern Sydney - NSLHD
Mid North Coast - MNCLHD	South Eastern Sydney - SESLHD
Murrumbidgee - MLHD	South Western Sydney - SWSLHD

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HEALTH OUTCOME 2: Safe care is delivered across all settings

Northern NSW - NNSWLHD	Sydney - SLHD
Southern NSW - SNSWLHD	Sydney Children's Hospital Network - SCHN
Western NSW - WNSWLHD	Western Sydney - WSLHD

Context

NSW Health has a network of specialist Sexual Assault Services (SAS) and specialist Violence Abuse & Neglect (VAN) Services delivered by local health districts and specialty health networks. Every district has a SAS or VAN Service that operates 24 hours a day, seven days a week. SAS and VAN Services provide responses to clients/patients and their families/significant others, professionals and communities, and are responsible for ensuring that 24/7 coverage is provided across the District.

Approximately \$53 million over four years was committed under the 2023 State Budget for the Medical and Forensic Workforce Plan. The funding will establish an additional 48 full-time equivalent staff across the state, with the overarching objective of improving the provision of care to adult and child victims/survivors of sexual assault and abuse. This KPI will support the monitoring of the implementation of this funding.

There are different definitions of underperforming for metropolitan and rural / regional Districts. This difference recognises the impact of distance and travel on timeliness of responses in rural and regional areas.

Related Policies/ Programs

Responding to Sexual Assault (adult and child) Policy and Procedures (PD2020_006)

Useable data available from

July 2021

Frequency of Reporting

Quarterly

Time lag to available data

2 weeks

Business owners

Government Relations Branch

Contact - Policy

Director, Prevention and Response to Violence, Abuse and Neglect Unit

Contact - Data

Senior Analyst, Data Management (PARVAN)

Representation

Data type

Numeric

Form

Number, presented as a percentage (%)

Representational layout

NNN.N

Minimum size

3

Maximum size

4

Data domain

N/A

Date effective

July 2021 as an improvement measure
July 2024 as a shadow KPI

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HEALTH OUTCOME 2: Safe care is delivered across all settings

Related National Indicator	N/A
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2026-27 Service Performance Agreements
HEALTH OUTCOME 3: People are healthy and well

HEALTH STRATEGIC OUTCOME 3: People are healthy and well

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	

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HEALTH OUTCOME 3: People are healthy and well

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

2026-27 Service Performance Agreements
HEALTH OUTCOME 3: People are healthy and well

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

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HEALTH OUTCOME 3: People are healthy and well

INDICATOR: KPI21-02

NSW Health First 2000 Days Implementation Strategy - Delivery of the 1-4 week health and development check (%)

All babies who receive a 1-4 week health check (%) (KPI21-02)

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

1.3

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 and development 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 and development 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 2)
Legacy – Non-admitted Patient Data Collection
or interim summary report from source system

Indicator definition

The percentage of families with a new baby who receive a 1–4-week health and development check by a Child and Family Health Nurse within 4.3 weeks of the baby's birth.

Numerator

Numerator definition

Number of families* who receive a 1–4-week health and development check by a Child and Family Health Nurse within 4.3 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 4.3 weeks of the birth of the child.

Note: The Non-admitted Patient Data Collection does not support applying exclusions and therefore a manual process is being explored to assist with applying the nominated 'Exclusion' (i.e. declines).

Numerator source

EDWARD or interim summary report from source system

Numerator availability

Available monthly

Denominator

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HEALTH OUTCOME 3: People are healthy and well

Denominator definition	Number of live births in NSW, plus estimate of babies born to NSW residents who gave birth interstate as described below. An escalation factor is applied to the denominator to estimate the number of interstate births for the following Districts: 1. Far West NSW: 21% 2. Murrumbidgee: 19% 3. Northern NSW: 12% 4. Southern NSW: 34%
Denominator source	Perinatal Data Collection Escalation factors derived from Australian Institute of Health and Welfare (AIHW) data (National Perinatal Data Collection) on interstate births by District (based on interstate births data from calendar year 2023).
Denominator availability	Perinatal Data Collection available six-monthly. Denominator data is available one calendar year prior to the reported period (e.g. a reporting period of Oct to Dec 2024 will use denominator data from Oct to Dec 2023).
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

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HEALTH OUTCOME 3: People are healthy and well

- 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

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 and development 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 and development 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 and development 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 and development checks.

Indicators are reported to the Chief Executives Performance Review, Local Health District Performance Agreements and NSW Health Annual Report

Related Policies/ Programs

- First 2000 Days Framework (PD2019_008); First 2000 Days Implementation Strategy 2020-25
- 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

Financial year 2020/21

Frequency of Reporting

Quarterly

Time lag to available data

Data available 3 months post end of reporting Quarter

2026-27 Service Performance Agreements
HEALTH OUTCOME 3: People are healthy and well

Business owners

Healthy Families and Communities Branch

Contact - Policy

Director, Child, Youth and Families

Contact - Data

Director, Child, Youth and Families

Representation

Data type

Numeric

Form

Number, presented as a percentage (%)

Representational layout

NNN.NN

Minimum size

1

Maximum size

6

Data domain

Data effective

Related National Indicator

N/A

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HEALTH OUTCOME 3: People are healthy and well

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.

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	• 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: $\geq 70\%$ • Under Performing: $\geq 60\%$ 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

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HEALTH OUTCOME 3: People are healthy and well

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	

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INDICATOR: SSA140, SSA140a, SSA140b

Previous IDs: 8A1, 0037 SSA126, SSA127, SSA128, SSA129, SSA130, SSA131

Breast Screen Participation Rates:

All women aged 50-74 (%) (SSA140)

Aboriginal women aged 50-74 (%) (SSA140a)

Culturally and Linguistically Diverse (CALD) women aged 50-74 (%) (SSA140b)

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

2.0

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

≥55% of women aged 50-74 years participate in screening in the most recent 24-month period.

≥50% of Aboriginal women aged 50-74 years participate in screening in the most recent 24-month period.

≥50% of CALD 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 and demographic groups who were screened by BreastScreen NSW during the most recent 24-month period

Numerator

Numerator definition

All women SSA140

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.

Aboriginal women SSA140a

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Number of individual Aboriginal 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.

CALD women SSA140b

Number of individual CALD 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 All women SSA140

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

Aboriginal women SSA140a

The population for all Aboriginal women is the weighted average of the projected population for Aboriginal women aged 50-74 years for the two reporting years as at 30 June

CALD women SSA140b

The population for all CALD women is the weighted average of the projected population for CALD 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.)

Targets

Women aged 50-74 years:

- Performing $\geq 55\%$

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- Underperforming $\geq 50\%$ and $< 55\%$
- Not performing $< 50\%$

Aboriginal and CALD Women aged 50-74 years:

- Performing $\geq 50\%$
- Underperforming $\geq 45\%$ 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	2017
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

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HEALTH OUTCOME 3: People are healthy and well

INDICATOR: KPI2509

Health Outcomes Action Plan – Achievement of Actions (%)

Shortened Title	Health Outcomes Action Plan achievement of actions
Service Agreement Type	Key Performance Indicator.
NSW Health Strategic Outcome	3 People are healthy and well
Status	Final
Version number	1.1
Scope	NSW Health Local Health Districts, Sydney Children's Hospitals Network, St Vincent's Health Network and Justice Health and Forensic Mental Health Network
Goal	Health entities have a long-term action plan in place to improve outcomes for people living in NSW in relation to • Physical activity • Prevalence of smoking and e-cigarette (vaping) use in adults • Healthy birthweight • Prevalence of diabetes in adults • Immunisation rates in adolescents and adults
Desired outcome	Prevent disease and improve wellbeing
Primary point of collection	Manual reporting to the Office of the Deputy Secretary Population and Public Health and Chief Health Officer
Data Collection Source/System	As above
Primary data source for analysis	As above
Indicator definition	The organisation delivers actions as agreed in the 4-year Health Outcomes Action Plan
Numerator	
Numerator definition	Number of actions completed
Numerator source	Reporting via Office of Approved by the Chief Health Officer
Numerator availability	New
Denominator	
Denominator definition	Total number of actions agreed to be completed in 2026/27

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Denominator source	Reporting via Office of the Deputy Secretary Population and Public Health and Chief Health Officer
Denominator availability	New
Inclusions	NSW Health Local Health Districts and Sydney Children's Hospitals, St Vincent's Health and Justice Health and Forensic Mental Health Networks
Exclusions	NSW Ambulance
Targets	Target $\geq 90\%$ of agreed actions completed for the financial year • Performing $\geq 90\%$ • Underperforming $\geq 80\%$ and $< 90\%$ • Not performing $< 80\%$
Context	A core function of the Districts and Networks is to promote, protect and maintain the health of the community. Investment and targeted improvement is required to keep people healthy, prevent ill health and tackle health inequality in our communities. NSW Health is focusing on improving outcomes in NSW communities relating to: • Physical activity • Prevalence of smoking and e-cigarette (vaping) use in adults • Healthy birthweight • Prevalence of diabetes in adults • Immunisation rates in adolescents and adults
Related Policies/ Programs	Policies or programs related to population health
Useable data available from	2025/26
Frequency of Reporting	6 monthly
Time lag to available data	N/A
Business owners	Population and Public Health Division
Contact - Policy	Office of the Deputy Secretary Population and Public Health and Chief Health Officer
Contact - Data	Office of the Deputy Secretary Population and Public Health and Chief Health Officer
Representation	
Data type	N/A

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Form	N/A
Representational layout	N/A
Minimum size	N/A
Maximum size	N/A
Data domain	N/A
Date effective	N/A
Related National Indicator	N/A

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HEALTH OUTCOME 3: People are healthy and well

INDICATOR: KPI2606

Prescription, Recreational and Illicit Substance Evaluation (PRISE) - Final
Results for all Biological Samples
Reported within 35 Business Days of Sample
Receipt (%).

Shortened Title	PRISE final results
Service Agreement Type	Key Performance Indicator
NSW Health Strategic Outcome	3 People are healthy and well
Status	
Version number	1.0
Scope	All cases referred to NSW Health Pathology Forensic & Analytical Science Service (FASS) under the PRISE program, for toxicological testing of biological samples
Goal	Greater accountability for performance management to support allocation of existing resources for toxicology testing in substance-related toxicity.
Desired outcome	Improved availability of final results from toxicology testing for patients with severe and unusual substance-related toxicity or clusters of overdoses in NSW Health acute care services
Primary point of collection	Data collection at FASS
Data Collection Source/System	The primary data collection system at FASS
Primary data source for analysis	Time stamp of receipt of sample, and time stamp of final result
Indicator definition	Measures the time it takes for FASS to deliver final results to Ministry of Health (MoH), for cases under the PRISE program. The time will be calculated from sample receipt time, to final result reporting to MoH, in business days.
Numerator	
Numerator definition	Count of cases for which final results are reported within 35 business days, calculated from receipt time, to final result reporting time.
Numerator source	Calculated from existing fields in FASS data collection
Numerator availability	FASS have advised that necessary data fields are available and reliable
Denominator	

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Denominator definition	Count of all cases for which final results have been reported, within any time frame.
Denominator source	Deduced from existing fields in FASS data collection
Denominator availability	FASS have advised that necessary data fields are available and reliable
Inclusions	The following parameters defined the population of data to be included in the indicator: • PRISE cases (all triage categories) tested by Forensic Toxicology laboratory, FASS, NSW HP • Final results reported
Exclusions	This KPI applies to NSW Health Pathology only. The indicator does not relate to cases outside of the PRISE program
Targets	Target: 95% Performing: $\geq 95\%$ Underperforming: $\geq 90\%$ and $<95\%$ Not performing: $< 90\%$
Context	The Prescription, Recreational and Illicit Substance Evaluation (PRISE) program provides an understanding of the specific drugs causing severe and unusual toxicity in NSW. Rapid identification of substances ensures timely public health interventions that support clinical management and improve care of critically ill patients. Measuring provision of final results in a timely fashion will assist with monitoring return on investment.
Related Policies/ Programs	NSW Health Prescription Recreational and Illicit Substance Evaluation (PRISE)
Useable data available from	01 July 2025
Frequency of Reporting	Quarterly
Time lag to available data	Calendar quarter
Business owners	Centre for Alcohol and Other Drugs
Contact - Policy	Toxicity Response and Epidemiology and Surveillance Team, Centre for Alcohol and Other Drugs, NSW Ministry of Health And PRISE project advisory committee

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Contact - Data

Forensic Toxicology laboratory, FASS, NSW Health Pathology

And

Toxicity Response and Epidemiology and Surveillance Team, Centre for Alcohol and Other Drugs, NSW Ministry of Health

Representation

Data type Numeric

Form Number

Representational layout XXX%

Minimum size 1

Maximum size 3

Data domain N/A

Date effective 1 July 2026

Related National Indicator N/A – NSW program

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Health Outcome 4: Our staff are engaged and well supported

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

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: <u>Reportable Claims</u>

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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

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	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	

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INDICATOR: KPI2601	Agreed Composite Diversity Targets (Aboriginal participation, Women in leadership, Disability, CALD) - Increase in Overall Score for Diversity Index (Number) - Diversity rate
Shortened Title	Diversity Index
Service Agreement Type	Key Performance Indicator
NSW Health Strategic Outcome	1: Patients and carers have positive experiences and outcomes that matter 4: Our staff are engaged and well supported
Status	Draft
Version number	1.0
Scope	All NSW Health entities excluding Albury Wodonga Health and St Vincents Hospital Network.
Goal	Diverse teams are associated with better innovation, decision-making, and cultural competence. Tracking diversity holistically helps align workforce composition with strategic goals
Desired outcome	Improvement in overall diversity across different groups.
Primary point of collection	Stafflink EEO data.
Data Collection Source/System	Stafflink
Primary data source for analysis	Corporate Data Analytics Warehouse
Indicator definition	Average year on year change in Diversity measure on last year: • Where Diversity composite is $= (\Delta A + \Delta W + \Delta D + \Delta C)/4$ • Where each diversity group calculates the change in diversity measure on last year • $= \Delta i = \text{Current} i - \text{Last Year} i$ • For each diversity group, % of staff that identify as in the diversity group relative to the figure from last year • Aboriginal Employees (out of total workforce) • Women in Leadership (out of total in leadership positions) • People with a Disability (out of total workforce) • Culturally and Linguistically Diverse (out of total workforce)
Numerator	
Numerator definition	The average year on year change across the 4 diversity elements.
Numerator source	Stafflink, corporate data analytics warehouse.

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Numerator availability	Annual data will be used for the measure.
Denominator	
Denominator definition	Denominator is total respondents to EEO questions in stafflink.
Denominator source	Stafflink, corporate data analytics warehouse.
Denominator availability	Data available in stafflink.
Inclusions	All Employees by location so measure is able to be rolled up and down the organisational structure
Exclusions	Nil
Targets	Target = Improvement in average diversity rate on previous year Performing = Improvement in average diversity rate on previous year Underperforming = No change in average diversity rate on previous year Not performing = Decrease in average diversity rate on previous year
Context	Rate may differ to PMES diversity responses as PMES data is anonymous. However, this data can be used to cross validate or target areas of uplift.
Related Policies/ Programs	Employee Engagement, Employee Wellbeing, PCFH.
Useable data available from	2025 (however component measures available for several years prior)
Frequency of Reporting	Quarterly
Time lag to available data	1-2 weeks
Business owners	Ministry of Health - Workforce Planning and Talent Development
Contact - Policy	Director Employee Experience and Talent Development
Contact - Data	Director Workforce Insights and Transformation
Representation	
Data type	Number
Form	%
Representational layout	NN.N%
Minimum size	N.N
Maximum size	NNN.

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Data domain	People and Culture, expressed as % change quarter on quarter
Date effective	2026
Related National Indicator	N/A

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Health Outcome 4: Our staff are engaged and well supported

INDICATOR: KPI2602	People Matter Employee Survey (PMES): Increase in Overall Engagement Index Score (Number)
Shortened Title	PMES Engagement
Service Agreement Type	KPI.
NSW Health Strategic Outcome	4: Our staff are engaged and well supported
Status	Draft
Version number	1.0
Scope	All workforce in all facilities with PMES above reporting thresholds excluding SVHN.
Goal	Measurement of the change in employee engagement score in the last 12 months.
Desired outcome	Enhanced employee engagement and uplift in culture retention and outcomes.
Primary point of collection	Annual PMES survey
Data Collection Source/System	PMES – Qualtrix survey
Primary data source for analysis	Qualtrix, PMES reports
Indicator definition	A combined score reflecting key dimensions of organisational culture, such as employee engagement, values alignment, and leadership trust. Each dimension is typically measured through validated survey items and weighted to form a single index
Numerator	
Numerator definition	Composite Engagement score (PMES – sourced from 5 PMES questions): 7i) I am proud to tell others I work for my organisation 7h) I would recommend my organisation as a great place to work 7j) I feel a strong personal attachment to my organisation 7l) My organisation inspires me to do the best in my job 7k) My organisation motivates me to help it achieve its goals

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Numerator source	PMES
Numerator availability	PMES Survey results – PMES questions may change over time impacting the time series of the measure. However, this doesn't occur without consultation.
Denominator	
Denominator definition	100, Engagement is range bound between 0 and 100
Denominator source	PMES Survey results
Denominator availability	PMES Survey results – PMES questions may change over time impacting the time series of the measure. However, this doesn't occur without consultation. Limited risk to change in Engagement as this is the primary measurement of the survey.
Inclusions	All reportable business units within the parent entity
Exclusions	N/A
Targets	Target = Improvement on previous year Performing = Improvement on previous year Underperforming = No change from previous year Not performing = Decrease from previous year
Context	Index measure out of 100.
Related Policies/ Programs	Employee Engagement, Employee Wellbeing, PCFH.
Useable data available from	2023
Frequency of Reporting	Annually
Time lag to available data	3 months following closure of PMES survey.
Business owners	Ministry of Health - Workforce Planning and Talent Development
Contact - Policy	Director Employee Experience and Talent Development
Contact - Data	Director Workforce Insights and Transformation
Representation	
Data type	Numeric

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Form	Numeric
Representational layout	NN.N
Minimum size	1
Maximum size	100
Data domain	People and Culture, expressed as change year on year
Date effective	2026
Related National Indicator	N/A

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Health Outcome 4: Our staff are engaged and well supported

INDICATOR: KPI2603	Sick Leave Per FTE Amount of Sick Leave (Hours) Taken Per Full Time Equivalent Per Quarter Relative to Same Quarter Last Year
Shortened Title	Sick per FTE
Service Agreement Type	KPI
NSW Health Strategic Outcome	4: Our staff are engaged and well supported
Status	Draft
Version number	1.0
Scope	All employees.
Goal	Reduction in instances of sick leave by next financial year. Lower instances of sick leave may reduce premium labour use and may indicate an improvement in overall psychological safety.
Desired outcome	Reduction in instances of sick leave and consequently overtime and premium labour usage
Primary point of collection	Stafflink data via corporate data analytics warehouse
Data Collection Source/System	Stafflink
Primary data source for analysis	Corporate Data Analytics Warehouse
Indicator definition	Average number of sick leave days taken per Full-Time Equivalent (FTE) employee during a specified period (e.g., monthly or annually). Formula: Sick Leave per FTE=Total Sick Leave hours Taken/ Average FTE
Numerator	
Numerator definition	Sick leave hours taken
Numerator source	Stafflink, corporate data analytics warehouse.
Numerator availability	Data available in stafflink as at last pay fortnight of each month.

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Denominator

Denominator definition	FTE
Denominator source	Stafflink, corporate data analytics warehouse.
Denominator availability	Data available in stafflink as at last pay fortnight of each month.

Inclusions All Employees by location so measure is able to be rolled up and down the org structure

Exclusions Nil

Targets

Improvement: Reduction in sick leave per FTE

Decline: increase in sick leave per FTE

Target: 60 hours per FTE

- Performing: < 60 hours
- Under performing: ≥ 60 and ≤ 68 hours
- Not performing: > 68 hours

Context Figures will be impacted by seasonality; proposed point of comparison is same quarter year prior.

Related Policies/ Programs Employee Engagement, Employee Wellbeing, PCFH.

Useable data available from 2025

Frequency of Reporting Quarterly

Time lag to available data 1 week

Business owners Ministry of Health - Workforce Planning and Talent Development

Contact - Policy Director Employee Experience and Talent Development

Contact - Data

- Director Workforce Insights and Transformation

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Representation

Data type	Numeric
Form	Number
Representational layout	NN.NN
Minimum size	N.N
Maximum size	NNN.N
Data domain	People and Culture
Date effective	2025
Related National Indicator	NA

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INDICATOR: KPI2604

Nursing Hours Per Patient Day (NHPPD): Hours Under

Previous measure	IM21-007 Weekly Compliance Providing or Exceeding the Award Minimum Nursing Hours per Patient Day (NHPPD) (Variance in Hours)
Shortened Title	NHPPD
Service Agreement Type	Key Performance Measure
NSW Health Strategic Outcome	1: Patients and carers have positive experiences and outcomes that matter 2: Safe care is delivered across all settings 4: Our staff are engaged and well supported
Status	Final
Version number	1.0
Scope	All NHPPD identified wards
Goal	Increase compliance with NHPPD required nursing hours
Desired outcome	Reduced number of hours under NHPPD by LHD and ward
Primary point of collection	Mandatory nursing hours per patient day reporting from LHDs
Data Collection Source/System	Healthroster, manual collation of data for NHPPD ward
Primary data source for analysis	Reports received from each LHD
Indicator definition	Weekly NHPPD hours shortfall per ward relative to long run hours short per ward. Sum of hours under / count of NHPPD wards
Numerator	
Numerator definition	Total hours short per ward for the LHD
Numerator source	Weekly data collection from LHDs
Numerator availability	Weekly
Denominator	
Denominator definition	Count of NHPPD wards per LHD
Denominator source	Weekly data collection from LHDs
Denominator availability	Data provided via survey return with some lag, concern is timeliness and accuracy of data returned by LHDs
Inclusions	All LHDs except SCHN and JHFMHN
Exclusions	Statewide agencies, non-NHPPD wards

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Targets	0 hours under
	Performance Thresholds: • Performing ≥ 0 hours under • Underperforming > 11 and < 0 hours under • Not performing ≤ 11 hours under
Context	NHPPD is an agreed methodology set out in the award that sets the minimum nursing time patients should receive in a ward/unit over 24 hours. It's used to plan rosters, ensure safe staffing, and monitor whether patients are getting the nursing care time their ward category requires.
Related Policies/ Programs	Industrial compliance, Employee Engagement, Employee Wellbeing, PCFH.
Useable data available from	2021
Frequency of Reporting	Monthly
Time lag to available data	2 months
Business owners	Ministry of Health - Workforce Relations Branch
Contact - Policy	Director, Industrial Relations and Management - Nursing
Contact - Data	Director, Industrial Relations and Management - Nursing
Representation	
Data type	Numeric
Form	Number
Representational layout	NN.NN
Minimum size	3
Maximum size	5
Data domain	N/A
Date effective	1 July 2026
Related National Indicator	N/A

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Health 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

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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: $\geq 75\%$ • Under Performing: $\geq 55\%$ 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

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service delivery**

Date effective

Related National Indicator

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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 Indicator

NSW Health Strategic Outcome

Strategic Outcome 5: Research and innovation, and digital advances inform service delivery.

Status

Final

Version number

1.1

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.

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Primary data source for analysis	Data fields common to both CTMS and REGIS, with linkage point as STE ID.
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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.
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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.
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Numerator source	CTMS
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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.
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Denominator

Denominator definition	Number of SSA authorised clinical trials in REGIS for that LHD during the reporting period.
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Denominator source	REGIS.
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Denominator availability	REGIS has dashboards and reporting functionality accessible at Ministry, Local Health District, and trial site level.
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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.

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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 • JHFMHN & NSW
Targets	85% concordance for FY27 • Performing: $\geq 85\%$ • Underperforming: $\geq 75\%$ and $< 85\%$ • Not performing: $< 75\%$
Context	High concordance indicates more accurate clinical trial reporting in both CTMS and REGIS. The CTMS is a relatively new system and districts 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. An initial target of 60% for the FY25 reporting period eased in a performance target which was accessible and accommodated resource limited trial units and investigators. In FY26 the indicator increased to a target of 75% which was successfully met by all districts. For the current financial year (FY27), the target has been further increased to 85%. This step change acknowledges the need for gradual system-wide improvements, recognising that achieving high levels of concordance requires incremental progress over time A low concordance indicates either the clinical trial has not been entered in CTMS or the information entered in the specified common data fields is 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. The CTMS is integrating with the Single Digital Patient Record to enable streamlined sharing of study and patient enrolment information.
Useable data available from	The CTMS was first implemented in November 2022 and has been mandatory at almost all districts from September 2023.

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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 2026
Related National Indicator	

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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

2.1

Scope

All facilities in scope of ABF and small hospitals

Goal

Greater certainty concerning the amount of activity to be performed in a year

Desired outcome

- To improve operating efficiency by enhancing the capacity to manage costs and monitor performance by creating an explicit relationship between funds allocated and services provided.
- To achieve greater accountability for management of resources and performance

Primary point of collection

Patient Medical Record

Data Collection Source/System

Hospital PAS, 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 Admitted
- Sub-Acute Admitted
- AoD Admitted
- Non-Admitted – 10/20 Series
- Non-Admitted – 40 Series
- Non-Admitted AoD
- Non-Admitted - Dental
- Non-Admitted - Mental Health

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

To determine uncoded records the following rule is used:

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	When MDC_v11_CD in ('-1','','ER') THEN 'Uncoded' ELSE 'Coded'
	In the Non-Admitted count ensure Dental and Mental Health are not counted. Mental Health Admitted and non-admitted are calculated using the rules and inclusions of the AMHCC.
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	<u>For Acute Admitted and AoD Admitted</u> ▪ SE_SERVICE_CATEGORY = 1 and 5 ▪ Service Events with an end date within the reporting period ▪ All facilities in scope of ABF 2026-27 and small hospitals <u>For Non-Admitted</u>, only the following Non-admitted Patient Funding Source National Standard Codes: ▪ 01 Health service budget (not covered elsewhere) ▪ 02 Health service budget (due to eligibility for Reciprocal Health Care Agreement) ▪ 03 Health service budget (no charge raised due to hospital decision) ▪ 04 Department of Veterans' Affairs ▪ 06 Correctional facility ▪ 08 Other hospital or public authority (contracted care) ▪ 10 Worker's compensation ▪ 11 Motor vehicle third party personal claim ▪ 12 Other compensation ▪ 98 Not known
Exclusions	<u>For Acute Admitted and AoD Admitted:</u> 1. ED only service events i.e. SE_ED_VISIT_IND_CD in ("1","4") where: 1 = Admitted and discharged within ED (ED Level >=3) 4 = Admitted and discharged within ED (ED Level 1 or 2) 2. Unqualified Neonates i.e. SE_SRV_CATEGORY_CD = "5" and CT_TOT_SE_QUAL_D_CT = 0 <u>For Emergency Department, exclusion sequence:</u> 3. ED_SEPR_MODE_CD = '98' i.e. Data error – record pending deletion

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4. ED_VIS_TYPE_CD of '06' '12' or '13', (Pre-arranged admission – without ED workup, Telehealth presentation, current admitted patient presentation).
5. Duplicate records with same facility code, AUID (if AUID missing – use MRN), arrival date, arrival time and birth date (EDW: HEALTH_ORG, CL_ID, CL_ARRIVAL_DTTM and CL_DOB). Retain single row with the latest SOURCE_MODIFIED DTTM.
6. Records where CL_ID (AUID and MRN) are missing
7. Duplicate records with same facility and SRV_ENC_REC_ID. Retain single row by selecting the record with the latest SOURCE_MODIFIED_DTTM

For Non-Admitted: the following Tier 2 clinics:

8. 10.04 Dental
9. 10.12 Radiation Therapy – Treatment
10. 10.20 Radiation Therapy – Simulation and Planning
11. 10.19 Ventilation – Home Delivered

Diagnostic Services:

12. 30.01 General Imaging
13. 30.02 Magnetic Resonance Imaging (MRI)
14. 30.03 Computerised Tomography (CT)
15. 30.04 Nuclear Medicine
16. 30.05 Pathology (Microbiology, Haematology, Biochemistry)
17. 30.06 Positron Emission Tomography (PET)
18. 30.07 Mammography Screening
19. 30.08 Clinical Measurement
20. 30.09 COVID-19 response diagnostics

Allied Health &/or Clinical Nurse Specialist Interventions:

21. 40.34 Specialist mental health

Other Service Type:

22. 99.94 Excluded Data – Clinical Service Not In-Scope
23. 99.95 Excluded Data – Admitted, Residential or ED Services
24. 99.96 Excluded Data - Non Clinical Service
25. 99.98 Service Unit Establishment Type Code Not Mapped
26. All facilities that fall outside the scope of ABF, as described in Service Agreements.

Targets

Target: $\geq 0\%$ and $\leq +1.5\%$ of the NHRA activity target.

- Performing: $\geq 0\%$ and $\leq +1.5\%$
- Not performing: $< -1.5\%$ or $> +2.5\%$
- Under performing: $\geq -1.5\%$ and $< 0\%$ or $\geq +1.5\%$ and $\leq +2.5\%$

LHD/N	Total NWAU
Central Coast	176,346
Far West	17,303

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Hunter New England	443,334
Illawarra Shoalhaven	200,316
Mid North Coast	142,512
Murrumbidgee	123,123
Nepean Blue Mountains	182,246
Northern NSW	184,217
Northern Sydney	319,226
South Eastern Sydney	323,056
South Western Sydney	428,879
Southern NSW	85,310
St Vincent's Health Network	86,952
Sydney Children's Network	131,051
Sydney	318,283
Western NSW	165,500
Western Sydney	345,898

Context	Official ABF and block funded facility list managed by Service Utilisation and Activity Modelling Unit, Systems Information and Analytics.
Comment	NWAU without final Hospital Acquired Complication (HAC) (WAU_FINAL_WITHOUT_HAC_ADJ) and Re-admission adjustment used
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 Financial Performance Branch
Contact - Policy	Executive Director, System Financial Performance Branch
Contact - Data	Executive Director, System Information and Analytics
Representation	
Data type	Numeric

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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 2026-27 Pricing Framework for Australian Public Hospital Services 2026–27 Resources IHACPA

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Health Outcome 6: The health system is managed sustainably

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

2.1

Scope

All facilities in scope of ABF in 2026-27

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 NHFB 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-Admitted

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- Sub-Acute Admitted
- AoD Admitted
- Non-Admitted – 10/20 Series
- Non-Admitted – 40 Series
- Non-Admitted - Dental
- Non-Admitted - AoD
- Non-Admitted - Mental Health

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

To determine uncoded records the following rule is used:

When MDC_v11_CD in ('-1','','ER') THEN 'Uncoded' ELSE 'Coded'

Mental Health Admitted and non-admitted are calculated using the rules and inclusions of the AMHCC

Numerator source	EDW
Numerator availability	Available 2 months after the end of the period of measurement
Denominator	
Denominator definition	Total NHRA Activity Based Funding target for the year to date in NWAU
Denominator source	LHD NHRA Activity Targets
Denominator availability	Available when targets finalised
Inclusions	▪ Episode end date within the period ▪ Facilities eligible for ABF in 2026-27 ▪ For Acute Admitted SE_SERVICE_CATEGORY = 1 and 5
Exclusions	Excludes services that are funded by other programs such as DVA and compensable <u>For Emergency Department,</u> Exclusion sequence: 1. ED_SEPR_MODE_CD = '98' i.e. Data error – record pending deletion 2. ED_VIS_TYPE_CD of '06' '12' or '13', (Pre-arranged admission – without ED Workup, Telehealth presentation, current admitted patient presentation). 3. Duplicate records with same facility code, AUID (if AUID missing – use MRN), arrival date, arrival time and birth date (EDW: HEALTH_ORG, CL_ID, CL_ARRIVAL_DTTM and CL_DOB). Retain single row with the latest SOURCE_MODIFIED DTTM. 4. Records where CL_ID (AUID and MRN) are missing 5. Duplicate records with same facility and SRV_ENC_REC_ID. Retain single row by selecting the record with the latest SOURCE_MODIFIED_DTTM

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Financial classes:

EDC.01, EDC.02, EDC.05, EDC.07, EDC.08, EDC.09, EDN.02, EDN.04, EDP.01, EDP.02, EDP.03, EDP.04, EDP.05

For Acute Admitted:

- ED only service events i.e. SE_ED_VISIT_IND_CD in ("1","4") where:
 - 1 = Admitted and discharged within ED (ED Level >=3)
 - 4 = Admitted and discharged within ED (ED Level 1 or 2)
- Unqualified Neonates i.e. SE_SRV_CATEGORY_CD = "5" and CT_TOT_SE_QUAL_D_CT = 0
- Medicare ineligible i.e. Medicare Eligibility Status Code = 3 Ineligible Overseas Visitor

For Admitted:

Financial Classes

DVA

- Expired: 12, 23, 24, 25, 32, 56, 57, 58, AD, NAN.05
- Current: DNH, DVN, NAC.05, NAC.08

Compensable:

- Expired: AT, AV, L1, L2, L3, L4, L5, L6, LA, LB, LNW, LSA, LTA, LTB, LX,

MVA:

- Expired: FA, FB, FC, FD, FE, FF, FG, FH, FI, FJ, FK, FL, FM, FN, FO, FP, FQ, FR, FS, FT, V1, V2, V3, V4, V5, V6, V7, V8, V9, VNW, V11, V13, V15
- Current: RMA, V10, V12, V16, Y1, Y2

Worker's Compensation:

- Expired: AW, W1, W2, W3, W4, NAV,
- Current: WCD, WCP, WNW, WSA, NAW

Other Compensable:

- Expired: AO, C1, C2, C3, C4, NAM.01, NAM.02, T1, T2, T3, T4
- Current: CDS, CNW, CPO, CSA, NAL, NAM

Other:

- Chargeable non-hospital: CA
- DC Deferred: DC
- Overseas: OCV, OHP, OID, OIM
- Prisoner: PO, TD, TO, VD, VO
- Australian Defence Force: DFO, DFP, DFS
- Expired: PD

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For non-admitted:

Financial Classes

Current: NAN.08, NAC.02, NAC.06, NAI.02, NAN.02, NAN.04, NAN.06, NAN.16

Compensable: NAO, NAS, NAT

Expired: NAN.07, NAN.10, NAZ, NAC.04, NAC, NAI, NAN, NAP.01, NAP.02, NAP

Funding Source National Standard Codes:

- 04 Department of Veterans' Affairs,
- 05 Department of Defence,
- 07 Medicare Benefits Scheme,
- 09 Private health insurance,
- 10 Worker's compensation,
- 11 Motor vehicle third party personal claim,
- 12 Other compensation,
- 13 Self-funded and
- 88 Other funding Source

Tier 2 clinics:

10.04, 10.12, 10.19, 10.20, 20.06, 30.01, 30.02, 30.03, 30.04, 30.05, 30.06, 30.07, 30.08, 30.09, 40.02, 40.08, 40.27, 40.33, 40.34, 99.94, 99.95, 99.96, 99.97, 99.98.

Non_admitted aggregate activity

Targets

Target: $\geq 0\%$ and $\leq +1.5\%$ of the NHRA activity target.

- Performing $\geq 0\%$ and $\leq +1.5\%$
- Not performing: $< -1.5\%$ or $> +2.5\%$
- Under performing: $\geq -1.5\%$ and $< 0\%$ or $\geq +1.5\%$ and $\leq +2.5\%$

State and territory aggregate	Annual NWAU estimate Total
Central Coast LHD	170,516
Far West LHD	13,604
Hunter New England LHD	407,453
Illawarra Shoalhaven LHD	194,656
Mid North Coast LHD	131,215
Murrumbidgee LHD	94,229
Nepean Blue Mountains LHD	177,215
Northern NSW LHD	175,567
Northern Sydney LHD	300,429
South Eastern Sydney LHD	307,430
South Western Sydney LHD	411,742
Southern NSW LHD	77,272

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St Vincent's Health Network	82,910
Sydney Children's Hospitals Network	126,273
Sydney LHD	305,539
Western NSW LHD	139,362
Western Sydney LHD	328,458

Context	All facilities that fall in the scope of the NHRA reporting, are described in National Efficient Price/Cost documentation. Official ABF and block funded facility list managed by Service Utilisation and Activity Modelling Unit, Systems Information and Analytics.
Comment	NWAU with Hospital Acquired Complication (HAC) and Re-admission adjustment used. (WAU_FINAL)
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	Finance
Contact - Policy	Executive Director, Financial Accounting, Policy, Insurance and Revenue
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 2026-27 Pricing Framework for Australian Public Hospital Services 2026–27 Resources IHACPA

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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	4.0
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

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Denominator availability	Available
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: $\geq 0\%$ - Under performing: $\geq -1.5\%$ and $< 0\%$ - Not performing: $< -1.5\%$

LHD/N	Outcome 1 indicator Public dental clinical service (DWAU)
Central Coast	23,377
Far West	3,479
Hunter New England	57,656
Illawarra Shoalhaven	25,611
Mid North Coast	19,130
Murrumbidgee	17,652
Nepean Blue Mountains	27,076
Northern NSW	26,954
Northern Sydney	18,465
South Eastern Sydney	19,959
South Western Sydney	52,042
Southern NSW	13,151
St Vincent's Health Network	352
Sydney Children's Network	685
Sydney	66,384
Western NSW	18,860
Western Sydney	73,611
Total	464,444

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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.

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INDICATOR: KFA101

Expenditure Matched to Budget: General Fund - Year to date variance (%)

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	1.5
Scope	Financial Management
Goal	Health entities to operate within approved expense budget 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 SMRS Financial Reports
Indicator definition	General fund year-to-date expense variance divided by year-to-date expense budget.
Numerator	
Numerator definition	Financial YTD Expenditure Variance
Numerator source	SMRS
Numerator availability	Available
Denominator	
Denominator definition	Financial YTD Expense Budget
Denominator source	SMRS
Denominator availability	Available
Inclusions	General Fund – expense accounts
Exclusions	General Fund – revenue accounts General Fund – other items accounts RFA – all accounts
Targets	Target: On budget or favourable Performing: ≥ 0 Under performing: < 0 and ≥ -0.25

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Not Performing: <-0.25

Context	Health entities are expected to operate within approved budget
Related Policies/ Programs	Financial Strategy
Useable data available from	Monthly (usually from working day five of the following month)
Frequency of Reporting	Monthly
Time lag to available data	Available at month end (usually from working day five of the following month)
Business owners	
Contact - Policy	Chief Financial Officer
Contact - Data	Executive Director System Financial Performance & Deputy Chief Financial Officer
Representation	
Data type	Numeric
Form	Number, presented as a percentage (%)
Representational layout	NNN.NN%
Minimum size	3
Maximum size	6
Data domain	General fund Financial YTD Expense Variance divided by Financial YTD Expense Budget expressed as a percentage to two decimal places.
Data effective	Ongoing
Related National Indicator	

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INDICATOR: KPI22-04

Net Cost of Service (NCOS) Matched to Budget:
General Fund - Year to date variance (%)

Shortened Title	NCOS 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 expense budget 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 SMRS Financial Reports
Indicator definition	General fund year-to-date NCOS variance divided by the sum of the absolute value of the year-to-date expense budget, the absolute value of the year-to-date revenue budget, and the absolute value of the year-to-date other items budget.
Numerator	
Numerator definition	Financial YTD NCOS Variance
Numerator source	SMRS
Numerator availability	Available
Denominator	
Denominator definition	Absolute Value of Financial YTD Expense Budget + Absolute Value of Financial YTD Revenue Budget + Absolute Value of Financial YTD Other Items Budge
Denominator source	Calculated from values in SMRS
Denominator availability	Available
Inclusions	General Fund – expense accounts General Fund – revenue accounts General Fund – other items accounts
Exclusions	RFA – all accounts

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Targets	Target: On budget or favourable Performing: ≥ 0 Under performing: < 0 and ≥ -0.25 Not Performing: < -0.25
Context	Health entities are expected to operate within approved budget
Related Policies/ Programs	Financial Strategy
Useable data available from	Monthly (usually from working day five of the following month)
Frequency of Reporting	Monthly
Time lag to available data	Available at month end (usually from working day five of the following month)
Business owners	
Contact - Policy	Chief Financial Officer
Contact - Data	Executive Director System Financial Performance & Deputy Chief Financial Officer
Representation	
Data type	Numeric
Form	Number, presented as a percentage (%)
Representational layout	NNN.NN%
Minimum size	3
Maximum size	6
Data domain	General fund Financial YTD NCOS Variance divided by the sum of the absolute value of Financial YTD Expense Budget, absolute value of Financial YTD Revenue Budget and absolute value of Other Items Budget with the results expressed as a percentage to two decimal places.
Data effective	01/07/2026
Related National Indicator	

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INDICATOR: KFA103

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

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	1.4
Scope	Financial Management
Goal	Health entities to achieve approved revenue budget
Desired outcome	Health entities achieve an on budget or favourable result
Primary point of collection	Health entities
Data Collection Source/System	Oracle Accounting System
Primary data source for analysis	Health Entity SMRS Financial Reports
Indicator definition	General fund year-to-date revenue variance divided by year-to-date revenue budget.
Numerator	
Numerator definition	Financial YTD Revenue Variance
Numerator source	SMRS
Numerator availability	Available
Denominator	
Denominator definition	Financial YTD Revenue Budget
Denominator source	SMRS
Denominator availability	Available
Inclusions	General Fund – revenue accounts
Exclusions	General Fund - expense accounts General Fund – other items accounts RFA – all accounts
Targets	Target: On budget or favourable - Performing: ≥ 0 - Under performing: < 0 and ≥ -0.25

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	• Not Performing: <-0.25
Context	Health entities are expected to achieve approved budget
Related Policies/ Programs	Financial Strategy
Useable data available from	Monthly (usually from working day five of the following month)
Time lag to available data	Available at month end (usually from working day five of the following month).
Business owners	
Contact - Policy	Chief Financial Officer
Contact - Data	Executive Director System Financial Performance & Deputy Chief Financial Officer
Representation	
Data type	Numeric
Form	Number, expressed as a percentage (%)
Representational layout	NNN.NN%
Minimum size	3
Maximum size	6
Data domain	General fund Financial YTD Revenue Variance divided by Financial YTD Revenue Budget expressed as a percentage to two decimal places.
Date effective	Ongoing
Related National Indicator	

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INDICATOR: KFA109

Net Result Matched to Budget: General Fund - Year to date variance (%)

Shortened Title	Net Result 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	2.1
Scope	Financial Management This indicator applies to Shared Services – eHealth, HealthShare and NSW Health Pathology only
Goal	Health entities to operate within approved budget 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 SMRS Financial Reports
Indicator definition	General fund year-to-date Net Result variance divided by the sum of the absolute value of the year-to-date expense budget, the absolute value of the year-to-date revenue budget, the absolute value of the year-to-date other items budget and the absolute value of the year-to-date Net Cost of Services budget, and the absolute value of the year-to-date Government Contributions budget.
Numerator	
Numerator definition	Financial YTD Net Result Variance
Numerator source	SMRS
Numerator availability	Available
Denominator	
Denominator definition	Absolute Value of Financial YTD Expense Budget + Absolute Value of Financial YTD Revenue Budget + Absolute Value of Financial YTD Other Items Budget + Absolute Value of Financial YTD Government Contributions Budget
Denominator source	Calculated from values in SMRS
Denominator availability	Available
Inclusions	General Fund – expense accounts

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	General Fund – revenue accounts General Fund – other items accounts General Fund - Government Contributions accounts
Exclusions	RFA – all accounts
Targets	Target: On budget or favourable - Performing: ≥ 0 - Under performing: < 0 and ≥ -0.25 - Not Performing: < -0.25
Context	Health Entities are expected to operate within approved budget
Related Policies/ Programs	Financial Strategy
Useable data available from	Monthly (usually from working day five of the following month)
Frequency of Reporting	Monthly
Time lag to available data	Available at month end (usually from working day five of the following month)
Business owners	
Contact - Policy	Chief Financial Officer
Contact - Data	Executive Director System Financial Performance and Deputy Chief Financial Officer
Representation	
Data type	Numeric
Form	Number, expressed as a percentage (%)
Representational layout	NNN.NN%
Minimum size	3
Maximum size	6
Data domain	General fund Financial YTD Net Result Variance divided by the sum of the absolute value of Financial YTD Expense Budget, absolute value of Financial YTD Revenue Budget, absolute value of Financial YTD Other Items Budget and absolute value of Financial YTD Government Contributions Budget with the results expressed as a percentage to two decimal places.
Date effective	01/07/2026
Related National Indicator	

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INDICATOR: KPI23-005

Sustainability Towards 2030: Reducing Nitrous Oxide Wastage: Emissions Per Service Event

Shortened Title	Sustainability Towards 2030: N ₂ O
Service Agreement Type	Key Performance Indicator
NSW Health Strategic Outcome	6: The health system is managed sustainably.
Status	Final
Version number	1.1
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 from nitrous oxide wastage. Appropriate nitrous oxide use is determined by activity data in ED, ICU, Oral Health, Pediatrics, Theatres and Birthing units (CO ₂ e reduced 10%).
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 bi-annually 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 ₂ e) per admitted patient service event.
Numerator	
Numerator definition	YTD kg CO ₂ e emissions attributed to N ₂ O 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	

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Denominator definition	YTD Number of separations of Service Related Groups (SRG V6.0): 47 Oral and maxillofacial surgery 71 Gynaecology 72 Obstetrics And YTD Number of separations of Australian Emergency Care Classification (AECC) for under 16 years of age: - E08 Musculoskeletal and - E20 Injury and other externally – caused morbidity
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: 10% 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: $\geq 10\%$ - Under Performing: $\geq 5\%$ and $< 10\%$ - Not Performing: $< 5\%$
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 that a substantial proportion of nitrous oxide is wasted due to leaks in the manifolds, pipes, wall outlets and pendants. A 10% reduction 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	Bi-annually
Time lag to available data	8 weeks
Business owners	

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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

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INDICATOR: KPI2507

Same Day Surgery Performance for targeted procedures (%)

Shortened Title	Same day surgery
Service Agreement Type	Key Performance Indicator
NSW Health Strategic Outcome	6: The health system is managed sustainably
Status	Final
Version number	2.1
Scope	All surgery patients who are admitted for a planned procedure in the identified target group in NSW public hospitals.
Goal	To ensure that planned surgical patients receive their surgery within the clinically recommended timeframe in NSW public hospitals
Desired outcome	Better management of waiting lists to minimise waiting time for planned surgery.
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 percentage (%) of all planned surgery admitted patient episodes of care (service events) in the included target group who were treated as Day Only (DO). This group of DRGs has been identified as being suitable for DO admission and is not exclusive. Other DRGS may appropriately be admitted as DO.
Numerator	
Numerator definition	The number of planned surgery admitted patient service events in the target group who were treated as DO (Admission date = Discharge date) in NSW public hospitals.
Numerator source	Admitted Patient Data Collection
Numerator availability	Monthly
Denominator	
Denominator definition	The total number of planned admitted patient service events in the target group in NSW public hospitals.

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Denominator source	Admitted Patient Data Collection
Denominator availability	Monthly
Inclusions	• SE_TYPE_CD = '2' • Planned Admissions, Service Event and Admitted (Formal Admission Urgency Code = 2 and 5) • Planned surgery admitted patient service events with the target AR-DRG <u>Version 11.0</u> in a public hospital. ▪ D06Z Sinus and Complex Middle Ear Interventions ▪ D10Z Nasal Interventions ▪ D11Z Tonsillectomy and Adenoidectomy ▪ D14B Sublingual gland excision ▪ G07B Elective appendectomy ▪ G10B Hernia Interventions, Minor Complexity ▪ G11B Hemorrhoidectomy ▪ H08B Laparoscopic Cholecystectomy, Minor Complexity ▪ I16Z Rotator cuff repair ▪ I18B Meniscectomy excision, repair, trimming ▪ I25B Bone and joint diagnostic interventions including biopsy, minor complexity (Bunionectomy) ▪ I29B Arthroscopic knee ligament repairs/reconstruction ▪ J06B Major Interventions for Breast Disorders, Minor Complexity ▪ J07Z Lymph Node Biopsy ▪ J09Z Pilonidal sinus Excision ▪ K05B Parathyroidectomy ▪ K06B Thyroid Interventions, Minor Complexity ▪ N07B Myomectomy, including laparoscopically and hysteroscopic ▪ N04B Hysterectomy for Non-Malignancy, Minor Complexity ▪ N05B Laparoscopic oophorectomy/salpingectomy procedures, Minor Complexity ▪ N06B Female reproductive system reconstructive interventions, Minor Complexity (Colporrhaphy) ▪ N08B Therapeutic laparoscopic ablation/adhesiolysis, Minor Complexity For Sydney Children's Hospitals Network ▪ D06Z Sinus and complex middle ear interventions ▪ D10Z Nasal Interventions ▪ D11Z Tonsillectomy and/or Adenoidectomy ▪ D12 Other ear, mouth and throat interventions, Minor Complexity ▪ D13Z Myringotomy with tube insertion ▪ G10B Hernia Interventions, Minor Complexity ▪ I23 Local Excision and Removal of Internal Fixation devices, excluding Hip and Femur, Minor Complexity ▪ I27 Soft Tissue Interventions, Minor Complexity ▪ I29Z Arthroscopic knee ligament repairs/reconstruction

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- M04 Testes Intervention

Exclusions

Targets

Various

ISLHD

Target 66.6%

- Performing: $\geq 66.6\%$
- Under performing: $\geq 54.9\%$ and $< 66.6\%$
- Not performing: $< 54.9\%$

SWSLHD

Target 67.1%

- Performing: $\geq 67.1\%$
- Under performing: $\geq 54.9\%$ and $< 67.1\%$
- Not performing: $< 54.9\%$

Other Local Health Districts and St Vincent's Health Network

Target: 63.4%

- Performing: $\geq 63.4\%$
- Under performing: $\geq 54.9\%$ and $< 63.4\%$
- Not performing: $< 54.9\%$

For Sydney Children's Hospitals Network

Target 65.4%

- Performing: $\geq 65.4\%$
- Under performing: $\geq 54.9\%$ and $< 65.4\%$
- Not performing: $< 54.9\%$

Context

The weighted average of planned admitted patient service events treated as DO out of the total number of planned admitted patient service events in the targeted procedures has been calculated for the target.

Increasing same day surgery, where it is safe to do so, is a strategy for increasing the proportion of patients receiving their planned surgery within clinically recommended timeframes in NSW public hospitals.

Related Policies/ Programs

- Planned Surgery Access Policy
- Surgical Care Strategic Committee
- Agency for Clinical Innovation: Surgical Care Network
- Agency for Clinical Innovation Extended Day Only and Day Only guideline

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Useable data available from	July 2021
Frequency of Reporting	Monthly
Time lag to available data	2 months
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, presented as a percentage (%)
Representational layout	NNN.NN
Minimum size	3
Maximum size	5
Data domain	N/A
Date effective	1 November 2023
Related National Indicator	N/A