Commissioning and Performance

KEY PERFORMANCE INDICATORS

Master Definition Document

2021 - 2022

Government of South Australia

SA Health

CONTENTS

Version Control

Version No.	Changes Made	By Whom	Date
V1.0	First iteration	Lauren Bell	15/9/2020
V2.0	Updated KPIs where definitions or targets were previously unavailable.	Lauren Bell	21/12/2020
V3.0	Updated to reflect 2021/2022 KPIs	Lincy Varghese	30/09/2021

ACCESS AND FLOW

EMERGENCY DEPARTMENT

Emergency Department Length Of Stay Less Than Or Equal to 4 Hours	
Identifying and definitional attributes	
Short Name:	ED LOS <=4HR ED LOS <=4HR Admitted ED LOS <=4HR Non-admitted
Tier:	Tier 1 Monitor Monitor
KPI ID:	AF-ED-T1-1 AF-ED-M-1 AF-ED-M-2
Description:	Percentage (%) of patient presentations to an emergency department (ED) where the time from presentation to the time of physical departure, i.e. the length of the ED stay, is less than or equal to four hours.
Computation:	(Numerator/Denominator)*100
Numerator:	ED LOS <=4HR: Count (#) of ED presentations with a visit time of less than or equal to 4 hours (240 minutes). ED LOS <=4HR Admitted: Count (#) of ED presentations who were subsequently admitted from an ED where the visit time is less than or equal to 4 hours (240 minutes). ED LOS <=4HR Non-admitted: Count (#) of ED presentations who were not subsequently admitted from an ED where the visit time is less than or equal to 4 hours (240 minutes).
Denominator:	ED LOS <=4HR: Count (#) of all ED presentations. ED LOS <=4HR Admitted: Count (#) of ED presentations who were subsequently admitted from an ED. ED LOS <=4HR Non-admitted: Count (#) of ED presentations who were not subsequently admitted from an ED.
More Information	
Scope:	Data is reported for: • CALHN: RAH, TQEH • SALHN: FMC, NHS • NALHN: LMH, Modbury • WCHN: WCH • RMCLHN: Riverland (Berri), Murray Bridge • LCLHN: Mt Gambier • FUNLHN: Port Augusta, Whyalla • EFNLHN: Port Lincoln • YNLHN: Port Pirie • BHFLHN: Gawler, South Coast, Mount Barker
Benchmarks:	Performing (Target) >=90.0% Performance Concern <90.0% and >=80.0% Underperforming <80.0%
Representation Class:	Percentage (%)

Data Type:	Real
Unit of Measure:	Episode
Data Source:	Emergency Department Data Collection (EDDC)
Frequency of Reporting:	Monthly (i.e. July data reported in August)
Notes:	> Length of stay is calculated as the difference between the Presentation Date/Time and the Physical Departure Date/Time. > Patients who are transferred to Extended Emergency Care Unit (EECU), as an admitted patient or as Inpatient Overflow, are classified as leaving ED at the time of their EECU Arrival Date/Time. > ED LOS <= 4HR Admitted: Percentage of admissions from an ED where the time from presentation to the time of physical departure, i.e. the length of the ED stay, is less than or equal to four hours. > Admissions are calculated as the total number of presentations with Departure Status: Admission to ward and Admission within ED. > ED LOS <= 4HR Non-admitted: Percentage of presentations who were not subsequently admitted from an ED where the time from presentation to the time of physical departure, i.e. the length of the ED stay, is less than or equal to four hours. > Non-admissions are calculated as the total number of presentations with Departure Status: • Advised of Alternate Treatment Options (AATO) • Did Not Wait to be seen (DNW) • Died within ED (includes DOA with resus) • Episode Complete-Home • Episode Complete-Nursing Home • Episode Complete-Other • Left at own risk after treatment started • Not Stated/Unknown • Transfer out of this hospital to another. > Standard Emergency Department Business Rules are applied (refer to Appendix A).
Related Information:	> 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, 2021. https://meteor.aihw.gov.au/content/index.phtml/itemId/725783 > Australian Health Performance Framework: PI 2.5.7–Waiting times for emergency department care: percentage of patients whose length of emergency department stay is 4 hours or less, 2019 https://meteor.aihw.gov.au/content/index.phtml/itemId/715382 > Service Agreements 2021-2022 SA Health.

Emergency Department Length Of Stay Greater Than 24 Hours

Identifying and definitional attributes

Short Name:	ED LOS >24HR
Tier:	Tier 1
KPI ID:	AF-ED-T1-2
Description:	Count (#) of patient presentations to an emergency department (ED) where the time from presentation to the time of physical departure, i.e. the length of the ED stay, is greater than 24 hours.
Computation:	Count (#)

More Information

Scope:	Data is reported for: • CALHN: RAH, TQEH • SALHN: FMC, NHS • NALHN: LMH, Modbury
Benchmarks:	Performing (Target) = 0 Performance Concern = N/A Underperforming >0
Representation Class:	Count (#)
Data Type:	Integer
Unit of Measure:	Episode
Data Source:	Emergency Department Data Collection (EDDC)
Frequency of Reporting:	Monthly (i.e. July data reported in August)
Notes:	> Length of stay is calculated as the difference between the Presentation Date/Time and the Physical Departure Date/Time. > Patients who are transferred to Extended Emergency Care Unit (EECU), as an admitted patient or as Inpatient Overflow, are classified as leaving ED at the time of their EECU Arrival Date/Time. > Standard Emergency Department Business Rules are applied (refer to Appendix A).
Related Information:	> Service Agreements 2021-2022 SA Health.

Emergency Department Presentations Seen Within Clinically Recommended Time Overall

Identifying and definitional attributes

Short Name:	ED Seen on Time (Overall)
Tier:	Tier 1
KPI ID:	AF-ED-T1-3
Description:	Percentage (%) of patients who are treated within national benchmarks for waiting times for each triage category in a public hospital emergency department (ED).
Computation:	(Numerator/Denominator)*100
Numerator:	Count (#) of patients presenting at an ED who commenced treatment within the nationally specified benchmark.
Denominator:	Count (#) of patients presenting at an ED.

More Information

Scope:	Data is reported for: • CALHN: RAH, TQEH • SALHN: FMC, NHS • NALHN: LMH, Modbury • WCHN: WCH
Benchmarks:	Performing (Target) >=75.0% Performance Concern <75.0% and >=70.0% Underperforming <70.0%
Representation Class:	Percentage (%)
Data Type:	Real
Unit of Measure:	Episode
Data Source:	Emergency Department Data Collection (EDDC)
Frequency of Reporting:	Monthly (i.e. July data reported in August)
Notes:	> Data excludes patients classified as: • Did not wait • Advised of Alternate Treatment Options and • Dead on arrival, no resuscitation. > Standard Emergency Department Business Rules are applied (refer to Appendix A). > Benchmarks have been informed by Health Round Table (HRT) peer group data and Report on Government Services (RoGS) data.
Related Information:	> Service Agreements 2021-2022 SA Health.

Emergency Department Presentations Seen Within Clinically Recommended Time Per Triage Category

Identifying and definitional attributes

Short Name:	ED Seen on Time: Triage Cat 1 ED Seen on Time: Triage Cat 2 ED Seen on Time: Triage Cat 3 ED Seen on Time: Triage Cat 4 ED Seen on Time: Triage Cat 5
Tier:	Triage Cat 1: Monitor Triage Cat 2: Monitor Triage Cat 3: Tier 2 Triage Cat 4: Monitor Triage Cat 5: Monitor
KPI ID:	AF-ED-M-3 AF-ED-M-4 AF-ED-T2-1 AF-ED-M-5 AF-ED-M-6
Description:	Percentage (%) of patients who are treated within national benchmarks for waiting times for each triage category in a public hospital emergency department (ED).
Computation:	(Numerator/Denominator)*100
Numerator:	Count (#) of patients presenting at an ED who commenced treatment within the nationally specified benchmark for their clinically assigned triage category.
Denominator:	Count (#) of patients presenting at an emergency department within the same clinically assigned triage category.

More Information

Scope:	Data is reported for: • CALHN: RAH, TQEH • SALHN: FMC, NHS • NALHN: LMH, Modbury • WCHN: WCH • RMCLHN: Riverland (Berri), Murray Bridge • LCLHN: Mt Gambier • FUNLHN: Port Augusta, Whyalla • EFNLHN: Port Lincoln • YNLHN: Port Pirie • BHFLHN: Gawler, South Coast, Mount Barker
Benchmarks:	Triage Cat 1: Performing (Target) = 100% Performance Concern <100% and >=97.5% Underperforming <97.5% Triage Cat 2: Performing (Target) >=80.0% Performance Concern <80.0% and >=75.0% Underperforming <75.0% Triage Cat 3: Performing (Target) >=75.0% Performance Concern <75.0% and >=70.0%

	Underperforming <70.0% Triage Cat 4: Performing (Target) >=70.0% Performance Concern <70.0% and >=65.0% Underperforming <65.0% Triage Cat 5: Performing (Target) >=70.0% Performance Concern <70.0% and >=65.0% Underperforming <65.0%
Representation Class:	Percentage (%)
Data Type:	Real
Unit of Measure:	Episode
Data Source:	Emergency Department Data Collection (EDDC)
Frequency of Reporting:	Monthly (i.e. July data reported in August)
Notes:	> The maximum waiting times for each triage category are specified by the Australasian College for Emergency Medicine (ACEM) as: • Triage Cat 1: Resuscitation – seen within seconds, calculated as less than or equal to 2 minutes • Triage Cat 2: Emergency – seen within 10 minutes • Triage Cat 3: Urgent – seen within 30 minutes • Triage Cat 4: Semi-urgent – seen within 60 minutes • Triage Cat 5: Non-urgent – seen within 120 minutes. > Data excludes patients classified as: • Did not wait • Advised of Alternate Treatment Options • Dead on arrival, no resuscitation. > Standard Emergency Department Business Rules are applied (refer to Appendix A).
Related Information:	> National Healthcare Agreement: PI 21a–Waiting times for emergency hospital care: proportion seen on time, 2021 https://meteor.aihw.gov.au/content/index.phtml/itemId/725785 > Australian Health Performance Framework: PI 2.5.5–Waiting times for emergency department care: proportion seen on time, 2019 https://meteor.aihw.gov.au/content/index.phtml/itemId/715380 > Service Agreements 2021-2022 SA Health.

Transfer Of Patient Care Less Than Or Equal To 30 Minutes

Identifying and definitional attributes

Short Name:	ED Transfer of Patient Care <=30MIN
Tier:	Tier 1
KPI ID:	AF-ED-T1-4
Description:	Percentage (%) of patients arriving by ambulance whose care is transferred from ambulance paramedic to emergency department (ED) clinician within 30 minutes of ambulance arrival at a metropolitan public hospital.
Computation:	(Numerator/Denominator)*100
Numerator:	Count (#) of patients arriving by ambulance where the difference between patient time of arrival at a metropolitan public hospital and time of transfer of care from ambulance paramedic to ED clinician is less than or equal to 30 minutes.
Denominator:	Count (#) of patients who arrived at a metropolitan public hospital by ambulance.

More Information

Scope:	Data is reported for: • CALHN: RAH, TQEH • SALHN: FMC, NHS • NALHN: LMH, Modbury • WCHN: WCH
Benchmarks:	Performing (Target) >=90.0% Performance Concern <90.0% and >=85.0% Underperforming <85.0%
Representation Class:	Percentage (%)
Data Type:	Real
Unit of Measure:	Services Type
Data Source:	SAAS CAD as per OIU database
Frequency of Reporting:	Monthly (i.e. July data reported in August)
Notes:	> 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. > Includes patients arriving at ED where the ambulance incident priority is: • P1 • P2 • P3 • P4 • P5

	> Excludes patients arriving at ED where the ambulance incident priority is: • P6 • P7 • P8 > Data with missing timestamps is excluded.
Related Information:	> Service Agreements 2021-2022 SA Health.

ELECTIVE SURGERY

Elective Surgery Timely Admissions	
Identifying and definitional attributes	
Short Name:	ES Timely Admissions: Overall ES Timely Admissions: Cat 1 ES Timely Admissions: Cat 2 ES Timely Admissions: Cat 3
Tier:	Monitor Tier 1 Tier 2 Tier 2
KPI ID:	AF-ES-M-1 AF-ES-T1-1 AF-ES-T2-1 AF-ES-T2-2
Description:	Percentage (%) of elective surgery patients admitted within the clinically recommended time.
Computation:	(Numerator/Denominator)*100
Numerator:	Count (#) of patients who were admitted for elective surgery within the nationally specified waiting time benchmark for their clinically assigned urgency category. These are: • Category 1: 30 days • Category 2: 90 days • Category 3: 365 days
Denominator:	Count (#) of patients who were admitted for elective surgery, within the same urgency category.
More Information	
Scope:	Data is reported for: • CALHN: RAH, TQEH • SALHN: FMC, NHS • NALHN: LMH, Modbury • WCHN: WCH • RMCLHN: Riverland (Berri), Murray Bridge, Renmark, Loxton, Waikerie • LCLHN: Mt Gambier, Bordertown, Millicent, Naracoorte • FUNLHN: Port Augusta, Whyalla, Quorn • EFNLHN: Port Lincoln, Ceduna • YNLHN: Port Pirie, Balaklava, Clare, Crystal Brook, Jamestown, Wallaroo • BHFLHN: Gawler, South Coast, Mount Barker, Angaston, Kapunda, Kangaroo Island, Strathalbyn
Benchmarks:	Overall: Performing (Target) = N/A Performance Concern = N/A Underperforming = N/A Cat 1: Performing (Target) =100% Performance Concern <100% and >=95.0% Underperforming <95.0% Cat 2: Performing (Target) >=97.0%

	Performance Concern <97.0% and >=92.0% Underperforming <92.0% Cat 3: Performing (Target) >=95.0% Performance Concern <95.0% and >=90.0% Underperforming <90.0%
Representation Class:	Percentage (%)
Data Type:	Real
Unit of Measure:	Episode
Data Source:	Manual submissions - LMH, Modbury, WCH & FMC Operational Business Intelligence (OBI) - Sunrise/PAS sites & Regional Hospitals
Frequency of Reporting:	Monthly (i.e. July data reported in August)
Notes:	> Waiting time is determined as the time elapsed (in days) from the date the patient was added to the waiting list for their procedure to the date they were removed from the waiting list. > Days when the patient was 'not ready for surgery' are subtracted from the total count of days waited and is calculated by subtracting the date(s) the person was recorded as 'not ready for surgery' from the date(s) the person was subsequently recorded as again being 'ready for surgery'. > If, at any time since being added to the waiting list the patient has been assessed to fall within a less urgent clinical category for the same elective procedure than the category at removal, then the count of days waited at the less urgent clinical category should be subtracted from the total count of days waited. > In cases where there has been only one category reassignment (i.e. to the more urgent category attached to the patient at removal) the count of days at the less urgent clinical urgency category should be calculated by subtracting the date the patient was added to the list from the date the patient's urgency category was reassigned. If the patient's clinical urgency was reclassified more than once, days spent in each period of less urgent clinical urgency than the one applying at removal should be calculated by subtracting one category reassignment date from the subsequent category reassignment date, and then adding the days together. > When a patient is admitted from an elective surgery waiting list but the surgery is cancelled and the patient remains on or is placed back on the waiting list within the same hospital, the time waited on the list should continue. Therefore, at the removal date, the patient's waiting time includes the count of days waited on an elective surgery waiting list, before, during and after any cancelled surgery admission. > Excludes people who are not ready for surgery (deferred).
Related Information:	> National Healthcare Agreement: PI 20b–Waiting times for elective surgery: proportion seen on time, 2021 https://meteor.aihw.gov.au/content/index.phtml/itemId/725787 > Australian Health Performance Framework: PI 2.5.3–Waiting times for elective surgery: proportion admitted within clinically recommended time, 2019 https://meteor.aihw.gov.au/content/index.phtml/itemId/715378 > Service Agreements 2021-2022 SA Health.

Elective Surgery Overdue Patients

Identifying and definitional attributes

Short Name:	ES Overdue: All ES Overdue: Cat 1 ES Overdue: Cat 2 ES Overdue: Cat 3
Tier:	Monitor Tier 1 Tier 2 Tier 2
KPI ID:	AF-ES-M-2 AF-ES-T1-2 AF-ES-T2-3 AF-ES-T2-4
Description:	Count (#) of patients classified as ready for surgery on the elective surgery waiting list who, at the census date, are overdue for surgery according to the clinically recommended wait times for their assigned urgency category.
Computation:	Count (#)

More Information

Scope:	Data is reported for: • CALHN: RAH, TQEH • SALHN: FMC, NHS • NALHN: LMH, Modbury • WCHN: WCH • RMCLHN: Riverland (Berri), Murray Bridge, Renmark, Loxton, Waikerie • LCLHN: Mt Gambier, Bordertown, Millicent, Naracoorte • FUNLHN: Port Augusta, Whyalla, Quorn • EFNLHN: Port Lincoln, Ceduna • YNLHN: Port Pirie, Balaklava, Clare, Crystal Brook, Jamestown, Wallaroo • BHFLHN: Gawler, South Coast, Mount Barker, Angaston, Kapunda, Kangaroo Island, Strathalbyn
Benchmarks:	All: Performing (Target) = 0 Performance Concern = N/A Underperforming >0 Cat 1: Performing (Target) = 0 Performance Concern = N/A Underperforming >0 Cat 2: Performing (Target) = 0 Performance Concern = N/A Underperforming >0 Cat 3: Performing (Target) = 0 Performance Concern = N/A Underperforming >0

Representation Class:	Count (#)
Data Type:	Integer
Unit of Measure:	Person
Data Source:	Manual submissions - LMH, Modbury, WCH & FMC Operational Business Intelligence (OBI) - Sunrise/PAS sites & Regional Hospitals
Frequency of Reporting:	Monthly (i.e. July data reported in August)
Notes:	> Data can only be provided as a point in time measure. > A patient is overdue when they are: • assigned as Category 1 and waiting time >30 days; or • assigned as Category 2 and waiting time >90 days; or • assigned as Category 3 and waiting time >365 days. > Waiting time is determined as the time elapsed (in days) from the date the patient was added to the waiting list for their procedure to the date they were removed from the waiting list. > Days when the patient was deemed 'not ready for surgery' are subtracted from the total count of days waited and is calculated by subtracting the date(s) the patient was recorded as 'not ready for surgery' from the date(s) the patient was subsequently recorded as again being 'ready for surgery'. > In cases where there has been only one category reassignment (i.e. to the more urgent category attached to the patient at removal) the count of days at the less urgent clinical urgency category should be calculated by subtracting the date the patient was added to the list from the date the patient's urgency category was reassigned. If the patient's clinical urgency was reclassified more than once, days spent in each period of less urgent clinical urgency than the one applying at removal should be calculated by subtracting one category reassignment date from the subsequent category reassignment date, and then adding the days together. > When a patient is admitted from an elective surgery waiting list but the surgery is cancelled and the patient remains on or is placed back on the waiting list within the same hospital, the time waited on the list should continue. Therefore, at the removal date, the patient's waiting time includes the count of days waited on an elective surgery waiting list, before, during and after any cancelled surgery admission. > Excludes people who are not ready for surgery (deferred). If, at any time since being added to the waiting list for the elective surgical procedure, the patient has had a less urgent clinical urgency category than the category at removal, then the number of days waited at the less urgent clinical urgency should be subtracted from the total number of days waited.
Related Information:	> National Healthcare Agreement: PI 20a–Waiting times for elective surgery: waiting times in days, 2021 https://meteor.aihw.gov.au/content/index.phtml/itemId/725789 > Australian Health Performance Framework: PI 2.5.2–Waiting times for elective surgery: waiting times in days, 2019 https://meteor.aihw.gov.au/content/index.phtml/itemId/715376 > Service Agreements 2021-2022 SA Health.

Elective Surgery Treat In Turn

Identifying and definitional attributes

Short Name:	ES Treat in Turn
Tier:	Monitor
KPI ID:	AF-ES-M-3
Description:	Percentage (%) of patients admitted and treated in turn if every patient was treated strictly in the order in which they were placed on the elective surgery waiting list. Applicable to Urgency Category 2 and Urgency Category 3 only.
Computation:	(Numerator/Denominator)*100
Numerator:	Count (#) of the top (X) records with the longest TinTWaitDays who were admitted where (X) = total admissions within the reporting period. To derive the numerator, the list of patients admitted and treated within the reporting period is combined with the patients remaining ready for surgery on the Elective Surgery Waiting list (ESWL) for each relevant urgency category on the last day of the reporting period. TinTWaitDays for this cohort is then calculated by increasing the length of wait (LOW) for admitted patients by the difference between their removal date and the last day of the reporting period and using the LOW for patients remaining on the ESWL. LOW is defined as: Number of days between Date Added and Removal Date less any days spent as Urgency Category 4. The list is then ordered in descending order of TinTWaitDays, and the number of patients who were admitted and treated within the top (X) patients are counted (where (X) = total admissions within the reporting period).
Denominator:	Count (#) of patients admitted and treated in the reporting period.

More Information

Scope:	Data is reported for: • CALHN: RAH, TQEH • SALHN: FMC, NHS • NALHN: LMH, Modbury • WCHN: WCH
Benchmarks:	Performing (Target) >=60.0% Performance Concern <60.0% and >=55.0% Underperforming <55.0%
Representation Class:	Percentage (%)
Data Type:	Real
Unit of Measure:	Episode
Data Source:	Manual submissions - LMH, Modbury, WCH, FMC & Regional Sites Sunrise/PAS sites – data extracted from BLIS Elective Surgery
Frequency of Reporting:	Monthly (i.e. July data reported in August)

Notes:	> Performance is calculated for Category 2 and Category 3 patient cohorts only. This measure is not applicable for Category 1 patients. > Targets are set at an overall site level. > Performance is calculated at the lowest level (Site, Specialty and Category) and Specialty (ie Cat 2 and 3 combined) and Site level (i.e. all specialties at a site) performance derived based on aggregation of the numerator and denominator. > Performance is not reported (shown as N/A) where there were fewer than 5 admissions in a reporting period. > Performance data is not cumulative and is reported for month to date (MTD) only.
Related Information:	> Service Agreements 2021-2022 SA Health.

Flow	
Identifying and definitional attributes	
Short Name:	Flow
Tier:	Monitor
KPI ID:	AF-CC-M-1
Description:	Proportion (%) of public hospital inpatient services which are provided to local residents.
Computation:	(Numerator/Denominator)*100
Numerator:	Count (#) of XLHN resident separations from XLHN hospitals (i.e. number of NALHN resident separations from NALHN hospitals).
Denominator:	Count (#) of separations from XLHN hospitals (i.e. number of separations from NALHN hospitals).
More Information	
Scope:	Data is reported for: • CALHN • SALHN • NALHN • RMCLHN • LCLHN • FUNLHN • EFNLHN • YNLHN • BHFLHN
Benchmarks:	N/A
Representation Class:	Percentage (%)
Data Type:	Real
Unit of Measure:	Service Contact
Data Source:	Central Data Warehouse (CDW): Admitted Activity
Frequency of Reporting:	Quarterly (i.e. July – September data reported in October)
Notes:	> XLHN is the LHN for which the indicator is calculated.
Related Information:	> Service Agreements 2021-2022 SA Health.

Self-Sufficiency

Identifying and definitional attributes

Short Name:	Self-Sufficiency
Tier:	Monitor
KPI ID:	AF-CC-M-2
Description:	Proportion (%) of public hospital inpatient services for residents of a particular geographic area (catchment area), provided in their particular local catchment area, or in hospitals across that LHN.
Computation:	(Numerator/Denominator)*100
Numerator:	Count (#) of XLHN resident separations from XLHN hospitals (i.e. number of NALHN resident separations from NALHN hospitals).
Denominator:	Count (#) of XLHN residents separations from any LHN (i.e. number of NALHN residents separations from any LHN).

More Information

Scope:	Data is reported for: • CALHN • SALHN • NALHN • RMCLHN • LCLHN • FUNLHN • EFNLHN • YNLHN • BHFLHN
Benchmarks:	N/A
Representation Class:	Percentage (%)
Data Type:	Real
Unit of Measure:	Episodes
Data Source:	Central Data Warehouse (CDW): Admitted Activity
Frequency of Reporting:	Quarterly (i.e. July – September data reported in October)
Notes:	> XLHN is the LHN for which the indicator is calculated. > For separations with CALHN – Patient Residence, need to ensure that these are mapped to WCH as Patient Residence for the relevant SRGs/ESRGs/DRGs.
Related Information:	> Service Agreements 2021-2022 SA Health.

PRODUCTIVITY AND EFFICIENCY

FINANCE

End Of Year Net Variance To Budget	
Identifying and definitional attributes	
Short Name:	EOY Variance to Budget
Tier:	Tier 1
KPI ID:	PE-F-T1-1
Description:	End of year forecasted expenditure of providing services for a given period, minus the end of year adjusted budget for the same period
Computation:	Variance
More Information	
Scope:	Data is reported for: • CALHN • SALHN • NALHN • WCHN • BHFLHN • FUNLHN • EFNLHN • RMCLHN • LCLHN • YNLHN • DHW (including Drug and Alcohol Services South Australia) • South Australian Ambulance Services • State-wide Clinical Support Services • Wellbeing SA
Benchmarks:	Performing (Target) <=0 Performance Concern = N/A Underperforming >0
Representation Class:	Dollar
Data Type:	Real
Unit of Measure:	Monetary amount
Data Source:	SHARP
Frequency of Reporting:	Monthly (i.e. July data reported in August)

Notes:	> Net Grant Funded Services impact. > For monthly reporting, indicator data is disaggregated to show the following elements: (a) End of year Projection Net Variance to Budget (b) Expenditure Variance to Budget (c) Revenue (All) Variance to Budget (d) Revenue (Earned) Variance to Budget > A percentage calculation is also available in the monthly workbooks.
Related Information:	> Service Agreements 2021-2022 SA Health.

Delivery of Savings Initiatives

Identifying and definitional attributes

Short Name:	Savings Initiatives
Tier:	Tier 2
KPI ID:	PE-F-T2-1
Description:	The variance of savings achieved against the savings target nominated by the LHN for the reporting period.
Computation:	(Numerator/Denominator)*100
Numerator	Total savings achieved by the health service minus total savings nominated by the health service for the reporting period
Denominator	Total savings nominated by the health service for the reporting period

More Information

Scope:	Data is reported for: • CALHN • SALHN • NALHN • WCHN • BHFLHN • FUNLHN • EFNLHN • RMCLHN • LCLHN • YNLHN • South Australian Ambulance Services • State-wide Clinical Support Services • Wellbeing SA
Benchmarks:	Performing (Target) >= 0% Performance Concern > -10% and <0% Underperforming < -10%
Representation Class:	Percentage (%)
Data Type:	Real
Unit of Measure:	Monetary Amount
Data Source:	Department for Health and Wellbeing, Health Performance Unit
Frequency of Reporting:	Monthly (i.e. July data reported in August)
Notes:	> LHNs and health agencies forecasting to deliver an unfavourable variance to approved budget will be required to develop a financial improvement strategy to ensure the delivery of a balanced budget

	position by the end of the financial year. > LHNs and health agencies will nominate the distribution of the required savings over the remaining months of the financial year. This will formulate the reporting period savings targets that LHN and health agencies must maintain to achieve a balanced budget position by the end of the financial year. > LHN and health agency that are reporting a balanced budget position are not required to deliver savings initiatives. If an LHN or health agency's end of financial year net variance to budget estimate indicates an unfavourable position during the financial year, a financial improvement strategy with savings initiative will be required to mitigate a potential unfavourable position by the end of the financial year.
Related Information:	> Service Agreements 2021-2022 SA Health.

Comparison to National Efficient Price

Identifying and definitional attributes

Short Name:	%NEP
Tier:	Tier 2
KPI ID:	PE-F-T2-2
Description:	Variance in adjusted cost per gross NWAU compared to the National Efficient Price against the commissioned cost per NWAU compared to the National Efficient Price.
Numerator	Adjusted cost per gross NWAU
Denominator	National Efficient Price Determination 2021-22
Computation:	Variance

More Information

Scope:	Data is reported for: • CALHN • SALHN • NALHN • WCHN • BHFLHN • FUNLHN • EFNLHN • RMCLHN • LCLHN • YNLHN
Benchmarks:	CALHN, NALHN, SALHN, WCHN Performing <= 100% LCLHN Performing <= 91.0% BHFLHN, RMCLHN Performing <= 86.0% EFNLHN, FUNLHN, YNLHN Performing <= 85.0%
Representation Class:	Percentage (%)
Data Type:	Real
Unit of Measure:	Monetary Amount
Data Source:	Department for Health and Wellbeing, Funding Models

Frequency of Reporting:	Quarterly
Notes:	> NWAU is the Nationally Weighted Activity Unit. > NEP is the National Efficient Price. The NEP Determination is provided by the Independent Hospital Pricing Authority (IHPA) for the current financial year. > An LHN's average cost per NWAU is the LHN's Adjusted Costs ($) over the LHN's Gross NWAUs. o The Adjusted Costs ($) are calculated from the actual activity cost ($) submitted by the LHN for the reporting period, less work in progress (WIP) patients, less out of scope (non-funded) products and costs. o The Gross NWAUs are calculated from the LHN's actual activity in NWAUs for the reporting period less NWAUs from separations resulting in a Hospital Acquired Complication (HAC).
Related Information:	> Independent Hospital Pricing Authority - Nationally Weighted Activity Unit Calculations 2021-22 > Independent Hospital Pricing Authority - National Efficient Price Determination 2021-22 > Service Agreements 2021-2022 SA Health.

COMMISSIONED ACTIVITY

Commissioned Activity	
Identifying and definitional attributes	
Short Name:	Overall NWAU activity to CAP Inpatient Acute Admitted - SEPS Inpatient Acute Admitted - NWAUs Inpatient Sub-Acute - SEPS Inpatient Sub-Acute - NWAUs Emergency Department - Presentations Emergency Department - NWAUs Outpatients - Service Events Outpatients - NWAUs
Tier:	Tier 1 Supplementary Indicator Supplementary Indicator Supplementary Indicator Supplementary Indicator Supplementary Indicator Supplementary Indicator Supplementary Indicator Supplementary Indicator
KPI ID:	PE-CA-T1-1 PE-CA-S-1 PE-CA-S-2 PE-CA-S-3 PE-CA-S-4 PE-CA-S-5 PE-CA-S-6 PE-CA-S-7 PE-CA-S-8
Description:	Variance in actual activity to commissioned levels of activity.
Computation:	(Numerator/Denominator)*100
Numerator:	Overall NWAU activity to CAP: Actual total activity National Weighted Activity Units (NWAUs) minus the commissioned cap for total activity NWAUs. Inpatient Acute Admitted - SEPS: Actual inpatient acute separations minus the commissioned cap for inpatients acute separations. Inpatient Acute Admitted - NWAUs: Actual inpatient acute admitted NWAUs minus the commissioned cap for inpatient acute admitted NWAUs. Inpatient Sub-Acute - SEPS: Actual inpatient sub-acute separations minus the commissioned cap for inpatient sub-acute separations. Inpatient Sub-Acute - NWAUs: Actual inpatient sub-acute NWAUs minus the commissioned cap for inpatient sub-acute NWAUs. Emergency Department - Presentations: Actual emergency department (ED) presentations minus the commissioned cap for ED presentations. Emergency Department - NWAUs:

	Actual ED NWAUs minus the commissioned cap for ED NWAUs. Outpatients - Service Events: Actual outpatient service events minus the commissioned cap for outpatient service events. Outpatients - NWAUs: Actual outpatient NWAUs minus the commissioned cap for outpatient NWAUs.
Denominator:	Overall NWAUS activity to CAP: Commissioned cap for total activity National Activity Weighted Units (NWAUs). Inpatient Acute Admitted - SEPS: Commissioned cap for inpatients acute separations. Inpatient Acute Admitted - NWAUs: Commissioned cap for inpatient acute admitted NWAUs. Inpatient Sub-Acute - SEPS: Commissioned cap for inpatient sub-acute separations. Inpatient Sub-Acute - NWAUs: Commissioned cap for inpatient sub-acute NWAUs. Emergency Department - Presentations: Commissioned cap for emergency department (ED) separations. Emergency Department - NWAUs: Commissioned cap for ED NWAUs. Outpatients - Service Events: Commissioned cap for outpatient service events. Outpatients - NWAUs: Commissioned cap for outpatient NWAUs.
More Information	
Scope:	Data is reported for: • CALHN • SALHN • NALHN • WCHN • BHFLHN • FUNLHN • EFNLHN • RMCLHN • LCLHN • YNLHN
Benchmarks:	Metro LHNs: Performing (Target) <= +/-0.5% Performance Concern > +/-0.5% and <= +/-1.0% Underperforming > +/-1.0% Regional LHNs: Performing (Target) <= +/-1.0% Performance Concern > +/-1.0% and <= +/-3.0% Underperforming > +/-3.0%
Representation Class:	Percentage (%)
Data Type:	Real
Unit of Measure:	Services Type
Data Source:	Overall NWAUs Actual to CAP: NWAUs: Casemix Performance Monitoring and Reporting (PMR) monthly report Acute/Sub-Acute/Emergency/Outpatients Activity: Commissioning_Report (monthly coded)

	NWAUs: Casemix Performance Monitoring and Reporting (PMR) monthly report
Frequency of Reporting:	Monthly (i.e. July data reported in August)
Notes:	> NWAUs are the National Weighted Activity Units. > Inpatient overall admitted is the sum of acute and sub-acute/maintenance for separations and NWAUs respectively. > In the monthly performance workbooks, for all inpatient admitted figures, the data for the latest reported month is based on estimated data, while data for the previous months is based on coded data. The following month, the estimated data is updated with coded data. > The Commissioning Report only contains coded data. As such it has a lag of one month in data compared with the monthly performance workbooks (which has the estimated data for the latest month). > The Department supplies the LHNs with end of year caps as part of the Service Agreements. The LHNs flow the caps monthly to derive monthly and year to date caps.
Related Information:	> Service Agreements 2021-2022 SA Health.

EFFICIENCY

Relative Stay Index	
Identifying and definitional attributes	
Short Name:	Relative Stay Index (RSI)
Tier:	Tier 1
KPI ID:	PE-E-T1-1
Description:	Count (#) of patient days for acute care separations in selected AR-DRGs divided by the expected count (#) of patient days, adjusted for Casemix.
Computation:	(Numerator/Denominator)*100
Numerator:	Count (#) of actual acute care length of stay (LOS) days for the hospital.
Denominator:	Count (#) of expected acute care LOS days for the hospital.
More Information	
Scope:	Data is reported for: • CALHN: RAH, QEH • SALHN: FMC, NHS • NALHN: LMH, Modbury • WCHN: WCH • BHFLHN: Gawler, Mount Barker, South Coast • EFNLHN: Port Lincoln • FUNLHN: Port Augusta, Whyalla • RMCLHN: Riverland, Murray Bridge • LCLHN: Mount Gambier • YNLHN: Port Pirie
Benchmarks:	Performing (Target) <=0.95 Performance Concern = N/A Underperforming >0.95
Representation Class:	Ratio
Data type:	Real
Unit of Measure:	Hospital Bed
Data Source:	Operational Business Intelligence (OBI) - Sunrise/PAS sites Chiron, Homer and ATS - FMC Australian Institute of Health and Welfare (AIHW) RSI method currently applied
Frequency of Reporting:	Quarterly (1 month lag i.e. July – September data reported in November)

Notes:	> Count of expected LOS days is based on the methodology and coefficients provided by the Australian Institute of Health and Welfare and requires adjustment for Casemix and patient age profile of the hospital. The DHW can assists LHN's should they wish to apply provided coefficients at an LHN level. > A Relative Stay Index (RSI) of greater than 1.00 indicates that the count of patient days for a hospital is higher than would be expected given its Casemix and age distribution. A RSI of less than 1.00 indicates that the count of patient days is less than would have been expected. > Calculated on the basis of a 12 month rolling period. > The following exclusions are applied to SA public hospitals: • Non-acute episodes of care - separations which do not meet the criteria of Acute, Qualified Newborns and Hospital- -in the-Home (HITH) without Rehabilitation component (Episodes of Care=1,5,99 OR Episode of Care=7 AND Additional Diagnosis 1 <> Z878, I698, Z479, Z509 AND Additional Diagnosis 2 to 99<>Z509). • LOS > 120 days. • Died or transferred within 2 days of admission (reference AHS 2017-18). • Same day DRGs version 8. • Any other DRG version 8 codes not included in the methodology set down by the Australian Institute of Health and Welfare. > RSI calculations for Hospital in the Home (HITH): • If the separation is entirely a HITH care type, the separation i.e. the entire LOS is excluded. • If the separation is not a HITH care type but has some HITH LOS component, the separation is included but the calculation excludes HITH LOS portion of the total LOS. > Coefficients are based on national data 2016-17 in DRG v8.
Related Information:	> Service Agreements 2021-2022 SA Health.

Mental Health – Acute Average Length of Stay (Hospital or "Non-Linked" ALOS)

Identifying and definitional attributes

Short Name:	MH Acute ALOS
Tier:	Tier 2
KPI ID:	PE-E-T2-2
Description:	Average length of stay of in-scope overnight separations from acute psychiatric inpatient public hospital services.
Computation:	(Numerator/Denominator)*100
Numerator:	Count (#) of psychiatric care days for acute admitted patient mental health care service unit(s) during the reference period.
Denominator:	Count (#) separations occurring within the reference period having psychiatric care days in an acute admitted patient mental health care service unit(s).

More Information

Scope:	Data is reported for: • CALHN • SALHN • NALHN • WCHN • BHFLHN: Glenside Rural and Remote Ward • RMCLHN: Riverland • LCLHN: Mount Gambier • FUNLHN: Whyalla
Benchmarks:	Adult wards: (Combined total including “General acute” wards and MH Short stay wards.) Metropolitan LHNs (excluding WCHN), RMCLHN, LCLHN, FUNLHN: Performing (Target) <=14 days Performance Concern >14 days and <=16 days Underperforming >16 days BHFLHN: Performing (Target) <=16 days Performance Concern >16 days and <=18 days Underperforming >18 days Older Persons wards: Metropolitan LHNs (excluding WCHN): Performing (Target) <=40 days Performance Concern >40 days and <=45 days Underperforming >45 days Child & Adolescent wards: WCHN only (Mallee ward): Performing (Target) <=11 days Performance Concern >11 days and <=14 days Underperforming >14 days
Representation Class:	Mean (average)
Data Type:	Real

Unit of Measure:	Days
Data Source:	Admitted Patient Care, formerly Integrated South Australian Activity Collection (ISAAC)/ Community Mental Health Systems (CBIS, CCCME)
Frequency of Reporting:	Monthly (1 month lag i.e. July data reported in September)
Notes:	> Includes: • Episodes where Psychiatric Care Days > 0 (meaning overnight ward is a designated mental health ward). • Separations for clients remaining admitted for longer than 12 months. • Mental health treatment in regional hospitals where Integrated Mental Health Inpatient Units (IMHIUs) are operational. • Forensic wards included in KPI analysis. • "Acute" mental health episodes (where separations have the Last Mental Health Ward indicated as "acute"). • Specialist adult wards - Jamie Larcombe Centre (Veterans) and Ward 4G (Eating Disorders, Anxiety, Gambling). > Excludes: • Separations where hospital admission date is equal to hospital separation date. • Separations where length of stay is one night only and procedure codes for ECT or TMS are recorded. • Separations where the Last Mental Health Ward is a non-acute designated mental health ward. • Separations where mental health treatment is occurring within general wards. • Patient leave days (based on hours of leave as per standard CDW methodology) and Hospital at Home days from the occupied bed days' calculation. > Admitted Patient Care, CDW bundling rules must be applied to ensure episodes are not wrongly included or excluded. • "State" bundled episodes should be used for psychiatric hospitals (Glenside, James Nash House) to accurately process administrative separations between Acute and Non-acute wards (and sub-type of MH Care Type) • "National" bundled episode should be used for general hospitals with acute MH wards to accurately exclude internal transitions from one MH sub-care-type to another within a ward > Total length of stay in a ward within a single hospital stay needs to be counted as one separation even if, for example, the EoC changes from MH Acute to MH Rehabilitation or MH Maintenance. > Ward level attributes the numerator/denominator based on Last Mental Health Ward (rather than Ward on Discharge which may not be a mental health ward). This also supports correct attribution to LHN, e.g. Glenside Rural and Remote ward is governed by BHFLHN not CALHN, whereas Glenside might be counted as a "CALHN hospital". > Specialist adult wards to be included in future analysis, with a specific benchmark to be determined: • SALHN – Jamie Larcombe Centre (Veterans). • SALHN – Ward 4G (Eating Disorders, Anxiety, Gambling). • WCHN – Helen Mayo House (Perinatal; excludes patients less than 16 years of age).
Related Information:	> KPIs for Australian Public Mental Health Services: PI 04J – Average length of acute inpatient stay, 2019 (Service Level). https://meteor.aihw.gov.au/content/index.phtml/itemId/723369 > Service Agreements 2021-2022 SA Health.

Mental Health - Average Treatment Days Per Three Month Community Care Period

Identifying and definitional attributes

Short Name:	MH Three month community care
Tier:	Monitor
KPI ID:	PE-E-M-1
Description:	Average treatment days per three month community mental health care period.
Computation:	Numerator/Denominator
Numerator:	Count (#) of community mental health care treatment days provided by public mental health services within the reference period.
Denominator:	Count (#) of mental health ambulatory care statistical episodes treated by the mental health service organisation's ambulatory services within the reference period (three-months).

More Information

Scope:	Data is reported for: • CALHN • SALHN • NALHN • WCHN • BHFLHN • EFNLHN • RMCLHN • LCLHN • FUNLHN • YNLHN
Benchmarks:	To be finalised
Representation Class:	Mean (average)
Data Type:	Real
Unit of Measure:	Days
Data Source:	Admitted Patient Care, formerly Integrated South Australian Activity Collection (ISAAC)/ Community Mental Health Systems (CBIS, CCCME)
Frequency of Reporting:	Quarterly (1 month lag i.e. July – September data reported in November)

Notes:	> All community mental health care service activity (treatment days and statistical episodes) associated with non-uniquely identified consumers is excluded. > Methodology: • Reference period for 2021/22 performance reporting: 2019–20 • For the purposes of this measure, community mental health care statistical episodes consist of the following fixed three-monthly periods; January–March, April–June, July–September, and October–December. > A community mental health care statistical episode is defined as a three-month period of ambulatory care for a uniquely identifiable person where the individual was under 'active care'. Active care is defined as one or more treatment days in the period. Each uniquely identifiable person is counted uniquely at the specialised mental health service organisation level, regardless of the number of teams or community programs involved in his/her care.
Related Information:	> KPIs for Australian Public Mental Health Services: PI 06J – Average treatment days per three-month community mental health care period, 2019 https://meteor.aihw.gov.au/content/index.phtml/itemId/723371 > Service Agreements 2021-2022 SA Health.

Critical Errors – Admitted Patient Care

Identifying and definitional attributes

Short Name:	APC Critical Errors
Tier:	Tier 2
KPI ID:	PE-QHI-T2-1
Description:	Proportion (%) of active admitted patient records that produce a critical error in the Admitted Patient Care system (formerly known as ISAAC).
Computation:	(Numerator/Denominator)*100
Numerator:	Count (#) of active admitted patient records that produce a critical error in the Admitted Patient Care system.
Denominator:	Count (#) of all active admitted patient records in the Admitted Patient Care system.

More information

Scope:	Data is reported for: • CALHN • SALHN • NALHN • WCHN • BHFLHN • FUNLHN • EFNLHN • RMCLHN • LCLHN • YNLHN
Benchmarks:	Performing (Target) <=1.0% Performance Concern >1.0% and <= 2.0% Underperforming >2.0%
Representation Class:	Percentage (%)
Data Type:	Real
Unit of Measure:	Separations
Data Source:	Admitted Patient Care.
Frequency of Reporting:	Monthly (1 month lag i.e. July data reported in September)

Notes:	> A critical error will arise when an invalid or inconsistent value is submitted for a data item that is required for one or more of the following: • Assigning Australian Refined - Diagnostic Related Groups (AR-DRGs) • Public Hospital Casemix Funding Model (CFM) calculation • Establishing correct place of residence • Establishing Veteran Affair eligibility. > Records that have a critical error are not assigned AR-DRGs (grouped) and are not extracted for the CFM. Consequently, all critical errors require prompt attention and correction so the record can be grouped accurately, included in the CFM and funded. > Critical errors consist of Invalid Errors (where a reported value is not valid) and Inconsistent Reporting Errors (where a reported value is inconsistent with another reported value). This includes specific rejected records relating to Edits: • 1131 • 1341 • 1351 • 1361. > Active admitted records used in the denominator calculation include all valid records and those records producing a critical error. > Critical errors are generated as part of the monthly refresh; corrections in the source will be reflected in a subsequent refresh.
Related Information:	> Admitted Patient Care: Data Elements 2021-2022 > 2021-2022 Monthly Data File Submission Schedule. > Service Agreements 2021-2022 SA Health.

Critical Errors – Emergency Department

Identifying and definitional attributes

Short Name:	ED Critical Errors
Tier:	Tier 2
KPI ID:	PE-QHI-M-1
Description:	Proportion (%) of emergency department (ED) records that produce a critical error due to invalid or inconsistent data.
Computation:	(Numerator/Denominator)*100
Numerator:	Count (#) of ED records with a URG code of either: • E1 • E2 • E3 • E5 • E6 • E7 • E8.
Denominator:	Count (#) of all ED records.

More information

Scope:	Data is reported for: • CALHN • SALHN • NALHN • WCHN • BHFLHN • FUNLHN • EFNLHN • RMCLHN • LCLHN • YNLHN
Benchmarks:	Performing (Target) <=1.0% Performance Concern >1.0% and <= 2.0% Underperforming >2.0%
Representation Class:	Percentage (%)
Data Type:	Real
Unit of Measure:	Presentations
Data Source:	Central Data Warehouse (CDW): Casemix view
Frequency of Reporting:	Monthly (1 month lag i.e. July data reported in September)

Notes:	> A critical error will arise when an invalid or inconsistent value is submitted for a data item that is required for one or more of the following: • Non-admitted patient emergency department care National Minimum Data Set (NAPEDC NMDS) • Activity Based Funding (ABF) as provided by Independent Hospital Pricing Authority (IHPA). > Critical Errors consist of: • Invalid errors (where a reported value is not valid) • Inconsistent reporting errors (where a reported value is inconsistent with another reported value). > Invalid errors include invalid data for: • Mapped (National) Departure Status not 1,2,3,4,5,6,7 or 8 • Diagnosis Code invalid or not provided • Diagnosis Code doesn't map to Shortlist Diagnosis Code • Mapped (National) Type of Visit Code not 1, 2, 3 or 5. > Inconsistent reporting errors include: • Sex code not 1, 2 or 3 consistent with diagnosis code > Records that do not attract funding are excluded from the numerator and denominator, including records where: • URN, Presentation Date Time or Departure Date Time has not been provided • Departure Date Time provided is before Presentation Date Time • Seen by Date time is before Presentation Date Time or after Departure Date Time • Triage Category Code not 1, 2, 3, 4 or 5 • Seen by Date Time is null and Mapped (National) Departure status is not 4, 8 or 9. > All critical errors are to be reviewed by the hospital. > Critical errors are generated as part of the monthly refresh; corrections in the source will be reflected in a subsequent refresh.
Related Information:	> Service Agreements 2021-2022 SA Health.

SAFE AND EFFECTIVE CARE

SAFE CARE

Healthcare Associated SAB Infection Rate	
Identifying and definitional attributes	
Short Name:	SAB Infection Rate
Tier:	Tier 1
KPI ID:	SEC-SC-T1-1
Description:	Patient episodes of healthcare associated Staphylococcus aureus bacteraemia (SAB) per 10,000 patient bed days.
Computation:	(Numerator/Denominator)*10,000
Numerator:	Count (#) of patient episodes of healthcare associated SAB.
Denominator:	Count (#) of bed days for all patients who were admitted for an episode of care.
More Information	
Scope:	Data is reported for: • CALHN • SALHN • NALHN • WCHN • BHFLHN: Gawler, South Coast, Mount Barker • FUNLHN: Port Augusta, Whyalla • EFNLHN: Port Lincoln • RMCLHN: Riverland (Berri), Murray Bridge • LCLHN: Mount Gambier • YNLHN: Port Pirie
Benchmarks:	Performing (Target) <=1.0 Performance Concern = N/A Underperforming >1.0
Representation Class:	Ratio
Data Type:	Real
Unit of Measure:	Disease Type
Data Source:	Operational Business Intelligence (OBI) plus externally supplied for BHFLHN and Murray Bridge
Frequency of Reporting:	Monthly (1 month lag i.e. July data reported in September)
Notes:	> A patient episode of bacteraemia (bloodstream infection) is defined as a positive blood culture for Staphylococcus aureus. For surveillance purposes, only the first isolate per patient is counted, unless at least 14 days has passed without a positive blood culture, after which an additional

	episode is recorded. > A SAB specimen is healthcare associated if: • EITHER o the patient's first SAB blood culture was collected more than 48 hours after hospital admission or less than 48 hours after discharge • OR o the patient's first SAB blood culture was collected less than or equal to 48 hours after hospital admission and one or more of the following key clinical criteria was met for the patient-episode of SAB: 1. SAB is a complication of the presence of an indwelling medical device (e.g. intravascular line, haemodialysis vascular access, CSF shunt, urinary catheter). 2. SAB occurs within 30 days of a surgical procedure where the SAB is related to the surgical site 3. SAB was diagnosed within 48 hours of a related invasive instrumentation or incision 4. SAB is associated with neutropenia (less than 1 x 109/L) contributed to by cytotoxic therapy. > Includes same-day patients, overnight admitted patients and unqualified newborns. > Excludes cases where a known previous positive test has been obtained within the last 14 days.
Related Information:	> National Healthcare Agreement: PI 22–Healthcare associated infections: Staphylococcus aureus bacteraemia, 2020. https://meteor.aihw.gov.au/content/index.phtml/itemId/725781 > National Healthcare Agreement: PB g–Better health services: the rate of Staphylococcus aureus (including MRSA) bacteraemia is no more than 2.0 per 10,000 occupied bed days for acute care public hospitals by 2011–12 in each state and territory, 2021 https://meteor.aihw.gov.au/content/index.phtml/itemId/725830 > Australian Health Performance Framework: PI 2.2.2–Healthcare-associated Staphylococcus aureus bloodstream infections, 2019 https://meteor.aihw.gov.au/content/index.phtml/itemId/716034 > Service Agreements 2021-2022 SA Health.

Hospital Acquired Complication Rate

Identifying and definitional attributes

Short Name:	HAC Rate
Tier:	Tier 1
KPI ID:	SEC-SC-T1-2
Description:	Percentage (%) of overnight episodes where one or more hospital-acquired complications (HAC) was reported at diagnosis level.
Computation:	(Numerator/Denominator)*100
Numerator:	Count (#) of overnight episodes where one or more HAC was reported at diagnosis level.
Denominator:	Count (#) of overnight episodes.

More Information

Scope:	Data is reported for: • CALHN • SALHN • NALHN • WCHN • BHFLHN: Gawler, South Coast, Mount Barker • FUNLHN: Port Augusta, Whyalla • EFNLHN: Port Lincoln • RMCLHN: Riverland (Berri), Murray Bridge • LCLHN: Mount Gambier • YNLHN: Port Pirie
Benchmarks:	Metro LHNs: Performing (Target) <=2.0% Performance Concern = N/A Underperforming >2.0% Regional LHNs: Performing (Target) <=1.0% Performance Concern = N/A Underperforming >1.0%
Representation Class:	Ratio
Data Type:	Real
Unit of Measure:	Episode
Data Source:	Raw data utilises bundled data from Central Data Warehouse (CDW) Admitted Activity standard views (business sub-setting applied). Independent Hospital Pricing Authority (IHPA) and Australian Commission on Safety and Quality in Health Care hospital acquired complications (HACs) algorithm (toolkit version 1.1) then applied.
Frequency of Reporting:	Monthly (1 month lag i.e. July data reported in September)

Notes:

- A HAC refers to a complication for which clinical risk mitigation strategies may reduce (but not necessarily eliminate) the risk of that complication occurring.
- Diagnosis level refers to the sub-category of the HAC.
- Includes acute and mental health episodes only.
- Excludes data where HAC diagnosis code and/or the condition onset flag field(s) are incomplete.
- The HAC algorithm groups episode into the 16 different complications which occur during a hospital stay and for which clinical risk mitigation strategies may reduce (but not necessarily eliminate) the risk of that complication occurring.
- Work is underway to implement version 2.0 of the toolkit into CDW for 2021-22.
- The national list of HACs developed by the Australian Commission on Safety and Quality in Health Care is defined as:

Complication	Diagnosis
Pressure injury	> Stage III ulcer > Stage IV ulcer > Unspecified decubitus ulcer and pressure area > Unstageable pressure injury > Suspected deep tissue injury
Falls resulting in fracture or intracranial injury	> Intracranial injury > Fractured neck of femur > Other fractures
Healthcare-associated infection	> Urinary tract infection > Surgical site infection > Pneumonia > Blood stream infection > Infection or inflammatory complications associated with peripheral/central venous catheters > Multi-resistant organism > Infection associated with prosthetics/implantable devices > Gastrointestinal infections > Other high impact infections
Surgical complications requiring unplanned return to theatre	> Post-operative haemorrhage/haematoma requiring transfusion and/or return to theatre > Surgical wound dehiscence > Anastomotic leak > Vascular graft failure > Other surgical complications requiring unplanned return to theatre
Unplanned intensive care unit admission	> Unplanned admission to intensive care unit
Respiratory complications	> Respiratory failure including acute respiratory distress syndrome requiring ventilation > Aspiration pneumonia > Pulmonary oedema
Venous thromboembolism	> Pulmonary embolism > Deep vein thrombosis
Renal failure	> Renal failure requiring haemodialysis or continuous veno-venous haemodialysis
Gastrointestinal bleeding	> Gastrointestinal bleeding
Medication complications	> Drug related respiratory complications/depression > Haemorrhagic disorder due to circulating anticoagulants > Movement disorders due to psychotropic medication > Serious alteration to conscious state due to psychotropic medication
Delirium	> Delirium
Persistent incontinence	> Urinary incontinence > Faecal incontinence
Malnutrition	> Malnutrition > Hypoglycaemia

	<table><tr><td>Cardiac complications</td><td>> Heart failure and pulmonary oedema > Arrhythmias > Cardiac arrest > Acute coronary syndrome including unstable angina, STEMI and NSTEMI > Infective endocarditis</td></tr><tr><td>Third and fourth degree perineal laceration during delivery</td><td>> Third and fourth degree perineal laceration during delivery</td></tr><tr><td>Neonatal birth trauma</td><td>> Neonatal birth trauma > Hypoxic ischaemic encephalopathy</td></tr></table> > 'Unplanned intensive care unit admission' is currently unmeasurable, as this data is not captured in the current dataset specification.
Related Information:	> Australian Commission on Safety and Quality in Health Care, Hospital-Acquired Complications. https://www.safetyandquality.gov.au/our-work/indicators/hospital-acquired-complications > Service Agreements 2021-2022 SA Health.

Mental Health – Seclusion Per 1,000 Bed Days In Acute MH Wards

Identifying and definitional attributes

Short Name:	Rate of Seclusion
Tier:	Tier 1
KPI ID:	SEC-SC-T1-3
Description:	Rate per 1,000 bed days of mental health episodes where a seclusion event was recorded.
Computation:	(Numerator/Denominator)*1,000
Numerator:	Count (#) of mental health seclusion events.
Denominator:	Count (#) of mental health patient bed days.

More Information

Scope:	Data is reported for: • CALHN • SALHN • NALHN • WCHN • BHFLHN: Glenside Rural and Remote Ward • RMCLHN: Riverland • LCLHN: Mount Gambier • FUNLHN: Whyalla
Benchmarks:	Performing (Target) <=3.0 Performance Concern >3.0 and <=5.0 Underperforming >5.0
Representation Class:	Ratio
Data Type:	Real
Unit of Measure:	Episode
Data Source:	Safety learning System (SLS) via Operational Business Intelligence (OBI)
Frequency of Reporting:	Monthly (i.e. July data reported in August)
Notes:	> A Mental Health patient is defined as a patient admitted to an acute mental health ward, including short stay. > Excludes: • Noarlunga Hospital's Hospital at Home program • Electro-Convulsion Therapy (ECT) wards • NALHN Aldgate ward (Aldgate data is made available in performance workbooks to provide visibility of seclusion rates only and does not contribute to NALHN's performance level). > Seclusion is defined as the confinement of the consumer/patient at any time of the day or night alone in a room or area from which free exit is prevented. > Measured via midnight occupancy snapshot.

Related Information:	> KPIs for Australian Public Mental Health Services: PI 15J – Seclusion rate, 2019. https://meteor.aihw.gov.au/content/index.phtml/itemId/723392 > Service Agreements 2021-2022 SA Health.

CHBOI 1– Hospital Standardised Mortality Ratio

Identifying and definitional attributes

Short Name:	CHBOI 1 HSMR
Tier:	Tier 2
KPI ID:	SEC-SC-T2-1
Description:	Ratio of the observed count (#) of hospital separations that end in the patient's death, to the count (#) of separations expected to end in death based on the patient's characteristics, for principal diagnoses accounting for 80% of in-hospital mortality.
Computation:	(Numerator/Denominator)*100
Numerator:	Observed count (#) of in-hospital deaths.
Denominator:	Expected count (#) of in-hospital deaths.

More Information

Scope:	Data is reported for: • CALHN • SALHN • NALHN • WCHN
Benchmarks:	Performing (Target) = Inlier Performance Concern = N/A Underperforming = Outlier
Representation Class:	Ratio
Data Type:	Time Period
Unit of Measure:	Life event (e.g. birth, death)
Data Source:	Raw data utilises bundled data from Central Data Warehouse (CDW) Admitted Activity standard views (business sub-setting applied). Australian Commission on Safety and Quality in Health Care core, hospital-based outcome indicators (CHBOI) algorithm (version 3.1 released July 2021) is then applied.
Frequency of Reporting:	Quarterly (1 month lag i.e. July – September data reported in November)
Notes:	> For reporting, an LHN's reported Hospital Standardised Mortality Ratio (HSMR) is identified as an inlier or outlier. > Inlier - reported HSMR is within the confidence limit of the national population mean for HSMR i.e. within the Expected HMSR rate. > Outlier - reported HSMR is outside the confidence limit of the national population mean for HSMR i.e. outside the Expected HMSR rate. > Observed count of in-hospital deaths is where the separation mode is documented as died. > Expected count of in-hospital deaths is the sum of the estimated probabilities of death for all

	separations meeting criteria, calculated using national risk-adjustment coefficients. > Australian Commission on Safety and Quality in Health Care core, hospital-based outcome indicators (CHBOI) algorithm contains a range of mortality indicators which have been developed to enhance safety and quality reporting and feedback. > Criteria: • Principal diagnosis is in the national list of the top 80% of diagnoses, by frequency of in-hospital death, in the latest reference period. • Age at date of admission is between 29 days and 120 years, inclusive. • Care type = acute care, geriatric evaluation and management and maintenance care. • Length of stay, including leave days, is between 1 and 365 days, inclusive. • Both emergency and elective admissions. > Risk adjustment: • Age at admission (years) • Sex • Principal diagnosis code (mapped to national in-hospital mortality risk deciles) • Admission category: emergency, elective • Length of stay • Additional (comorbid) diagnoses • Referral Source: admitted patient transferred from another hospital. > A value of 100 indicates that the mortality rate is the same as the national rate for patients with similar characteristics to those treated. A value of more than 100 corresponds to a higher than expected mortality rate, while a value of less than 100 corresponds to a lower than expected mortality rate.
Related Information:	> National core, hospital-based outcome indicator specification (2021), Version 3.1, Australian Commission on Safety and Quality in Health Care (yet to be published). > Version 3.1 incorporates • ICD10 version change: from v.10 to v.11. • DRG version change: from v.9 to v.10. https://www.safetyandquality.gov.au/publications-and-resources/resource-library/national-core-hospital-based-outcome-indicator-specification > Service Agreements 2021-2022 SA Health.

Healthcare Associated MRSA Infection Rate

Identifying and definitional attributes

Short Name:	MRSA Infection Rate
Tier:	Tier 2
KPI ID:	SEC-SC-T2-2
Description:	Patient episodes of healthcare associated Methicillin-resistant Staphylococcus aureus (MRSA) per 10,000 patient bed days.
Computation:	(Numerator/Denominator)*10,000
Numerator:	Count (#) of patient episodes of healthcare associated MRSA.
Denominator:	Count (#) of bed days for all patients who were admitted for an episode of care.

More Information

Scope:	Data is reported for: • CALHN: RAH, TQEH • SALHN: FMC, NHS • NALHN: LMH, Modbury • WCHN: WCH • BHFLHN: Gawler, South Coast, Mount Barker • FUNLHN: Port Augusta, Whyalla • EFNLHN: Port Lincoln • RMCLHN: Riverland (Berri), Murray Bridge • LCLHN: Mount Gambier • YNLHN: Port Pirie
Benchmarks:	LMH, WCHN, RAH, QEH and CALHN: Performing (Target) <=1.2 Performance Concern > target to <=2.0% above target Underperforming >2.0% above target MH: Performing (Target) <=1.0 Performance Concern > target to <=2.0% above target Underperforming >2.0% above target NALHN and SALHN: Performing (Target) <=1.1 Performance Concern > target to <=2.0% above target Underperforming >2.0% above target FMC: Performing (Target) <=1.3 Performance Concern > target to <=2.0% above target Underperforming >2.0% above target NH: Performing (Target) <=0.0 Performance Concern > target to <=2.0% above target Underperforming >2.0% above target Regional LHNs: Performing (Target) <=0.4 Performance Concern > target to <=2.0% above target Underperforming >2.0% above target

Representation Class:	Ratio
Data Type:	Real
Unit of Measure:	Disease Type
Data Source:	Operational Business Intelligence (OBI) plus externally supplied for BHFLHN and Murray Bridge
Frequency of Reporting:	Monthly (1 month lag i.e. July data reported in September)
Notes:	> MRSA infection (morbidity) rate is an indicator of the rate of preventable infection in the hospitals. This rate is not dependent on the degree of active screening for MRSA carriage undertaken by the individual hospitals, therefore is a more robust indicator of the burden of disease due to MRSA. > The MRSA infection rate is recommended as the primary performance indicator of MRSA control for external benchmarking purposes, as it is the least likely to be affected by changes over time in screening practices. > The infection (morbidity) rate includes all patients, both newly identified and known carriers. > A MRSA specimen is healthcare associated if: • EITHER o the episode occurred >48 hours after admission/delivery at your facility and was not present or incubating on admission • OR o within 48 hours of discharge/transfer • OR o the episode is epidemiologically linked to a previous admission/intervention. > Includes same-day patients, overnight admitted patients, Maintenance Care Consolidated Episode, Hospital at Home Consolidated Episode, Rehabilitation at Home Consolidated Episode and unqualified newborns.
Related Information:	> National Healthcare Agreement: PI 22–Healthcare associated infections: Staphylococcus aureus bacteraemia, 2020. https://meteor.aihw.gov.au/content/index.phtml/itemId/725781 > National Healthcare Agreement: PB g–Better health services: the rate of Staphylococcus aureus (including MRSA) bacteraemia is no more than 2.0 per 10,000 occupied bed days for acute care public hospitals by 2011–12 in each state and territory, 2021 https://meteor.aihw.gov.au/content/index.phtml/itemId/725830 > Australian Health Performance Framework: PI 2.2.2–Healthcare-associated Staphylococcus aureus bloodstream infections, 2019 https://meteor.aihw.gov.au/content/index.phtml/itemId/716034 > Service Agreements 2021-2022 SA Health.

Mental Health - Restraint Events Per 1,000 Bed Days

Identifying and definitional attributes

Short Name:	Mental Health Restraints
Tier:	Tier 2
KPI ID:	SEC-SC-T2-3
Description:	Rate per 1,000 bed days of mental health episodes where a restraint event was recorded.
Computation:	(Numerator/Denominator)*1,000
Numerator:	Count (#) of mental health restraint events.
Denominator:	Count (#) of number of mental health bed days.

More Information

Scope:	Data is reported for: • CALHN • SALHN • NALHN • WCHN • BHFLHN: Gawler, South Coast, Mount Barker • RMCLHN: Riverland (Berri) • LCLHN: Mount Gambier • FUNLHN: Whyalla
Benchmarks:	Performing (Target) <= 2.0 Performance Concern >2.0 to <=4.0 Underperforming >4.0
Representation Class:	Ratio
Data Type:	Real
Unit of Measure:	Episode
Data Source:	Safety learning System (SLS) via Operational Business Intelligence (OBI)
Frequency of Reporting:	Monthly (i.e. July data reported in August)
Notes:	> A mental health patient is defined as a patient admitted to an acute mental health ward, including short stay. > Excludes: • Noarlunga Hospital's Hospital at Home program > Electro-Convulsion Therapy (ECT) wards. For this indicator, only mechanical and physical restraint events are included in the computation. Unspecified restraint events are not included. > Measured via midnight occupancy snapshot.

Related Information:	> KPIs for Australian Public Mental Health Services: PI 16 – Restraint rate, 2019 (Service level) https://meteor.aihw.gov.au/content/index.phtml/itemId/712107 > Mental health seclusion and restraint NBEDS 2015-2018; Quality Statement. https://meteor.aihw.gov.au/content/index.phtml/itemId/708420 > Service Agreements 2021-2022 SA Health.

Open Disclosure Rate Of Actual SAC 1 & 2 Patient Incidents

Identifying and definitional attributes

Short Name:	Open Disclosure Actual SAC 1 & 2
Tier:	Monitor
KPI ID:	SEC-SC-M-1
Description:	Proportion (%) of all actual Safety Assessment Code (SAC) 1 and 2 patient incidents that are disclosed to the patient/consumer.
Computation:	(Numerator/Denominator)*100
Numerator:	Count (#) of actual SAC 1 and 2 incidents disclosed to the patient/consumer.
Denominator:	Count (#) of all actual SAC 1 and 2 patient incidents.

More Information

Scope:	Data is reported for: • CALHN • SALHN • NALHN • WCHN • BHFLHN: Gawler, South Coast, Mount Barker • FUNLHN: Port Augusta, Whyalla • EFNLHN: Port Lincoln • RMCLHN: Riverland (Berri), Murray Bridge • LCLHN: Mount Gambier • YNLHN: Port Pirie • Drug and Alcohol Services South Australia • South Australian Ambulance Service • State-wide Clinical Support Services
Benchmarks:	Performing (Target) >=95.0% Performance Concern <95.0% and >=85.0% Underperforming <85.0%
Representation Class:	Ratio
Data Type:	Real
Unit of Measure:	Person
Data Source:	SA Health Incident Management reporting system – Safety Learning System (SLS)
Frequency of Reporting:	Monthly (1 month lag i.e. July data reported in September)
Notes:	> Safety Assessment Code (SAC) - a numerical score applied to an incident, which is based on the type of event, its likelihood of recurrence and its consequence. The score is determined using the SAC Matrix and guides the level of incident investigation or review that is undertaken.

	> Reporting of SAC 1 and 2 incidents via the SA Health incident management reporting system called Safety Learning System (SLS) for reporting and documenting the management and open disclosure of patient incidents. > Data excludes notifier incidents. > Open disclosure is defined as an open discussion with a patient and carer (unless declined or deferred) about an incident that resulted in harm to the patient while receiving health care. The criteria of open disclosure are an expression of regret, and a factual explanation of what happened, the potential consequences, and the steps taken to manage the even and prevent recurrence.
Related Information:	> Australian Commission on Safety and Quality in Health Care, Australian Open Disclosure Framework. https://www.safetyandquality.gov.au/publications-and-resources/resource-library/australian-open-disclosure-framework-better-communication-better-way-care > Service Agreements 2021-2022 SA Health.

Hospital Hand Hygiene Compliance Rate - Overall

Identifying and definitional attributes

Short Name:	Hand Hygiene
Tier:	Monitor
KPI ID:	SEC-SC-M-2
Description:	Percentage (%) of correct hand hygiene actions undertaken for Moments 1-5.
Computation:	(Numerator/Denominator)*100
Numerator:	Count (#) of correct hand hygiene actions for Moments1-5 within a given period.
Denominator:	Count (#) of hand hygiene opportunities for Moments 1-5 observed within the same period.

More Information

Scope:	Data is reported for: • CALHN • SALHN • NALHN • WCHN • BHFLHN: Gawler, South Coast, Mount Barker • FUNLHN: Port Augusta, Whyalla • EFNLHN: Port Lincoln • RMCLHN: Riverland (Berri), Murray Bridge • LCLHN: Mount Gambier • YNLHN: Port Pirie
Benchmarks:	Performing (Target) >=80.0% Performance Concern <80.0% and >=70.0% Underperforming <70.0%
Representation Class:	Ratio
Data Type:	Integer
Unit of Measure:	Episode
Data Source:	SA Health Hand Hygiene Australia (HHA) Compliance Application (HHCApp)
Frequency of Reporting:	3 Times per financial year July – October; November – March; April – June (1 Month lag i.e. July – October reported in November)

Notes:	> A moment or opportunity is defined as a point in patient care where the performance of hand hygiene is required to prevent the cross-transmission of potentially infective micro-organisms. The 5 moments are: 1. before touching a patient 2. before performing a procedure on a patient 3. after a procedure or a body fluid exposure risk 4. after touching a patient 5. after touching a patient's surroundings (note – reporting of Moment 5 is not included in a Local Health Network's Service Agreement for reporting but should still be monitored for compliance). > Correct hand hygiene opportunities relate to the count of hand hygiene actions where action code = 'R' (rub) or 'W' (wash). > Primary and ambulatory care settings e.g. SAAS, Dental, Mental Health, Community Health and aged care beds are not required to submit data using the national HHA moments audit tool to the HHA program, however these services are required to follow the SA Health Hand Hygiene Policy Directive and Guideline and should audit using the appropriate SA Health resources.
Related Information:	> Hand Hygiene Australia 5 Moments for Hand Hygiene Manual; Australian Commission for Safety and Quality in Healthcare. https://www.hha.org.au/hand-hygiene/5-moments-for-hand-hygiene > Hand Hygiene Policy Directive. SA Health. Inside SA Health Intranet Link > Service Agreements 2021-2022 SA Health.

Rate Of Surgical Site Infection: Hip Replacement

Identifying and definitional attributes

Short Name:	Rate of SSI: HPRO
Tier:	Monitor
KPI ID:	SEC-SC-M-3
Description:	Rate of episodes where there was a surgical site infection post hip replacement, per 100 procedures.
Computation:	(Numerator/Denominator)*100
Numerator:	Count (#) of patient episodes of surgical site infection (SSI) after hip replacement procedures during the reference period.
Denominator:	Count (#) of hip replacement procedures undertaken during the reference period.

More Information

Scope:	Data is reported for: • CALHN -TQEH, RAH • NALHN - LMH • SALHN - FMC • BHFLHN – Gawler, South Coast, Mt Barker EFNLHN – Pt Lincoln FUNLHN -Pt Augusta, Whyalla LCLHN – Mt Gambier RMCLHN – Riverland, Murray Bridge YNLHN – Pt Pirie
Benchmarks:	To be finalised
Representation Class:	Ratio
Data Type:	Real
Unit of Measure:	Episode
Data Source:	Manually supplied by Infection Control Service Communicable Disease Control Branch SA Department for Health and Wellbeing
Frequency of Reporting:	Quarterly (4month lag i.e. July – September data reported in January)
Notes:	> A surgical site infection (SSI) is an infection that develops as a direct result of an operative procedure. These infections are associated with increased morbidity and mortality, increased length of stay and higher healthcare costs. > SSI rates will have a reporting lag time of 3 months due to follow up surveillance periods. > SSI should only be reported by the hospital where the procedure was undertaken.

Related Information:	> Australian Commission on Safety and Quality in Health Care, Approaches to Surgical Site Infection Surveillance – For acute care settings in Australia, May 2017, ACSQHC, Sydney. https://www.safetyandquality.gov.au/publications-and-resources/resource-library/approaches-surgical-site-infection-surveillance-acute-care-settings-australia > Australian Commission on Safety and Quality in Health Care, Safety and Quality Improvement Guide Standard 3: Preventing and Controlling Healthcare Associated Infections, 2012 ACSQHC, Sydney. https://www.safetyandquality.gov.au/sites/default/files/migrated/Standard3_Oct_2012_WEB.pdf > SA Health Surgical Site infection (SSI) Surveillance > Service Agreements 2021-2022 SA Health.

Rate Of Surgical Site Infection: Knee Replacement

Identifying and definitional attributes

Short Name:	Rate of SSI: KPRO
Tier:	Monitor
KPI ID:	SEC-SC-M-4
Description:	Rate of episodes where there was a surgical site infection post knee replacement, per 100 procedures.
Computation:	(Numerator/Denominator)*100
Numerator:	Count (#) of patient episodes of surgical site infection (SSI) after knee replacement procedures during the reference period.
Denominator:	Count (#) of knee replacement procedures undertaken during the reference period.

More Information

Scope:	Data is reported for: • CALHN -TQEH, RAH • NALHN - LMH • SALHN - FMC • BHFLHN – Gawler, South Coast, Mt Barker • EFNLHN – Pt Lincoln • FUNLHN -Pt Augusta, Whyalla • LCLHN – Mt Gambier • RMCLHN – Riverland, Murray Bridge • YNLHN – Pt Pirie
Benchmarks:	To be finalised
Representation Class:	Ratio
Data Type:	Real
Unit of Measure:	Episode
Data Source:	Manually supplied by Infection Control Service Communicable Disease Control Branch SA Department for Health and Wellbeing
Frequency of Reporting:	Quarterly (4 month lag i.e. July – September data reported in January)
Notes:	> A surgical site infection (SSI) is an infection that develops as a direct result of an operative procedure. These infections are associated with increased morbidity and mortality, increased length of stay and higher healthcare costs. > SSI rates will have a reporting lag time of 3 months due to follow up surveillance periods. > SSI should only be reported by the hospital where the procedure was undertaken.

Related Information:	> Australian Commission on Safety and Quality in Health Care, Approaches to Surgical Site Infection Surveillance – For acute care settings in Australia, May 2017, ACSQHC, Sydney. https://www.safetyandquality.gov.au/publications-and-resources/resource-library/approaches-surgical-site-infection-surveillance-acute-care-settings-australia > Australian Commission on Safety and Quality in Health Care, Safety and Quality Improvement Guide Standard 3: Preventing and Controlling Healthcare Associated Infections, 2012 ACSQHC, Sydney. https://www.safetyandquality.gov.au/sites/default/files/migrated/Standard3_Oct_2012_WEB.pdf > National Healthcare Safety Network (NHSN), Surveillance for Surgical Site Infection (SSI) Events. > Service Agreements 2021-2022 SA Health.

Rate Of Surgical Site Infection: Lower Segment Caesarean Section

Identifying and definitional attributes

Short Name:	Rate of SSI: CSEC
Tier:	Monitor
KPI ID:	SEC-SC-M-5
Description:	Rate of episodes where there was a surgical site infection after lower segment caesarean section, per 100 procedures.
Computation:	(Numerator/Denominator)*100
Numerator:	Count (#) of patient episodes of surgical site infection (SSI) after lower segment caesarean sections during the reference period.
Denominator:	Count (#) of lower segment caesarean sections undertaken during the reference period.

More Information

Scope:	Data reported for: • NALHN – LMH, MH • SALHN - FMC • WCHN • BHFLHN – Gawler, South Coast, Mt Barker • EFNLHN – Pt Lincoln • FUNLHN -Pt Augusta, Whyalla • LCLHN – Mt Gambier • RMCLHN – Riverland, Murray Bridge • YNLHN – Pt Pirie
Benchmarks:	To be finalised
Representation Class:	Ratio
Data Type:	Real
Unit of Measure:	Person
Data Source:	Manually supplied by Infection Control Service Communicable Disease Control Branch SA Department for Health and Wellbeing
Frequency of Reporting:	Quarterly (4 month lag i.e. July – September data reported in January)
Notes:	> A surgical site infection (SSI) is an infection that develops as a direct result of an operative procedure. These infections are associated with increased morbidity and mortality, increased length of stay and higher healthcare costs. > SSI rates will have a reporting lag time of 1 month due to follow up surveillance periods. > SSI should only be reported by the hospital where the procedure was undertaken.

Related Information:	> Australian Commission on Safety and Quality in Health Care, Approaches to Surgical Site Infection Surveillance – For acute care settings in Australia, May 2017, ACSQHC, Sydney. https://www.safetyandquality.gov.au/publications-and-resources/resource-library/approaches-surgical-site-infection-surveillance-acute-care-settings-australia > Australian Commission on Safety and Quality in Health Care, Safety and Quality Improvement Guide Standard 3: Preventing and Controlling Healthcare Associated Infections, 2012 ACSQHC, Sydney. https://www.safetyandquality.gov.au/sites/default/files/migrated/Standard3_Oct_2012_WEB.pdf > SA Health Surgical Site infection (SSI) Surveillance > Service Agreements 2021-2022 SA Health.

Sentinel Events

Identifying and definitional attributes

Short Name:	Sentinel Events
Tier:	Monitor
KPI ID:	SEC-SC-M-6
Description:	Count (#) of sentinel events within reporting period.
Computation:	Count (#)

More Information

Scope:	Data reported for: • CALHN • NALHN • SALHN • WCHN • BHFLHN • EFNLHN • FUNLHN • LCLHN • RMCLHN • YNLHN
Benchmarks:	Performing (Target) = 0 Performance Concern = N/A Underperforming >0
Representation Class:	Count (#)
Data Type:	Integer
Unit of Measure:	Episode
Data Source:	Operational Business Intelligence (OBI) - Sunrise/PAS sites Chiron, Homer
Frequency of Reporting:	Quarterly (1 month lag i.e. July – September data reported in November)
Notes:	> List of sentinel events: • Surgery or other invasive procedure performed on the wrong site resulting in serious harm or death. • Surgery or other invasive procedure performed on the wrong patient resulting in serious harm or death. • Wrong surgical or other invasive procedure performed on a patient resulting in serious harm or death. • Unintended retention of a foreign object in a patient after surgery or other invasive procedure resulting in serious harm or death. • Haemolytic blood transfusion reaction resulting from ABO incompatibility resulting in serious harm or death. • Suspected suicide of a patient in an acute psychiatric unit or acute psychiatric ward. • Medication error resulting in serious harm or death.

	• Use of physical or mechanical restraint resulting in serious harm or death. • Discharge or release of an infant or child to an unauthorised person. • Use of an incorrectly positioned oro- or naso- gastric tube resulting in serious harm or death.
Related Information:	> Australian Commission on Safety and Quality in Health Care, Australian sentinel events list https://www.safetyandquality.gov.au/our-work/indicators/australian-sentinel-events-list > Service Agreements 2021-2022 SA Health.

Consumer Experience: Involved in Decision Making
Consumer Experience: Feeling Cared About by Staff
Consumer Experience: Being Heard – Listened To
Consumer Experience: Overall Quality

Identifying and definitional attributes

Short Name:	Consumer Experience: Involved in Decisions Consumer Experience: Feeling Cared About Consumer Experience: Being Heard Consumer Experience: Overall
Tier:	Tier 1 Tier 1 Tier 2 Monitor
KPI ID:	SEC-CEC-T1-1 SEC-CEC-T1-2 SEC-CEC-T2-1 SEC-CEC-M-1
Description:	Percentage (%) of positive feedback from a selection of questions from the Australian Hospital Patient Experience Question Set (AHPEQS).
Computation:	(Numerator/Denominator)*100
Numerator:	Count (#) of respondents who: • Mostly or always felt they were involved as much as they wanted in making decisions about treatment and care. • Mostly or always felt cared for. • Mostly or always felt their views and concerns were listened to. • Reported the overall quality of the treatment and care received as good or very good.
Denominator:	Count (#) of all respondents.

More Information

Scope:	Data is reported for: • CALHN • SALHN • NALHN • WCHN • BHFLHN: Gawler, South Coast, Mount Barker • FUNLHN: Port Augusta, Whyalla • EFNLHN: Port Lincoln • RMCLHN: Riverland (Berri), Murray Bridge • LCLHN: Mount Gambier • YNLHN: Port Pirie

Benchmarks:	Performing (Target) >=85.0% Performance Concern <85.0% and >=80.0% Underperforming <80.0%
Representation Class:	Percentage (%)
Data Type:	Real
Unit of Measure:	Person
Data Source:	SA Consumer Experience Surveillance System
Frequency of Reporting:	Quarterly (2 Month lag i.e. July – September data reported in December)
Notes:	> The survey is compiled of a random sample of discharged patients from all SA public hospitals.
Related Information:	> Australian Hospital Patient Experience Question Set (AHPEQS); Australian Commission on Safety and Quality in Health Care (ACSQHC). https://www.safetyandquality.gov.au/publications-and-resources/resource-library/australian-hospital-patient-experience-question-set-ahpeqs-technical-specifications > Service Agreements 2021-2022 SA Health.

Maternity – HAC Rate 3rd And 4th Degree Perineal Tears

Identifying and definitional attributes

Short Name:	HAC Rate 3rd and 4th Degree Perineal Tears
Tier:	Tier 1
KPI ID:	SEC-AC-T1-1
Description:	Rate of third and fourth degree perineal laceration occurred during vaginal delivery per 10,000 vaginal deliveries.
Computation:	(Numerator/Denominator)*10,000
Numerator:	Count (#) of separations where a 3rd and 4th degree perineal laceration during vaginal delivery was recorded.
Denominator:	Count (#) of separations where a vaginal delivery occurred.

More Information

Scope:	Data is reported for: • SALHN • NALHN • WCHN • RMCLHN: Riverland (Berri), Murray Bridge • LCLHN: Mount Gambier • FUNLHN: Port Augusta, Whyalla • EFNLHN: Port Lincoln • YNLHN: Port Pirie • BHFLHN: Gawler, South Coast, Mount Barker
Benchmarks:	SALHN: Performing (Target) <= 320 Performance Concern > 320 and <= 352 Underperforming > 352 NALHN: Performing (Target) <= 280 Performance Concern > 280 and <= 308 Underperforming > 308 WCHN: Performing (Target) <= 320 Performance Concern > 320 and <= 352 Underperforming > 352 BHFLHN: Gawler (200), South Coast (100), Mt Barker (200) Performing (LHN Target) <= 451 Performance Concern > 451 and <= 496 Underperforming > 496 EFNLHN: Pt Lincoln Performing (Target) <= 260 Performance Concern > 260 and <= 286 Underperforming > 286 FUNLHN: Pt Augusta (200), Whyalla (100) Performing (LHN Target) <= 300

	Performance Concern > 300 and <= 330 Underperforming > 330 LCLHN: Mt Gambier Performing (Target) <= 180 Performance Concern > 180 and <= 198 Underperforming > 198 RMCLHN: Riverland (240), Murray Bridge (211) Performing (LHN Target) <= 451 Performance Concern > 451 and <= 496 Underperforming > 496 YNLHN: Pt Pirie Performing (Target) <= 100 Performance Concern > 100 and <= 110 Underperforming > 110
Representation Class:	Ratio
Data Type:	Real
Unit of Measure:	Episode
Data Source:	Admitted Patient Care, formerly Integrated South Australian Activity Collection (ISAAC) and Operational Business Intelligence (OBI) - Sunrise/PAS sites Chiron, Homer and ATS - FMC
Frequency of Reporting:	Quarterly (1 month lag i.e. July – September data reported in November)
Notes:	> The numerator for HAC rate 3rd and 4th degree perineal tears during delivery is defined as separations: • With at least one of the ICD-10-AM codes in Table A recorded as an additional diagnosis (i.e. NOT principal diagnosis) with ANY condition onset flag (COF).

Table A		
ICD-10-AM 11th Edition		
Code	Code	Description
O702	O70.2	Third degree perineal laceration during delivery
0703	070.3	Fourth degree perineal laceration during delivery

• AND meeting the denominator criteria (as below).

> The denominator is defined as:

• All vaginal births - separations where an outcome of delivery was recorded using one of the diagnosis codes in Table B, and a caesarean delivery was not recorded (Table C).

Table B		
ICD-10-AM 11th Edition		
Code	Code	Description
Z370	Z37.0	Single live birth
Z371	Z37.1	Single stillbirth
Z372	Z37.2	Twins, both liveborn
Z373	Z37.3	Twins, one liveborn and one stillborn
Z374	Z37.4	Twins, both stillborn
Z375	Z37.5	Other multiple births, all liveborn
Z376	Z37.6	Other multiple births, some liveborn
Z377	Z37.7	Other multiple births, all stillborn

Z379	Z37.9	Outcome of delivery, unspecified

Table C	
ACHI 11th Edition	
Code	Description
16520-00[1340]	Elective classical caesarean section
16520-01[1340]	Emergency classical caesarean section
16520-02[1340]	Elective lower segment caesarean section
16520-03[1340]	Emergency lower segment caesarean section
16520-04[1340]	Elective caesarean section, not elsewhere classified
16520-05[1340]	Emergency caesarean section, not elsewhere classified

> Excludes separations with ANY of the following:
  - Admission mode is 'Admitted patient transferred from another hospital'.
  - Care type is 'Newborn—unqualified days only'
  - Care type is 'Hospital boarder'
  - Care type is 'Organ procurement-posthumous'.
> Unplanned intensive care unit admission' is currently unmeasurable, as this data is not captured in the current dataset specification.
> Work is underway to implement version 2.0 of the toolkit into CDW for 2021-22.

Related Information:

> Australian Commission on Safety and Quality in Health Care, Hospital-Acquired Complications. https://www.safetyandquality.gov.au/our-work/indicators/hospital-acquired-complications
> Service Agreements 2021-2022 SA Health.

Mental Health - Post Discharge Community Follow Up Rate

Identifying and definitional attributes

Short Name:	MH Community Discharge
Tier:	Tier 1
KPI ID:	SEC-AC-T1-2
Description:	Percentage (%) of patients separated from an acute designated mental health ward who (or their Carer) received one or more mental health service contacts while in the community within 7 days following their discharge.
Computation:	(Numerator/Denominator)*100
Numerator:	Count (#) of separations from acute designated mental health wards with recorded community mental health service contact (patient or carer) dated within seven days of discharge.
Denominator:	Count (#) of separations from acute designated mental health wards.

More Information

Scope:	Data is reported for: • CALHN • NALHN • SALHN • WCHN • BHFLHN: Glenside Rural and Remote Ward • FUNLHN: Whyalla • RMCLHN: Riverland (Berri) • LCLHN: Mount Gambier
Benchmarks:	Performing (Target) >=80.0% Performance Concern <80.0% and >=75.0% Underperforming <75.0%
Representation Class:	Ratio
Data Type:	Real
Unit of Measure:	Service contact
Data Source:	Admitted Patient Care, formerly Integrated South Australian Activity Collection (ISAAC)/ Community Mental Health Systems (CBIS, CCCME)
Frequency of Reporting:	Monthly (1 month lag i.e. July data reported in September)
Notes:	> Includes: • All acute admitted mental health service units, including short-stay units and emergency acute mental health admitted units. • Treatment in regional hospitals where designated acute mental health facilities are

implemented (integrated units).
- Separation modes (Nature of Separation) 0, 1, 3, 4 representing more formal separation rather than transfers and patient self-discharge or death etc. 0 = Discharged on Leave; 1 = Home; 3 = Residential Aged Care Facility; 4 = Other Health Care Accommodation.

> Excludes:
- Helen Mayo House patients less than 16.
- Separations where hospital admission date is equal to hospital separation date.
- Separations where length of stay is one night only and procedure codes for ECT or TMS are recorded.
- Statistical and change of care type separations.
- Separations that end by transfer to another acute or psychiatric hospital.
- Separations that have Referral for Further Health Care = 11 (Residential mental health service).
- Separations that end in death or left against medical advice/discharge at own risk
- Separations that end by transfer to community residential mental health services.
- Follow-up contacts occurring on the date of separation (i.e. follow-up is +1 to 7 days after separation date), based on differences in date (not time).

> The following community mental health service contacts are excluded:
- Mental health service contacts on the day of separations.
- Contacts where a consumer does not participate.

> Implementation of this indicator requires the capacity to track service use across inpatient and community boundaries and is dependent on the capacity to link patient identifiers.

> For this indicator, when a mental health service organisation has more than one unit of a particular admitted patient care program, those units should be combined.

> Linking of the Admitted Patient Care and CBIS information via the AltId records in CBIS and CCCME.

> Mental Health Service Contacts are as per the NMDS for mental health and covers clinically significant contacts (e.g. excluding did-not-attends, administrative, health service, travel, measures, etc. type activities).

> For CBIS: procedures 04 and below; procedure type 60.0000; and 80.9010 CAMHS Risk Assessment.

> For CCC: procedures below 60 but also excluding 23.0000, 53.0000, 55.0000 and 58.0000.

> Eligible contacts for all the types listed include those recorded by admitted patient and residential mental health services as well as those recorded by community mental health teams, while the consumer is in the community i.e. that do not occur within an admitted patient or residential mental health care episode.

> Data is provided for both:
- Client Participating only [participation status = 1 Yes regardless of value in Parent/Carer involved data item].
- Client Participating OR Parent/Carer involved. These results should be used for performance monitoring against targets, for all mental health wards regardless of target population (CAMHS, Older Persons, Forensic, General/Adult).

> “Client Participating” or Parent/Carer contact are counted as an appropriate contact for reporting purposes.

> Per national definition both Face-to-face and Phone contact modes are to be counted.

> There are no catchment restrictions on community follow-up such that follow-up by any community team for any discharge is valid: not just follow-up within agency/region. Any follow-up is counted towards the discharging hospital/LHN.

> Bundling rules as per Health Intelligence Portal are applied to ensure episodes are not wrongly excluded e.g. where unbundled episode ends due to change of care type from Mental Health Acute to Acute. The bundled episode is the correct counting unit for this indicator.

> Mode of identification of mental health wards within scope is by nominated ward of discharge. These are specified in a separate list from this document. Note that the Psychiatric Care Days measure is not used in determining in-scope episodes for this measure; ward-on-discharge being a mental health ward is appropriate for this measure.

> Data is to be reported at Hospital level and at individual Ward level. Where reported at Ward level,

	attribution of numerator/denominator is to be based on Ward on Discharge.
Related Information:	> KPIs for Australian Public Mental Health Services: PI 12J – Rate of post-discharge community care, 2019 (Service Level). https://meteor.aihw.gov.au/content/index.phtml/itemId/723388 > The Fifth National Mental Health and Suicide Prevention Plan, 2018 https://meteor.aihw.gov.au/content/index.phtml/itemId/695585 > Service Agreements 2021-2022 SA Health.

Rehabilitation – Timeliness of Care

Identifying and definitional attributes

Short Name:	Rehab Commencement < 1 Day
Tier:	Tier 2
KPI ID:	SEC-AC-T2-1
Description:	Proportion (%) of patients who commence a rehabilitation program within one day of being clinically ready for rehabilitation.
Computation:	(Numerator/Denominator)*100
Numerator:	Count (#) of patients who commence a rehabilitation program within one day of being clinically ready for rehabilitation.
Denominator:	Count (#) of patients who commence rehabilitation on or after being clinically ready for rehabilitation.

More Information

Scope:	Data is reported for: • CALHN • SALHN • NALHN
Benchmarks:	Performing >= 70.0% Performance Concern = N/A Underperforming <70.0%
Representation Class:	Percentage (%)
Data Type:	Real
Unit of Measure:	Person
Data Source:	AROC extract file
Frequency of Reporting:	Monthly (1 month lag i.e. July data reported in September)
Notes:	> This KPI is the same as AROC indicator – Rehabilitation Inpatient Commencement Within 1 Day Of Clinical Readiness. > Clinically ready for rehabilitation defined in AROC data dictionary as: A patient is “clinically ready for rehabilitation” when the rehabilitation physician, or physician with an interest in rehabilitation or delegate, deems the patient ready to start their rehabilitation program and have documented this in the patient’s medical record. Record the date patient is ready for rehabilitation and not the data rehabilitation starts. > Numerator includes all separations from inpatient rehabilitation units (AROC pathway 3), where the AROC Episode begin date is less than or equal to the AROC Date Clinically Ready for Rehab date plus one day. > Denominator includes all separations from inpatient rehabilitation units (AROC pathway 3), where the AROC Episode begin date is greater than or equal to the AROC Date Clinically Ready for Rehab date.

Related Information:	> Australian Commission on Safety and Quality in Health Care. Acute Stroke Clinical Care Standard 4 – Early Rehabilitation (2019). https://www.safetyandquality.gov.au/our-work/clinical-care-standards/acute-stroke-clinical-care-standard > AROC outcome targets: http://ahsri.uow.edu.au/aroc/annualreports/index.html#outcome_target_report > Service Agreements 2021-2022 SA Health.

Proportion of Time Spent In Designated Stroke Unit

Identifying and definitional attributes

Short Name:	Time spent in Stroke Unit
Tier:	Monitor
KPI ID:	SEC-AC-M-1
Description:	Proportion (%) of patients diagnosed with stroke (Ischaemic or Haemorrhagic) who spent a minimum of 90% of their total acute hospital admission in a stroke unit.
Computation:	(Numerator/Denominator)*100
Numerator:	Count (#) of separations with a diagnosis of stroke (Ischaemic or Haemorrhagic) where the patient spent a minimum of 90% of their total acute hospital stay in a dedicated stroke unit.
Denominator:	Count (#) of separations with a diagnosis of stroke (Ischaemic or Haemorrhagic).

More Information

Scope:	Data is reported for: • CALHN • NALHN • SALHN
Benchmarks:	To be finalised
Representation Class:	Percentage (%)
Data Type:	Real
Unit of Measure:	Episode
Data Source:	Operational Business Intelligence (OBI) via LHN Analytics and Reporting Service (LARS) Stroke Form
Frequency of Reporting:	Monthly (i.e. July data reported in August)
Notes:	> Includes primary diagnosis of Ischaemic stroke or Haemorrhagic stroke and episode of care equals acute. > A dedicated stroke unit is defined as a hospital unit/ward where the following criteria is met: • co-located beds within a geographically defined unit • dedicated, multidisciplinary team with members who have a special interest in stroke or rehabilitation and has access to regular professional development and education relating to stroke • the team that meets at least once per week to discuss patient care. > The percentage of time in a stroke unit is calculated as the number of days on the stroke unit divided by the total number of days where the patient was classified as receiving acute care. > Excludes: • Regional LHNs and WCHN. • Transient ischemic attack (TIA) separations. • Maintenance care.

	• Rehabilitation. • Hospital in the Home/Rehabilitation in the Home. • Geriatric Evaluation and Management. • Patients for whom physiotherapy is contraindicated and the contraindication is documented. • Patients discharged within 48 hours. • Patients who died and the date of death was the date of the stroke admission.
Related Information:	> Acute stroke clinical care standard indicators: 3b-Proportion of patients with a final diagnosis of acute stroke who spent at least 90% of their acute hospital admission in a stroke unit 2019 https://meteor.aihw.gov.au/content/index.phtml/itemId/719054 > Service Agreements 2021-2022 SA Health.

Orthogeriatric Time To Surgery < 48 Hrs

Identifying and definitional attributes

Short Name:	Orthogeriatric surgery < 48 hrs
Tier:	Monitor
KPI ID:	SEC-AC-M-2
Description:	Proportion (%) of orthogeriatric patients presenting with a hip fracture, for whom surgery is indicated, receiving surgery on or the day after the presentation.
Computation:	(Numerator/Denominator)*100
Numerator:	Count (#) of separations in denominator where the patient underwent surgery on or the day after presentation.
Denominator:	Count (#) of separations in period from acute setting of geriatric patients with a hip fracture, on whom surgery was performed during the admission.

More Information

Scope:	Data reported for: • CALHN • SALHN • NALHN: LMH • LCLHN: Mount Gambier
Benchmarks:	Performing >= 90.0% Performance Concern <90.0 and >=87.5% Underperforming <87.5%
Representation Class:	Percentage (%)
Data Type:	Real
Unit of Measure:	Separations
Data Source:	Hospital PAS systems, Casemix data ORMIS (Operating Theatre data)
Frequency of Reporting:	Monthly (i.e. July data reported in August)
Notes:	> Numerator: • The day of presentation with a hip fracture is calculated as follows: o Where source of referral = Inter-hospital transfer, the arrival date/time at the transferring hospital is used (if transferring hospital is a metropolitan public hospital or one of the 16 casemix regional hospitals). o For other presentations, the emergency department (ED) presentation date/time is used (where a link to the ED episode has been achieved) or the admission date/time (where no link achieved). The end point is the first operation date for that patient during that admission. Note that this may return incorrect data for patients having multiple surgeries. Analysis shows that coding of surgical procedures in ORMIS is not currently of high enough quality to use for this indicator.

	> Denominator: • All separations in the period are counted where the following conditions are met: o The casemix record or the LARS record has a first operating theatre procedure date/time present. o Has an associated diagnosis (primary or secondary) in the range [S72.0x] or [S72.10, S72.11 or S72.2] – fracture of femur. o An external cause code indicating a fall is present in the coding for the admission [W00]-[W19]. o The patient is 65 years or older at time of admission or is aboriginal or Torres Strait islander and 50 years or older. o The patient had one of the following surgical procedures during the admission: ▪ 4751900 IF fracture trochanteric/subcapitl femur ▪ 4752200 Hemiarthroplasty of femur ▪ 4752801 Open reduction fracture femur with IF ▪ 4753100 Closed reduction fracture femur with IF ▪ 4931500 Partial arthroplasty of hip ▪ 4931800 Anthroplasty of hip, unilateral.
Related Information:	> Australian Commission on Safety and Quality in Health Care, Indicator Specification: Hip Fracture Care Clinical Care Standard, May 2018. https://meteor.aihw.gov.au/content/index.phtml/itemId/696436 > Service Agreements 2021-2022 SA Health.

Potentially Preventable Admissions

Identifying and definitional attributes

Short Name:	PPA
Tier:	Monitor
KPI ID:	SEC-AC-M-3
Description:	Percentage (%) of inpatient separations meeting the Potentially Preventable Admission (PPA) code criteria.
Computation:	(Numerator/Denominator)*100
Numerator:	Count (#) of inpatient separations meeting the Potentially Preventable Admission code criteria in the period.
Denominator:	Count (#) of inpatient separations in the same period.

More Information

Scope:	Data is reported for: • CALHN • SALHN • NALHN • WCHN • BHFLHN: Gawler, South Coast, Mount Barker • FUNLHN: Port Augusta, Whyalla • EFNLHN: Port Lincoln • RMCLHN: Riverland (Berri), Murray Bridge • LCLHN: Mount Gambier • YNLHN: Port Pirie
Benchmarks:	Performing (Target) <=8.0% Performance Concern >8.0% and <=10.0% Underperforming >10.0%
Representation Class:	Percentage (%)
Data Type:	Real
Unit of Measure:	Episode
Data Source:	Admitted Patient Care, formerly Integrated South Australian Activity Collection (ISAAC)and Operational Business Intelligence (OBI) - Sunrise/PAS sites Chiron, Homer
Frequency of Reporting:	Monthly (1 month lag i.e. July data reported in September)
Notes:	> Data is bundled as follows: • The last episode record is maintained for funding purposes as it contains the necessary ICD-10-AM diagnosis and procedure codes as well as the correct DRG. It is this last episode record

in which the aggregating process occurs – this record becomes the summarised record.

- The earliest admission date (from the first episode) is copied into the final record – this process is performed to help identify the record as "bundled" and to give a better indication of the total length of stay for all episodes.
- Bundling will occur so long as the difference in separation date/time and admission date/time of sequential records are within 1 minute and all records except for the final record submitted have NSep 'A'.

> 11th Edition of ICD-10-AM codes as follows:

Vaccine-preventable	Codes/Descriptions
Influenza and pneumonia, Other vaccine-preventable Conditions	J10, J11, J13, J14, J153, J154, J157, J159, J168, J181, J188 in any diagnosis field, excludes cases with additional diagnosis of D57 (sickle-cell disorders) and people under 2 months
Other vaccine-preventable Conditions	A35, A36, A37, A80, B05, B06, B161, B169, B180, B181, B26, G000, M014 in any diagnosis field
Chronic	**Codes/Descriptions**
Asthma	J45, J46 as principal diagnosis only
Congestive cardiac failure	I50, I110, J81 as principal diagnosis only, exclude cases with the following procedure codes: 3317200, 3825600, 3827001, 3830000, 3830300, 3830600, 3830602, 3835000, 3835002, 3835300,3835302, 3835800, 3835801, 3835802, 3835803, 3836200,3836800, 3836802, 3836804, 3845601, 3845610, 3845611,3845612, 3845615, 3845619, 3845626, 3845627, 3845628,3845633, 3845634, 3847000, 3847500, 3848000, 3848001,3848002, 3848700, 3848800, 3848802, 3848804, 3848806,3848900, 3848902, 3848903, 3848904, 3849000, 3849300, 3849700, 3849701, 3849702, 3849703, 3849704, 3850000,3850300, 3850500, 3861200, 3861500, 3865300, 3865402,3865405, 3870000, 3870002, 3873900, 3874200, 3874202,3874500, 3875100, 3875102, 3875700, 3875701, 3875702,9020300, 9020308, 9020309, 9020400, 9020500, 9021900,9022400.
Diabetes complications	E10–E149 as principal diagnoses and E10–E149 as additional diagnoses where the principal diagnosis was: • hypersmolarity (E870) • acidosis (E872) • transient ischaemic attack (G45) • nerve disorders and neuropathies (G50–G64) • cataracts and lens disorders (H25–H28) • retinal disorders (H30–H36) • glaucoma (H40–H42) • myocardial infarction (I21–I22) • other coronary heart diseases (I20, I23–I25) – heart failure (I50) – stroke and sequelae (I60–I64, I690–I694) – peripheral vascular disease (I70–I74) – gingivitis and periodontal disease (K05) • kidney diseases (N00–N29) [including end-stage renal disease (N17–N19)] – renal dialysis (Z49)
COPD	J20, J41, J42, J43, J44, J47 as principal diagnosis only, J20 only with additional diagnoses of J41, J42, J43,J44, J47
Angina	I20, I240, I248, I249 as principal diagnosis only, exclude cases with procedure codes not in blocks [1820] to [2016]
Iron deficiency anaemia	D501, D508, D509 as principal diagnosis only
Hypertension	I10, I119 as principal diagnosis only, exclude cases with the following procedure codes: 3317200,3825600, 3827001, 3830000, 3830300,3830600,3830602, 3835000, 3835002, 3835300, 3835302, 3835800,3835801, 3835802, 3835803, 3836200, 3836800, 3836802,3836804, 3845601, 3845610, 3845611, 3845612,

	3845615, 3845619, 3845626, 3845627, 3845628, 3845633, 3845634, 3847000, 3847500, 3848000, 3848001, 3848002, 3848700, 3848800, 3848802, 3848804, 3848806, 3848900, 3848902, 3848903, 3848904, 3849000, 3849300, 3849700, 3849701, 3849702, 3849703, 3849704, 3850000, 3850300, 3850500, 3861200, 3861500, 3865300, 3865402, 3865405, 3870000, 3870002, 3873900, 3874200, 3874202, 3874500, 3875100, 3875102, 3875700, 3875701, 3875702, 9020300, 9020308, 9020309, 9020400, 9020500, 9021900, 9022400
Nutritional deficiencies	E40, E41, E42, E43, E550, E643 as principal diagnosis only
Rheumatic heart disease	I00 to I09 as principal diagnosis only. (Note: includes acute rheumatic fever)
Acute	**Codes/Descriptions**
Dehydration and gastroenteritis	A099, E86, K522, K528, K529 as principal diagnosis only.
Pyelonephritis	N10, N11, N12, N136, N390 as principal diagnosis only
Pelvic inflammatory disease	N70, N73, N74 as principal diagnosis only
Ear, nose and throat infections	H66, H67, J02, J03, J06, J312 as principal diagnosis only
Dental conditions	K02, K03, K04, K05, K06, K08, K09.8, K09.9, K12, K13 and K14 as principal diagnosis only
Appendicitis with generalised peritonitis	K352 or K353 in any diagnosis field
Convulsions and epilepsy	G40, G41, O15, R56 as principal diagnosis only
Gangrene	R02 in any diagnosis field

Related Information:

> National Healthcare Agreement: PI 18–Selected potentially preventable hospitalisations, 2020
https://meteor.aihw.gov.au/content/index.phtml/itemId/725793

> Australian Health Performance Framework: PI 2.1.4–Selected potentially preventable hospitalisations, 2019
https://meteor.aihw.gov.au/content/index.phtml/itemId/715161

> Service Agreements 2021-2022 SA Health.

Neonatal - APGAR Score Less Than 7 At 5 Minutes For Live Birth Term Infants

Identifying and definitional attributes

Short Name:	APGAR Score
Tier:	Monitor
KPI ID:	SEC-AC-M-4
Description:	Proportion (%) of live born babies at or after term (from 37 completed weeks gestational age) with an APGAR score of less than 7 at 5 minutes after birth.
Computation:	(Numerator/Denominator)*100
Numerator:	Count (#) of live babies born at or after term (from 37 completed weeks gestational age) with an APGAR score of less than 7 at 5 minutes.
Denominator:	Count (#) of live babies born at or after term (from 37 completed weeks gestational age).

More Information

Scope:	Data is reported for: • NALHN: LMH • SALHN: FMC • WCHN: WCH • BHFLHN: Gawler, Mt Barker, South Coast • EFHLHN: Port Lincoln • FUNLHN: Whyalla, Port Augusta • LCLHN: Mt Gambier • RMCLHN: Riverland (Berri), Murray Bridge • YNLHN: Port Pirie, Wallaroo, Claire
Benchmarks:	To be finalised
Representation Class:	Percentage (%)
Data Type:	Real
Unit of Measure:	Person
Data Source:	Pregnancy Outcomes Unit
Frequency of Reporting:	Quarterly (1 month lag i.e. July – September data reported in November)
Notes:	> The APGAR score is a system of assessing the baby's breathing, pulse, colour, movement and reflexes at 5 minutes after birth. It is a score out of 10, with higher scores indicating better condition of the baby. A score of less than 7 at 5 minutes after birth is an indicator of complications and of compromise for the baby.

Related Information:	> National Core Maternity Indicators: PI 04–Apgar score of less than 7 at 5 minutes for births at or after term, 2019 https://meteor.aihw.gov.au/content/index.phtml/itemId/728719 > Service Agreements 2021-2022 SA Health.

Obstetrics - Induction Of Labour For Selected Primiparae

Identifying and definitional attributes

Short Name:	Induced Labour for Selected Primiparae
Tier:	Monitor
KPI ID:	SEC-AC-M-5
Description:	Proportion (%) of selected females who gave birth for the first time and who had labour induced.
Computation:	(Numerator/Denominator)*100
Numerator:	Count (#) of selected females who gave birth for the first time and who had labour induced.
Denominator:	Count (#) of all selected females.

More Information

Scope:	Data is reported for: • NALHN: LMH • SALHN: FMC • WCHN: WCH • BHFLHN: Gawler, Mt Barker, South Coast • EFHLHN: Port Lincoln • FUNLHN: Whyalla, Port Augusta • LCLHN: Mt Gambier • RMCLHN: Riverland (Berri), Murray Bridge • YNLHN: Port Pirie, Wallaroo, Claire
Benchmarks:	To be finalised
Representation Class:	Percentage (%)
Data Type:	Real
Unit of Measure:	Person
Data Source:	Pregnancy Outcomes Unit
Frequency of Reporting:	Quarterly (1 month lag i.e. July – September data reported in November)
Notes:	> Selected females' criteria is defined as females who gave birth for the first time and meet all of the following criteria: • aged between 20 and 34 • gestational age at birth between 37 and 41 completed weeks • pregnancy has one baby only (singleton) • the presentation of the baby is vertex (baby's head was at the cervix). > Excluded are those females who have given birth prior to the current pregnancy or do not meet the selected females' criteria. > A birth is defined as an event in which a baby comes out of the uterus after a pregnancy of at least

	20 weeks gestation or weighing 400 grams or more. > Induction of labour is a set of procedures (pharmacological and/or instrumental) to start the uterus contracting and begin the process of labour. > Gestational age is a clinical measure of the duration of the pregnancy. For the National Perinatal Data Collection gestational age is reported as completed weeks.
Related Information:	> National Core Maternity Indicators: PI 05–Induction of labour for selected females giving birth for the first time, 2019 https://meteor.aihw.gov.au/content/index.phtml/itemId/728721 > Service Agreements 2021-2022 SA Health.

Palliative Care – Timeliness of Care

Identifying and definitional attributes

Short Name:	Pall Care Timeliness of Care
Tier:	Monitor
KPI ID:	SEC-AC-M-7
Description:	Percentage (%) of palliative care patient episodes commenced within 2 days of the patient being ready for care.
Computation:	(Numerator/Denominator)*100
Numerator:	Count (#) of patient episodes that start on the day of, or the day after, the date the patient required palliative care.
Denominator:	Count (#) of all palliative care patient episodes within the reporting period.

More Information

Scope:	Data is reported for: • CALHN • NALHN • SALHN • BHFLHN • EFNLHN • FUNLHN • LCLHN • RMCLHN • YNLHN
Benchmarks:	Performing: >=90.0% Performance Concern <90.0% and >=85.0% Underperforming <85.0%
Representation Class:	Percentage (%)
Data Type:	Real
Unit of Measure:	Episode
Data Source:	Palliative Care Outcomes Collaboration
Frequency of Reporting:	To be finalised
Notes:	> Time from date ready for care to episode start reports responsiveness of palliative care services to patient needs. > Only includes episodes that have commenced in the reporting period. > Benchmark was set following feedback and subsequent consultation with PCOC participants. > Service providers acknowledge that, whilst there is wide variation in the delivery of palliative care across the country, access to palliative care should be measured based on patient need rather than

	service availability. As a result, services operating five days a week (Monday to Friday) are not distinguished from services operating seven days a week (all services are being benchmarked together).
Related Information:	> Palliative Care Outcomes Collaboration https://www.uow.edu.au/ahsri/pcoc/ > PCOC National Outcome Measures and Benchmarks https://documents.uow.edu.au/content/groups/public/@web/@chsd/@pcoc/documents/doc/uow264946.pdf > Service Agreements 2021-2022 SA Health.

Planned C-Sections Performed At < 39 Weeks' Gestation Without An Obstetric Or Medical Indication

Identifying and definitional attributes

Short Name:	Planned C-Section Performed at <39 weeks
Tier:	Monitor
KPI ID:	SEC-AC-M-8
Description:	Proportion (#) of women who gave birth by caesarean section at less than 39 completed weeks (273 days) gestation without an obstetric or medical indication.
Computation:	(Numerator/Denominator)*100
Numerator:	Count (#) of women who gave birth by caesarean section at less than 39 completed weeks (273 days) gestation without adequate obstetric/medical indication and where there was no established labour.
Denominator:	Count (#) of women who gave birth by caesarean section at less than 39 completed weeks (273 days) gestation and where there was no established labour.

More Information

Scope:	Data is reported for: • NALHN • SALHN • WCHN • RMCLHN • LCLHN • FUNLHN • EFNLHN • YNLHN • BHFLHN
Benchmarks:	N/A
Representation Class:	Percentage (%)
Data Type:	Real
Unit of Measure:	Person
Data Source:	Pregnancy Outcomes Unit
Frequency of Reporting:	Quarterly (1 month lag i.e. July – September rata reported in November)
Notes:	> A birth is defined as the event in which a baby comes out of the uterus after a pregnancy of at least 20 weeks' gestation or weighing 400 grams or more. > Births included are caesarean deliveries (where there was no established labour) at less than 39 completed weeks (273 days). > 'Without adequate obstetric/medical indication' includes the following reasons for caesarean section: • previous caesarean section

	• previous severe perineal trauma • previous shoulder dystocia • maternal choice in the absence of any obstetric, medical, surgical, psychological indications. > Births excluded are: • caesarean deliveries at or after (i) 39 completed weeks (273 days) gestation, (ii) 37 completed weeks (259 days) gestation • where there was established labour • all vaginal deliveries • those delivered pre-term by caesarean section (where there was no established labour) with obstetric/medical indication (all reasons for caesarean section other than those listed previously). > Cells of less than 5 have been suppressed. This is the lowest level of suppression that all states and territories have agreed to for the release of data from the National Perinatal Data Collection. > Proportions have been suppressed where the denominator is less than 100, for reliability purposes.
Related Information:	> Australian Commission on Safety and Quality in Health Care, Early planned caesarean section without medical or obstetric indication special report. https://www.safetyandquality.gov.au/publications-and-resources/resource-library/fourth-atlas-healthcare-variation-2021-early-planned-births-full-chapter > Service Agreements 2021-22 SA Health.

Low Value Care Procedures

Identifying and definitional attributes

Short Name:	Low value care procedures
Tier:	Monitor
KPI ID:	SEC-AC-M-9
Description:	Rate (%) of change in low value care procedures compared to previous year.
Computation:	(Numerator/Denominator)*100
Numerator:	Count (#) of current year low value care procedures minus count of previous year low value care procedures.
Denominator:	Count (#) of previous year low value care procedures.

More Information

Scope:	Data is reported for: • CALHN • NALHN • SALHN • WCHN • RMCLHN • LCLHN • FUNLHN • EFNLHN • YNLHN • BHFLHN
Benchmarks:	N/A
Representation Class:	Percentage (%)
Data Type:	Real
Unit of Measure:	Procedure
Data Source:	To be finalised
Frequency of Reporting:	Monthly (2 month lag i.e. July data reported in October)
Notes:	> Low value care (LVC) refers to health care where the intervention provides no or very little benefit to patients, or where the risk of harm exceeds the likely benefit. Eliminating or minimising LVC will improve both health outcomes for patients and the efficiency of the health system. LVC procedures can give rise to hospital acquired conditions (HACs), predominately infections. > For each procedure identified as LVC, there is a narrow measure (which is specific and captures only LVC) and a broad measure (which is sensitive and captures all LVC but also may capture some care which is clinically appropriate). For KPI reporting broad measure will be used. > List of Low Value Care Procedures:

Procedure	Broader low-value care definition
Abdominal hysterectomy for benign disease (vs laparoscopic or vaginal)	Women having hysterectomy with abdominal approach and not associated with caesarean or cancer. Minimum age: 18. Sex: female.
Arthroscopic lavage and debridement of knee for osteoarthritis or degenerative meniscal tears	Knee arthroscopy in patients with diagnosis of gonarthrosis or meniscal derangements and no diagnosis of ligament strain or damage and no diagnosis of septic (pyogenic) arthritis. Minimum age: 18. Sex: both.
Carotid endarterectomy for asymptomatic high-risk patients with limited life expectancy	Carotid endarterectomy with no stroke or focal neurological symptoms recorded in the episode, and ASA code 4–5 or age ≥ 75, or with any palliative care codes or flags present. Minimum age: 18. Sex: both.
Colonoscopy for constipation in people < 50 years	Colonoscopy in a person < 50 with diagnosis of constipation and no diagnoses of anaemia, weight loss, family or personal history of cancer of digestive system, or personal history of other diseases of the digestive system in the episode. Minimum age: 18. Maximum age: 49. Sex: both.
Electroconvulsive therapy in children	ECT with any diagnosis. Minimum age: 5. Maximum age: 11. Sex: both.
Electrotherapy for pressure ulcers	Electrotherapy with any diagnosis. Sex: both
Endometrial biopsy for investigation of female infertility	Endometrial biopsy with infertility diagnosis, and no cancer diagnosis codes. Minimum age: 18. Sex: female.
Endoscopic retrograde cholangiopancreatography (ERCP) without cholangitis	ERCP with diagnosis of calculus of bile duct or biliary acute pancreatitis, and cholangitis and obstruction not recorded. Minimum age: 18. Sex: both.
Endoscopy for dyspepsia for people < 55 years	Endoscopy in person < 55 with diagnosis of dyspepsia and no diagnoses of dysphagia, iron deficiency anaemia, other nutritional anaemia, abnormal weight loss, personal or family history of cancer of digestive system, or personal history of peptic ulcer disease in the episode. Minimum age: 18. Maximum age: 54. Sex: both.
Endovascular repair of infrarenal abdominal aortic aneurysm	Endovascular repair of aneurysm, with diagnosis of abdominal aortic aneurysm in the episode, and ASA score 4–5 or age ≥ 75, or with any palliative care codes or flags present. Minimum age: 18. Sex: both.
Epidural steroid injection for low back pain	Epidural steroid injection with diagnosis of low back pain with no mention of leg pain or radiculopathy in the episode. Minimum age: 18. Sex: both.
Hyperbaric oxygen for various conditions	Hyperbaric oxygen to treat foot ulcers, decubitus ulcers, carbon monoxide or carbon dioxide poisoning, Crohn's disease, cancer, open wounds, soft tissue injuries, or sudden deafness, and diagnosis of diabetes, necrosis, inflammation of genital organs, air embolism, or effects of radiation in the episode. Sex: both.
Laparoscopic uterine nerve ablation	LUNA in woman. Minimum age: 18. Sex: female.

Open bariatric surgery (vs laparoscopic)	-
Pelvic lymphadenectomy for the management of endometrial cancer	Women with diagnosis of endometrial cancer who receive pelvic lymphadenectomy. Minimum age: 18. Sex: female.
Percutaneous coronary intervention (PCI) with balloon angioplasty or stent placement for stable coronary disease	PCI with diagnosis of coronary disease excluding unstable angina in any episode between 6 and 18 months and not less than 6 months before PCI. Minimum age: 18. Sex: both..
Postoperative radiotherapy after radical prostatectomy (assuming external beam radiotherapy)	Men who have had radical prostatectomy (with or without prostate cancer coded). Radiotherapy procedure in same or later episode (within 6 weeks), or later episode (within 6 weeks) with radiotherapy as principal diagnosis. Minimum age: 18. Sex: male.
Removal of gallbladder during bariatric surgery	-
Renal artery angioplasty or stenting	-
Retinal laser or cryotherapy for lattice degeneration	Retinal laser or cryotherapy procedure and lattice degeneration diagnosis, with no procedure code indicating repair of retinal detachment, or history of diagnosis of retinal detachment. Minimum age: 18. Sex: both.
Sentinel lymph node biopsy for melanoma in situ or T1a melanoma	Sentinel lymph node biopsy for melanoma in situ or melanoma (morphology code M872–M879 /0–3). No other cancer code in the episode. Minimum age: 18. Sex: both.
Spinal fusion for low back pain	Spinal fusion with diagnosis of low back pain or spinal stenosis with no mention of sciatica, spondylolisthesis, spinal abnormality, or pain in legs in episode. Minimum age: 18. Sex: both.
Surgery for vesicoureteric reflux	-
Unblocking nasolacrimal duct in infants	Probing of nasolacrimal duct in infant. Maximum age: 12 months. Sex: both.
Vena cava filters for pulmonary embolism prevention	Any insertion of inferior vena cava filter, with no diagnosis of adverse effects of anticoagulant or antithrombotic drugs in the episode. Minimum age: 18. Sex: both.
Vertebral biopsy for vertebral fracture	Any needle biopsy of vertebra. Minimum age: 18. Sex: both

	Vertebroplasty for osteoporotic vertebral fracture	Procedure of vertebroplasty. Minimum age: 18. Sex: both.
Related Information:	> Peak bodies from which the evidence is drawn are: • Choosing Wisely Australia (CWA) • Royal Australasian College of Physicians EVOLVE initiative. > Service Agreements 2021-22 SA Health.	

EFFECTIVENESS OF CARE

Emergency Department Unplanned Re-attendances within 48 hours	
Identifying and definitional attributes	
Short Name:	ED Unplanned Re-Attendances <48HR
Tier:	Tier 2
KPI ID	SEC-EC-T2-1
Description:	Proportion (%) of emergency department (ED) presentations identified as an unplanned re-attendance occurring within 48 hours of initial presentation.
Computation:	(Numerator/Denominator)*100
Numerator:	Count (#) of ED presentations identified as an unplanned attendance within 48 hours of initial presentation.
Denominator:	Count (#) of ED presentations where previous Departure Status is Not Stated, Unknown or Episode Complete.
More Information	
Scope:	Data is reported for: • CALHN: RAH, QEH • SALHN: FMC, NHS • NALHN: LMH, Modbury • WCHN: WCH • RMCLHN: Riverland (Berri), Murray Bridge • LCLHN: Mount Gambier • FUNLHN: Port Augusta, Whyalla • EFNLHN: Port Lincoln • YNLHN: Port Pirie • BHFLHN: Gawler, South Coast, Mount Barker
Benchmarks:	Performing (Target) <=4.5% Performance Concern >4.5% and <=6.5% Underperforming >6.5%
Representation Class:	Percentage (%)
Data Type:	Real
Unit of Measure:	Episode
Data Source:	Manual submissions - LMH, Modbury, WCH & FMC Operational Business Intelligence (OBI) - Sunrise/PAS sites Admitted Patient Care, formerly Integrated South Australian Activity Collection (ISAAC) - Regional Hospitals
Frequency of Reporting:	Monthly (i.e. July data reported in August)

Notes:	> Re-attendance is defined as the same patient presenting to the same hospital ED within 48 hours or less of the previous presentation. > Previous Departure Status must equal: • 98 (Not Stated) • 99 (Unknown) • 1 (Episode Complete: home) • 9 (Episode Complete: nursing home). > The Current Presentation excludes Visit Type of: • 3 (planned review) • 5 (planned admission). > Standard Emergency Department Business Rules are applied (refer to Appendix A).
Related Information:	> Performance Indicators for the National Partnership Agreement on Improving Public Hospital Services Health, 2013 https://meteor.aihw.gov.au/content/index.phtml/itemId/489424 > Service Agreements 2021-2022 SA Health.

Unplanned/Unexpected Hospital Readmission for Select Elective Procedures within 28 Days

Identifying and definitional attributes

Short Name:	ES Select Readmissions
Tier:	Tier 2
KPI ID	SEC-EC-T2-2
Description:	Percentage (%) of hospital admissions identified as an unplanned/unexpected readmission occurring at the same hospital within 28 days of a select elective procedure.
Computation:	(Numerator/Denominator)*100
Numerator:	Count (#) of readmissions to the same hospital following a separation in which one of the selected procedures was performed.
Denominator:	Count (#) of separations in which one of the selected procedures was performed.

More Information

Scope:	Data is reported for: • CALHN: RAH, QEH • SALHN: FMC, NHS • NALHN: LMH, Modbury • WCHN: WCH* • BHFLHN: Gawler, South Coast, Mount Barker, Angaston, Kapunda, Kangaroo Island, Strathalbyn • FUNLHN: Port Augusta, Whyalla, Quorn • EFNLHN: Port Lincoln, Ceduna • RMCLHN: Riverland (Berri), Murray Bridge, Renmark, Loxton, Waikerie • LCLHN: Mount Gambier, Bordertown, Millicent, Naracoorte • YNLHN: Port Pirie, Balaklava, Clare, Crystal Brook, Jamestown, Wallaroo
Benchmarks:	Metro LHNs: Performing (Target) <= 2.0% Performance Concern > 2.0% and <= 4.5% Underperforming > 4.5% Regional LHNs: Performing (Target) <= 1.0% Performance Concern > +/-1.0% and <= 3.5% Underperforming > 3.5%
Representation Class:	Percentage (%)
Data Type:	Real
Unit of Measure:	Episode
Data Source:	Manual submissions - LMH, Modbury & FMC Operational Business Intelligence (OBI) - Sunrise/PAS sites

	Admitted Patient Care, formerly Integrated South Australian Activity Collection (ISAAC)- Regional Hospitals
Frequency of Reporting:	Monthly (2 month lag i.e. July data reported in October)
Notes:	* WCHN – reported data is limited to tonsillectomy and adenoidectomy procedures for paediatric patients. > Selected procedures include:- • Appendectomy (30571-00; 30572-00) • Cataract extraction (42698-00; 42702-00; 42702-01; 42698-01; 42702-02; 42702-03; 42698-02; 42702-04; 42702-05; 42698-03; 42702-06; 42702-07; 42698-04; 42702-07; 42698-04; 42702-08; 42702-09; 42731-01; 42698-05; 42702-10; 42702-11) • Hip replacement (49318-00; 49319-00) • Hysterectomy (35653-01; 35653-04; 35661-00; 35670-00; 90448-01; 90448-02; 35657-00; 35673-02; 35667-00; 35664-00; 35664-01; 35667-01; 90443-00) • Knee replacement (49518-00; 49519-00; 49521-02) • Prostatectomy (37207-00; 37201-00; 37203-00; 37203-02; 37203-04; 90408-00; 37207-01; 37200-03; 37200-04; 37224-00; 37224-01; 90407-00; 37203-03) • Tonsillectomy and adenoidectomy (41789-00; 41789-01; 41801-00). > A principal diagnosis for the readmission has one of the following ICD10-AM (9th Edition) codes: T80–88, E89, G97, H59, H95, I97, J95, K91, M96 or N99. > Excludes separations where the patient died in hospital. > Readmission must occur within 28 days of the previous date of separation.
Related Information:	> National Healthcare Agreement: PI 23–Unplanned hospital readmission rates, 2020 https://meteor.aihw.gov.au/content/index.phtml/itemId/725779 > Service Agreements 2021-2022 SA Health.

Aged Care: Rate Of Pressure Injury Per 1,000 Occupied Bed Days

Identifying and definitional attributes

Short Name:	Pressure injuries in aged care
Tier:	Monitor
KPI ID:	SEC-EC-M-5
Description:	Rate of care recipients who experienced a pressure injury per 1,000 occupied bed days.
Computation:	(Numerator/Denominator)*1,000
Numerator:	Count (#) of care recipients who experienced a pressure injury for the reporting period.
Denominator:	Count (#) occupied bed days for the reporting period.

More Information

Scope:	Data is reported for: • BHFLHN • RMCLHN • LCLHN • YNLHN
Benchmarks:	To be finalised
Representation Class:	Ratio
Data Type:	Real
Unit of Measure:	Episode
Data Source:	Residential aged care facilities - Leecare platform via Rural Support Service Multi-Purpose Services – manual data collection via Rural Support Service
Frequency of Reporting:	Quarterly (1 month lag i.e. July – September data reported in November)
Notes:	> Aligned with the National Aged Care Mandatory Quality Indicator program. > A pressure injury is a localised injury to the skin and/or underlying tissue, usually over a bony prominence, as a result of pressure, shear, or a combination of these factors. Previous terms used include pressure ulcer, bed sore and decubitus ulcer. > Six categories are measured and assessed in relation to pressure injuries: • Stage 1 pressure injuries: non-blanchable erythema of intact skin • Stage 2 pressure injuries: partial-thickness skin loss with exposed dermis • Stage 3 pressure injuries: full-thickness skin loss • Stage 4 pressure injuries: full-thickness loss of skin and tissue • Unstageable pressure injuries: obscured full-thickness skin and tissue loss • Suspected deep tissue injuries: persistent non-blanchable deep red, maroon or purple discolouration. > Every care recipient must be assessed for six stages of pressure injuries once each quarter. Residential care services should use the (National Pressure Ulcer Advisory Panel) NPUAP Pressure

	Injury Stages as a reference point. > Includes all respite care and end-of-life palliative care recipients. > Occupied bed days are determined as the number of days in care in the subsidy claiming system.
Related Information:	> National Aged Care Mandatory Quality Indicator Program. https://www.health.gov.au/resources/publications/national-aged-care-mandatory-quality-indicator-program-manual > Service Agreements 2021-22 SA Health.

Aged Care: Physical Restraints Per 1,000 Occupied Bed Days (Intent to Restrain)

Identifying and definitional attributes

Short Name:	Use of physical restraints in aged care (Intent).
Tier:	Monitor
KPI ID:	SEC-EC-M-6
Description:	Rate of care recipients who experienced an intent to restrain per 1,000 occupied bed days.
Computation:	(Numerator/Denominator)*1,000
Numerator:	Count (#) of care recipients who experienced an intent to restrain for the reporting period
Denominator:	Count (#) of occupied bed days for the reporting period.

More Information

Scope:	Data is reported for: • BHFLHN • RMCLHN • LCLHN • YNLHN
Benchmarks:	To be finalised
Representation Class:	Ratio
Data Type:	Real
Unit of Measure:	Episode
Data Source:	Residential aged care facilities - Leecare platform via Rural Support Service Multi-Purpose Services – manual data collection via Rural Support Service
Frequency of Reporting:	Quarterly (1 month lag i.e. July – September data reported in November)
Notes:	> Aligned with the National Aged Care Mandatory Quality Indicator program. > Restraint means any practice, device or action that interferes with a care recipient's ability to make a decision or restricts a care recipient's free movement. Physical restraint means any restraint other than: • a chemical restraint, or • the use of medication prescribed for the treatment of, or to enable treatment of, a diagnosed mental disorder, a physical illness or a physical condition. > Intent to restrain refers to physical restraint including, but is not limited to: • the intentional restriction of a care recipient's voluntary movement or behaviour by the use of a device, or removal of mobility aids, or use of physical force • actions to limit a care recipient to a particular environment. > The placement of furniture, use of concave mattresses, lap rugs with ties or any other devices used

	with the intention to restrict free movement should each be included in intent to restrain. Actions such as intentionally locking care recipients in their rooms or a room must also be included in intent to restrain. > Every care recipient must be assessed for intent to restrain. > The residential care service must carry out a total of nine observation assessments over the quarter. The residential care service must identify three assessment days in the quarter, approximately the same time each quarter. The residential care service must, on each of these assessment days, conduct three assessments of all care recipients—one in the morning, one in the afternoon and one at night. > Excludes: secure areas and perimeter alarms are not included for the purpose of the use of physical restraint indicator. > Includes: respite care recipients must be included in the observational assessments. > Occupied bed days are determined as the number of days in care in the subsidy claiming system.
Related Information:	> National Aged Care Mandatory Quality Indicator Program. https://www.health.gov.au/resources/publications/national-aged-care-mandatory-quality-indicator-program-manual > Service Agreements 2021-22 SA Health.

Aged Care: Physical Restraints Per 1,000 Occupied Bed Days (Physical Restraint)

Identifying and definitional attributes

Short Name:	Use of physical restraints in aged care (Physical).
Tier:	Monitor
KPI ID:	SEC-EC-M-7
Description:	Rate of care recipients who experienced a physical restraint per 1,000 occupied bed days.
Computation:	(Numerator/Denominator)*1,000
Numerator:	Count (#) of care recipients who experienced use of a physical restraint for the reporting period.
Denominator:	Count (#) of occupied bed days for the reporting period.

More Information

Scope:	Data is reported for: • BHFLHN • RMCLHN • LCLHN • YNLHN
Benchmarks:	To be finalised
Representation Class:	Ratio
Data Type:	Real
Unit of Measure:	Episode
Data Source:	Residential aged care facilities - Leecare platform via Rural Support Service Multi-Purpose Services – manual data collection via Rural Support Service
Frequency of Reporting:	Quarterly (1 month lag i.e. July – September data reported in November)
Notes:	> Aligned with the National Aged Care Mandatory Quality Indicator program. > Restraint means any practice, device or action that interferes with a care recipient's ability to make a decision or restricts a care recipient's free movement. Physical restraint means any restraint other than: • a chemical restraint, or • the use of medication prescribed for the treatment of, or to enable treatment of, a diagnosed mental disorder, a physical illness or a physical condition. > Physical restraint devices, inclusive of: • bedrails • chairs with locked tables • seatbelts other than those used during active transport • safety vests

	• shackles • manacles. > The placement of furniture, use of concave mattresses, lap rugs with ties or any other devices used with the intention to restrict free movement should each be included in intent to restrain. Actions such as intentionally locking care recipients in their rooms or a room must also be included in intent to restrain. > Every care recipient must be assessed for physical restraint devices. > The residential care service must carry out a total of nine observation assessments over the quarter. The residential care service must identify three assessment days in the quarter, approximately the same time each quarter. The residential care service must, on each of these assessment days, conduct three assessments of all care recipients—one in the morning, one in the afternoon and one at night. > Excludes: secure areas and perimeter alarms are not included for the purpose of the use of physical restraint indicator. > Includes: respite care recipients must be included in the observational assessments. > Occupied bed days are determined as the number of days in care in the subsidy claiming system.
Related Information:	> National Aged Care Mandatory Quality Indicator Program. https://www.health.gov.au/resources/publications/national-aged-care-mandatory-quality-indicator-program-manual > Service Agreements 2021-22 SA Health.

Aged Care: Unplanned Weight Loss (Significant)

Identifying and definitional attributes

Short Name:	Unplanned Weight Loss (Significant)
Tier:	Monitor
KPI ID:	SEC-EC-M-8
Description:	Rate of care recipients who experienced significant unplanned weight loss (5% or more) per 1,000 occupied bed days.
Computation:	(Numerator/Denominator)*1,000
Numerator:	Count (#) of care recipients who experienced significant unplanned weight loss for the reporting period
Denominator:	Count (#) of occupied bed days for the reporting period.

More Information

Scope:	Data is reported for: • BHFLHN • RMCLHN • LCLHN • YNLHN
Benchmarks:	To be finalised
Representation Class:	Ratio
Data Type:	Real
Unit of Measure:	Episode
Data Source:	Residential aged care facilities - Leecare platform via Rural Support Service Multi-Purpose Services – manual data collection via Rural Support Service
Frequency of Reporting:	Quarterly (1 month lag i.e. July – September data reported in November)

Notes:	> Aligned with the National Aged Care Mandatory Quality Indicator program. > Unplanned weight loss is where there is no written strategy and ongoing record relating to planned weight loss for the care recipient and is inclusive of both significant unplanned weight loss and consecutive unplanned weight loss. > Significant unplanned weight loss is unplanned weight loss equal to or greater than three kilograms over a three-month period. This result is determined by comparing the care recipient's weight at the last weigh this quarter (three-month period) with their weight at the last weigh last quarter. Both these weights must be available to provide this result. > Excludes: • care recipients who are absent, for example, in hospital • care recipients receiving end-of-life palliative care • respite care recipients. > Occupied bed days are determined as the number of days in care in the subsidy claiming system.
Related Information:	> National Aged Care Mandatory Quality Indicator Program. https://www.health.gov.au/resources/publications/national-aged-care-mandatory-quality-indicator-program-manual > Service Agreements 2021-22 SA Health.

Aged Care: Unplanned Weight Loss (Consecutive)

Identifying and definitional attributes

Short Name:	Unplanned Weight Loss (Consecutive)
Tier:	Monitor
KPI ID:	SEC-EC-M-9
Description:	Rate of care recipients who experienced Consecutive unplanned weight loss per 1,000 occupied bed days.
Computation:	(Numerator/Denominator)*1,000
Numerator:	Count (#) of care recipients who experienced consecutive unplanned weight loss for the reporting period.
Denominator:	Count (#) of occupied bed days for the reporting period.

More Information

Scope:	Data is reported for: • BHFLHN • RMCLHN • LCLHN • YNLHN
Benchmarks:	To be finalised
Representation Class:	Ratio
Data Type:	Real
Unit of Measure:	Episode
Data Source:	Residential aged care facilities - Leecare platform via Rural Support Service Multi-Purpose Services – manual data collection via Rural Support Service
Frequency of Reporting:	Quarterly (1 month lag i.e. July – September data reported in November)

Notes:	> Aligned with the National Aged Care Mandatory Quality Indicator program. > Unplanned weight loss is where there is no written strategy and ongoing record relating to planned weight loss for the care recipient. > Consecutive unplanned weight loss is unplanned weight loss of any amount every month over three consecutive months of the quarter. This can only be determined if the care recipient is weighed on all three occasions. > Excludes: • care recipients who are absent, for example, in hospital • care recipients receiving end-of-life palliative care • respite care recipients. > Occupied bed days are determined as the number of days in care in the subsidy claiming system.
Related Information:	> National Aged Care Mandatory Quality Indicator Program. https://www.health.gov.au/resources/publications/national-aged-care-mandatory-quality-indicator-program-manual > Service Agreements 2021-22 SA Health.

Avoidable Hospital Readmissions

Identifying and definitional attributes

Short Name:	Avoidable Hospital Readmissions
Tier:	Monitor
KPI ID:	SEC-EC-M-10
Description:	Percentage (%) of inpatient separations meeting the avoidable hospital readmissions criteria.
Computation:	(Numerator/Denominator)*100
Numerator:	Count (#) of inpatient separations meeting the avoidable hospital readmissions criteria in the period.
Denominator:	Count (#) of inpatient separations in the same period.

More Information

Scope:	Data is reported for: • CALHN • SALHN • NALHN • WCHN • BHFLHN: Gawler, South Coast, Mount Barker • FUNLHN: Port Augusta, Whyalla • EFNLHN: Port Lincoln • RMCLHN: Riverland (Berri), Murray Bridge • LCLHN: Mount Gambier • YNLHN: Port Pirie
Benchmarks:	To be finalised
Representation Class:	Percentage (%)
Data Type:	Real
Unit of Measure:	Episode
Data Source:	Admitted Patient Care, formerly Integrated South Australian Activity Collection (ISAAC)
Frequency of Reporting:	To be finalised
Notes:	> A hospital readmission occurs when a patient has been discharged from hospital and is admitted again within a certain time interval. > Generally, hospital readmissions can be considered in two broad categories: 1. Readmissions that relate to routine care, for example those that relate to necessary treatments such as chemotherapy or dialysis, and are required to ensure safe clinical care;

2. Readmissions that are potentially avoidable.

> Reducing avoidable hospital readmissions (AHRs) supports better health outcomes, improves patient safety and leads to greater efficiency in the health system.

> The Australian Commission on Safety and Quality in Health Care defines an 'avoidable hospital readmission' as occurring when a patient who has been discharged from hospital (index admission) is admitted again within a certain time interval, and the readmission:

- Is clinically related to the index admission, and
- Has the potential to be avoided through improved clinical management and/or appropriate discharge planning in the index admission.

> Codes/conditions considered to be avoidable hospital readmissions and associated condition-specific time intervals were developed by the Australian Commission on Safety and Quality in Health Care and endorsed by the Australian Health Ministers' Advisory Council and are summarised in the table below. Associated avoidable hospital readmission numbers and ICD codes can be found here.

List of conditions considered to be avoidable hospital readmissions

Readmission complication	Readmission diagnosis	Interval (days)
Pressure Injury	Stage III Ulcer	14
	Stage IV Ulcer	7
	Unspecified decubitus and pressure area	14
Infections	Urinary Tract Infection	7
	Surgical Site Infection	30
	Pneumonia	7
	Blood stream infection	2
	Central line and peripheral line associated blood stream infection	2
	Multi-resistant organism	2
	Infection associated with devices, implants and grafts	90
	Infection associated with devices, implants and grafts in genital tract or urinary system	30
	Infection associated with peritoneal dialysis catheter	2
	Gastrointestinal infections	28
Surgical Complications	Postoperative haemorrhage/haematoma	28
	Surgical wound dehiscence	28
	Anastomotic leak	28
	Cardiac vascular graft failure	28
	Pain following surgery	14
	Other surgical complications	28
Respiratory complications	Respiratory failure including acute respiratory distress syndromes	21

	Aspiration pneumonia	14
Venous thromboembolism	Venous thromboembolism	90
Renal failure	Renal failure	21
Gastrointestinal bleeding	Gastrointestinal bleeding	2
Medication complications	Drug-related respiratory complications/depression	2
	Hypoglycaemia	4
Delirium	Delirium	10
Cardiac complications	Heart failure and pulmonary oedema	30
	Ventricular arrhythmias and cardiac arrest	30
	Atrial tachycardia	14
	Acute coronary syndrome including unstable angina, STEMI and NSTEMI	30
Other	Constipation	14
	Nausea and vomiting	7

> Index admissions exclude separations with any of the following:
- Multi-purpose services and Mothercraft facilities.
- Hospital boarder, organ procurement, unqualified newborns (Care type: 9, 10, 7 with no qualified days).
- Not discharged alive (Nature of Separation: 5 or 6).
- Discharged against medical advice (Nature of Separation: 8).
- Admitted for same day and overnight chemotherapy and dialysis (DRG= R63Z, L61Z or L68Z, with length of stay < 2 days).
- Admitted for palliative care (Care type: 3).
- Admitted for oncology or haematology (any diagnosis: C00 to D89).
- Admitted for neonatal care (Care type: 7 with qualified days).

> Readmissions exclude separations with any of the following:
- Multi-purpose services and Mothercraft facilities.
- Not acute care type (Care type not 1).
- Admitted for same day and overnight chemotherapy and dialysis (DRG= R63Z, L61Z or L68Z, with length of stay < 2 days).
- Admitted for oncology or haematology (any diagnosis: C00 to D89).
- Admitted for childbirth (DRG: O01ABC, O02AB, O60ABC).
- Admitted for neonatal care (Care type: 7).

> A readmission is deemed as an avoidable hospital readmission if all the following are met:
- The index and readmission separations meet the respective exclusions criteria.
- The readmission has a Principal diagnosis on the 'Codes' list (and/or an additional diagnosis where specified).
- The readmission meets any additional criteria (where specified).
- The interval between the index admission and readmission (in days) is less than or equal to the interval specified.
  i.e. date of admission (of readmission) - date of separation (of index admission) ≤ interval.

Related Information:	> Australian Commission on Safety and Quality in Health Care: The National Health Reform Agreement Addendum reforms: Avoidable Hospital Readmissions. https://www.safetyandquality.gov.au/our-work/indicators/avoidable-hospital-readmissions > Service Agreements 2021-2022 SA Health.

PEOPLE AND CULTURE

WORKFORCE

Completion of Performance Reviews in line with the Commissioner's Determination	
Identifying and definitional attributes	
Short Name:	Performance Review Completion
Tier:	Tier 2
KPI ID:	PC-WF-T2-1
Description:	Percentage (%) of employees who have completed a Performance Review in the prior 6 month period.
Computation:	(Numerator/Denominator)*100
Numerator:	Employee headcount where a Performance Review was completed in the prior 6-month period.
Denominator:	Employee headcount at the time of the extract that are not: • Terminated; • Position ended (with a POS end date 2 months before the reporting period date) and no current position; • Seconded to other agencies; • Non-employees; • Board and Committee members. • Absent on unpaid leave greater than 20 days for contracted staff. • Casual staff who have not been paid greater than 28days.
More Information	
Scope:	Data is reported for: • CALHN: TEQH, RAH • SALHN: FMC, RGH, NHS • NALHN: LMHS, MH • WCHN: WCH • RMCLHN: Riverland (Berri), Murray Bridge, RMC Other • LCLHN: Mount Gambier, LC Other • FUNLHN: Port Augusta, Whyalla, FUN Other • EFNLHN: Port Lincoln, EFN Other • YNLHN: Port Pirie, YN Other • BHFLHN: Gawler, South Coast, Mount Barker, BHF Other • BHFLHN: Rural Support Service • South Australian Ambulance Service • State-wide Clinical Support Services • Drug and Alcohol Services South Australia • Department for Health and Wellbeing • Commission on Excellence & Innovation in Health • Wellbeing SA • State Total
Benchmarks:	Performing (Target): >=80.0% Performance Concern: <80.0% and >=75.0% Underperforming: <75.0%

Representation Class:	Percentage (%)
Data Type:	Real
Unit of Measure:	Person
Data Source:	CHRIS21
Frequency of Reporting:	6-monthly (i.e. July – December data reported in January)
Notes:	> An ended position is determined by an employee's POS end date being more than 2 months from the report date, i.e. for August data (compiled in September), employees who have a POS end date of 30 June and prior are excluded. > Performance reviews with a future date are excluded from the calculation. > Absent on unpaid leave greater than 20 days for contracted staff excluded from denominator. 20 days represents working days or 4 weeks. > Casual staff who have not been paid greater than 28 days excluded from denominator. 28 days represents 2 pay cycles, or 4 weeks. > Indicator aligns with the Officer for the Commissioner of Public Sector Employment reporting metrics. > This metric will be RAG rated and contribute to performance level assessment on a 6-monthly basis, with monthly data available via the workbooks.
Related Information:	> Guideline of the Commissioner for Public Sector Employment: Performance Management and Development: > https://www.publicsector.sa.gov.au/__data/assets/pdf_file/0017/214073/Guideline-Performance-Management-and-Development.pdf > Service Agreements 2021-22 SA Health.

New Workplace Injury Claims

Identifying and definitional attributes

Short Name:	New Workplace Injury Claims
Tier:	Tier 2
KPI ID:	PC-WF-T2-2
Description:	Count (#) of new workplace injury claims reported.
Computation:	Count (#)

More Information

Scope:	Data is reported for: • CALHN: TEQH, RAH • SALHN: FMC, RGH, NHS • NALHN: LMHS, MH • WCHN : WCH • RMCLHN: Riverland (Berri), Murray Bridge, RMC Other • LCLHN: Mount Gambier, LC Other • FUNLHN: Port Augusta, Whyalla, FUN Other • EFNLHN: Port Lincoln, EFN Other • YNLHN: Port Pirie, YN Other • BHFLHN: Gawler, South Coast, Mount Barker, BHF Other • BHFLHN: Rural Support Service • South Australian Ambulance Service • Statewide Clinical Support Services • Drug and Alcohol Services South Australia • Department for Health and Wellbeing • Commission on Excellence & Innovation in Health • Wellbeing SA • State Total
Benchmarks:	Performing (Target): <= previous year Performance Concern: N/A Underperforming: >above previous year
Representation Class:	Count (#)
Data Type:	Real
Unit of Measure:	Claims
Data Source:	Self-Insurance Management System (SIMS)
Frequency of Reporting:	6-monthly (i.e. July – December data reported in January)

Notes:	> This metric will be RAG rated and contribute to performance level assessment on a 6-monthly basis, with monthly data available via the workbooks. > The number of new workplace injury claims is calculated as the total number of new claims registered in the period, regardless of date of injury, determination or any other factor. This includes all claims whether accepted, rejected, pending determination or withdrawn. Every new claim has a 'Date Registered' date that does not change.
Related Information:	> South Australia's Strategic Plan Target 21: Greater Safety at Work. https://data.sa.gov.au/data/dataset/sasp-target-21-greater-safety-at-work > Service Agreements 2021-22 SA Health.

Employees with Excess Annual Leave Balance

Identifying and definitional attributes

Short Name:	Excess Leave
Tier:	Tier 2
KPI ID:	PC−WF−T2-3
Description:	Percentage (%) of employees with annual leave balance greater than or equal to 2 years entitlement (as recorded on LAC).
Computation:	(Numerator/Denominator)*100.
Numerator:	Employee headcount whose annual leave balance is greater than or equal to 2 years entitlement.
Denominator:	Employee headcount of employees eligible to annual leave that are not: • Terminated; • Seconded; • Non−employees; • Board and Committee members.

More Information

Scope:	Data is reported for: • CALHN: TEQH, RAH • SALHN: FMC, RGH, NHS • NALHN: LMHS, MH • WCHN: WCH • RMCLHN: Riverland (Berri), Murray Bridge, RMC Other • LCLHN: Mount Gambier, LC Other • FUNLHN: Port Augusta, Whyalla, FUN Other • EFNLHN: Port Lincoln, EFN Other • YNLHN: Port Pirie, YN Other • BHFLHN: Gawler, South Coast, Mount Barker, BHF Other • BHFLHN: Rural Support Service • South Australian Ambulance Service • State-wide Clinical Support Services • Drug and Alcohol Services South Australia • Department for Health and Wellbeing • Commission on Excellence & Innovation in Health • Wellbeing SA • State Total
Benchmarks:	Individual targets to be confirmed at Health Service Level, with a focus on an improvement trajectory.
Representation Class:	Percentage (%)
Data Type:	Real
Unit of Measure:	Person

Data Source:	CHRIS21 and SHARP
Frequency of Reporting:	6-monthly (i.e. July – December data reported in January)
Notes:	> Employees as recorded in CHRIS21. > Leave balance (years) for annual leave is a derived figure dependent on an employee being paid a leave average or contract hours when on annual leave represented by a field in PYD for all awards (except SA Public Sector Salaried employees who are all paid contract hours when on leave – the Shared Sector Model). > This metric will be RAG rated and contribute to performance level assessment on a 6-monthly basis, with monthly data available via the workbooks. > Payment Type: • Contract Hours (Shared Sector Model): Takes into account the employee's total accrual in hours, any future leave bookings, the leave entitlement in weeks specified by an employee's industrial instrument, and the number of hours per week that they are contracted to work. • Average Hours: Takes into account an employee's total accrual in days, any future leave bookings, the leave entitlement in weeks specified by an employee's industrial instrument, and the number of days per week they are contracted to work.
Related Information:	> Service Agreements 2021-22 SA Health.

Gross Expenditure for Workplace Injury Claims

Identifying and definitional attributes

Short Name:	Expenditure for workplace injury claims
Tier:	Monitor
KPI ID:	PC-WF-M-1
Description:	Gross workers compensation expenditure
Computation:	Gross workers compensation expenditure financial year to date

More Information

Scope:	Data is reported for: • CALHN: TEQH, RAH • SALHN: FMC, RGH, NHS • NALHN: LMHS, MH • WCHN: WCH • RMCLHN: Riverland (Berri), Murray Bridge, RMC Other • LCLHN: Mount Gambier, LC Other • FUNLHN: Port Augusta, Whyalla, FUN Other • EFNLHN: Port Lincoln, EFN Other • YNLHN: Port Pirie, YN Other • BHFLHN: Gawler, South Coast, Mount Barker, BHF Other • BHFLHN: Rural Support Service • South Australian Ambulance Service • State-wide Clinical Support Services • Drug and Alcohol Services South Australia • Department for Health and Wellbeing • Commission on Excellence & Innovation in Health • Wellbeing SA • State Total
Benchmarks:	N/A
Representation Class:	Count (#)
Data Type:	Real
Unit of Measure:	Currency
Data Source:	Self-Insurance Management System (SIMS)
Frequency of Reporting:	Monthly (i.e. July data reported in August)
Related Information:	> Service Agreements 2021-22 SA Health.

RESEARCH

RESEARCH

Human Research Ethics Committees (HREC) applications approval within 60 calendar days for more than low risk applications	
Identifying and definitional attributes	
Short Name:	HREC Application Approval
Tier:	Monitor
KPI ID:	R-R-M-1
Description:	Proportion (%) of research proposals (excluding low to negligible risk) approved by the reviewing HREC within 60 calendar days from the HREC meeting submission closing date.
Computation:	(Numerator/Denominator)*100
Numerator:	Count (#) of research proposals approved within 60 days.
Denominator:	Count (#) of all research proposals approved during the reporting month.
More Information	
Scope:	Data is reported for: • CALHN • SALHN • WCHN
Benchmarks:	Performing >=95.0% Performance Concern <95.0% and >=80.0% Underperforming <80.0%
Representation Class:	Percentage (%)
Data Type:	Real
Unit of Measure:	Research Proposals
Data Source:	Manual data submission via Health Translation SA/DHW Office for Research
Frequency of Reporting:	Quarterly (1 month lag i.e. July – September data reported in November)
Notes:	> All data will be a manual count until the Research Management System is implemented. > Includes all submissions to the HREC – single site, multi-site, investigator initiated and commercial trials. > Excludes all submissions that are defined as quality improvement, audit or low to negligible risk.
Related Information:	> Service Agreements 2021-22 SA Health.

SSA Approvals For More Than Low To Negligible Risk Applications

Identifying and definitional attributes

Short Name:	SSA Approvals
Tier:	Monitor
KPI ID:	R-R-M-2
Description:	Proportion (%) of site-specific applications (SSA) (excluding low to negligible risk) approved by the Research Governance Office (RGO) within 30 calendar days within the reporting month.
Computation:	(Numerator/Denominator)*100
Numerator:	Count (#) of SSAs approved within 30 days expressed.
Denominator:	Count (#) of SSAs received during the reporting month plus applications not yet approved from previous months.

More Information

Scope:	Data is reported for: • CALHN • SALHN • WCHN
Benchmarks:	Performing >= 95.0% Performance Concern <95.0% and >80.0% Underperforming <80.0%
Representation Class:	Percentage (%)
Data Type:	Real
Unit of Measure:	Research Proposals
Data Source:	Manual data submission via Health Translation SA/DHW Office for Research
Frequency of Reporting:	Quarterly (1 month lag i.e. July – September data reported in November)
Notes:	> All data will be a manual count until the Research Management System is implemented. > Includes all submissions to RGO – single site, multi-site, investigator initiated and commercial trials. > Excludes all submissions that are defined as quality improvement, audit or low to negligible risk.
Related Information:	> Service Agreements 2021-22 SA Health.

Joint HREC/SSA Approvals For Low To Negligible Risk Applications

Identifying and definitional attributes

Short Name:	Joint HREC/SSA Approvals
Tier:	Monitor
KPI ID:	R-R-M-3
Description:	Proportion (%) of low to negligible risk (LNR) applications approved by the Research Governance Office (RGO) including ethics assessment if required, within 20 calendar days within the reporting month.
Computation:	(Numerator/Denominator)*100
Numerator:	Count (#) of LNR applications approved within 20 calendar days of receipt of the application.
Denominator:	Count (#) of LNR applications approved during the reporting month.

More Information

Scope:	Data is reported for: • CALHN • SALHN • WCHN
Benchmarks:	Performing >=95.0% Performance Concern <95.0% and >80.0% Underperforming <80.0%
Representation Class:	Percentage (%)
Data Type:	Real
Unit of Measure:	Research Proposals
Data Source:	Manual data submission via Health Translation SA/DHW Office for Research
Frequency of reporting:	Quarterly (1 month lag i.e. July – September data reported in November)
Notes:	> All data will be a manual count until the Research Management System is implemented. > Includes all LNR applications. > Excludes all submission that are defined as higher than LNR.
Related Information:	> Service Agreements 2021-22 SA Health.

APPENDICES

APPENDIX A: EMERGENCY DEPARTMENT BUSINESS RULES AND ASSUMPTIONS

Details

Overview:	For all Emergency Department KPIs there are standard business rules that are automatically applied.
Business rules:	Invalid records are excluded from the numerator and denominator. Records are deemed invalid when: > Presentation date or time is missing > Departure date or time is missing > Departure is before Presentation (length of stay < 0) > Triage Category is not 1, 2, 3, 4, or 5 > Presenting Problem is missing > Departure status is missing > Seen by is before presentation or after departure (time points out of sequence) > Seen by is missing and departure status not 6 (Did not Wait), 85 (Advised of Alternate Treatment Options) or 99 (Not Stated/Unknown) Data excludes records from Women's Assessment Units at: > WCH > LMH

More information

Scope:	Business rules are applied to the following KPIs: > Emergency Department Length Of Stay Less Than Or Equal To 4 Hours > Emergency Department Seen On Time > Emergency Department Length of Stay Greater Than 24 Hours > Emergency Department Left At Own Risk > Emergency Department Unplanned Re-Attendance Within 48 Hours

For more information

Commissioning & Performance
health.performance@sa.gov.au

www.sahealth.sa.gov.au

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