LEGISLATIVE COUNCIL STANDING COMMITTEE ON ESTIMATES AND FINANCIAL OPERATIONS

2017-18 ANNUAL REPORTS QUESTIONS PRIOR TO HEARINGS

Department of Health
The Committee asked:

1) For each matter that had an impact in 2017-18, how much was spent on

   a) each spending change identified in the 2017-18 Budget and the 2018-19 Budget
   Refer to Attachment 1.
   Note: The Spending Changes tables only show incremental budget changes and are not representative of the total budget for each item.

   b) each capital project listed in the 2018-19 Budget asset investment program?
   Refer to Attachment 2.

2) How frequently do you review your

   a) key performance indicators
   Key Performance Indicators (KPIs) are reviewed annually as part of the development of the annual WA health system's Outcome Based Management Submission to the Under Treasurer.

   b) key performance indicator targets?
   KPI targets are reviewed annually as part of the Budget Paper development process.

3) When were your key performance indicators last reviewed?
A comprehensive review of the WA health system's Outcome Based Management Framework (service structure) and KPI suite was undertaken throughout 2015 to 2017, with resulting changes submitted to the Under Treasurer for approval as part of the 2017-18 Outcome Based Management submission. The submission was guided by extensive consultation with a broad range of stakeholders including Health Service Providers, Department of Treasury, the Office of the Auditor General and the Mental Health Commission.

4) Can you provide any documentation from your last review of your key performance indicators?
The attached 2017-18 Outcome Based Management Submission to the Under Treasurer (Att. 3 - September 2016) demonstrates the comprehensive review of the framework and KPIs (section 7) undertaken and consultative KPI development and testing process.

5) Can you list any new key performance indicators for this year?
Five (5) new KPIs were reported by the Department of Health in 2017-18:

- Percentage of people accessing community-based palliative care to assist them to die at home
- Percentage of Western Australian year 8 students that complete their HPV vaccination series
- Average cost per client who receives support services from the Home and Community Care Program
- Proportion of stakeholders who indicate the Department of Health to be meeting or exceeding expectations of the delivery of System Manager functions
- Average cost of Public Health Regulatory services per head of population.

Initialled by:----------

Hon Nick Goiran MLC asked:

1) I refer to supplementary information No A6 provided as an answer to questions taken on notice at the 2014/15 annual report hearing in which the Committee was informed that the Executive Director Public Health had given an undertaking to provide an annual report in August each year with the gestation and reason for termination of all post 20 week termination, and I ask:

   a) was this done in the 2017/18 reporting period:

      i) if not, why not; and
      The annual report with the gestation and reason for termination of all post 20 week termination for the 2017/18 reporting period was not done. The Department of Health was instructed by the Minister for Health that the above report is no longer required.

      ii) If yes, when was this done and will you table the report?
      Not applicable.

Initialled by----------

ATTACHMENT 1: SPENDING CHANGES TABLE

Spending Changes Table	Budget Papers 2017-18 Budget 2017-18 $'000	Budget Papers 2018-19 Estimated Actual 2017- 18 $'000
Adjustments to Public Hospital Services and Non-Hospital Services		
Hospital Services - Revised Activity and Cost Settings	246,009	(3,177)
Realignment of Non-Hospital Services Expenditure	(91,017)	-
Commonwealth Grant Expenditure		
Adult Public Dental Services	-	9,686
Commonwealth Respite and Carelink Centres	-	1,591
Essential Vaccines	27	22,488
Expansion of BreastScreen Australia Program	-	1,588
Home and Community Care	(17,745)	(2,672)
Improving Trachoma Control Services for Indigenous Australians	-	1,614
Multi-purpose Services Program Agreement	28,161	2,016
Hepatitis C Drug Program	(68,640)	-
Mental Health Respite - Carer Support Agreement	385	-
National Partnership Agreement on Pay Equity for the Social and Community Services Sector	14,664	-
Organ and Tissue Donation Agreement	3,973	-
Ozfoodnet	-	205
Perth Children's Hospital		
Perth Children's Hospital - Capella Parking	2,289	5,223
Perth Children's Hospital - Commissioning	15,963	14,183
Election Commitments		
Expand the Ear Bus Program	822	-
Find Cancer Early	382	-
Meet and Greet Service for People from Remote Communities	458	-
Let's Prevent Program (a)	611	-
Patient Opinion (a)	193	-
Urgent Care Clinics (a)	2,000	-
Government Initiatives and Budget Priorities		
Conversion of recurrent allocation to capital to continue the rollout of the Patient Administration System[1]	(10,827)	-
Sarich Neuroscience Research Institute[1]	(1,500)	-

Own Source Revenue		
Tariffs, Fees and Charges	6,522	-
Royalties for Regions		
Busselton Information and Communications Technology	1,000	-
Dongara Aged Care[2]	-	(1,000)
Savings Measures		
Agency Expenditure Review Savings Measure - Non-hospital Expenditure[3]	(47,481)	-
Revision to Indexation for Non-Salary Expenses[3]	(4,077)	-
Freeze Salaries and Allowances Tribunal Determined Salaries[3]	(11)	-
New Public Sector Wages Policy Savings[3]	-	44
Senior Executive Service Reduction[3]	-	(500)
State Fleet Policy and Procurement Initiatives[3]	-	(998)
Voluntary Targeted Separation Scheme	-	10,064
Other		
Update to Depreciation Expense	3,865	(23,477)
Non-Government Human Services Sector Indexation Adjustment[1]	(4,426)	-
Transfer funds to the Health and Disability Services Complaints Office[4]	(50)	-
Computerised Tomography Scanner for PathWest at State Mortuary	-	146
Government Office Accommodation Reform Program[5]	-	227
Revision to Road Trauma Trust Account Funding	-	512
Transfer of Funds to the Mental Health Commission[4]	-	(954)
(a) Internally Funded		

* Spending Changes for the 2017-18 Estimated Actual approved at the 2018-19 Budget.

(1) Budget adjustment only therefore no associated spending.

(2) RfR adjustment to reallocated funds.

(3) Savings measures that delivered a lower budgeted expenditure limit in 2017-18.

(4) Transfer of budget to another Agency.

(5) Actual relates to total accommodation lease expenditure. Unable to identify Government Office Accommodation specifically.

ATTACHMENT 2: ASSET INVESTMENT PROGRAM

Project	Actual 2017-18 in $'000
Broome Regional Resource Centre - Redevelopment Stage 1	0
Equipment Replacement Program	17,396
Minor Buildings Works	974
Fiona Stanley Hospital - Development	82
Armadale Kelmscott Hospital - Development	1,195
Midland Health Campus - Development Stage 1	244
Perth Children's Hospital - Development	29,673
Hedland Regional Resource Centre - Stage 2	0
Country Staff Accommodation - Stage 3	0
Kalgoorlie Regional Resource Centre - Redevelopment Stage 1	1,210
Busselton Health Campus	708
Harvey Hospital - Redevelopment	1,061
Esperance Integrated District Health Service	316
Eastern Wheatbelt District (incl Merredin) - Stage 1	1,000
Country - Staff Accommodation- Stage 4	219
Country - Transport Initiatives	0
Peel Health Campus - Development Stage 1	513
Princess Margaret Hospital - Holding	0
WACHS PACS - Regional Resource Centre	0
King Edward Memorial Hospital - Maternal Fetal Assessment Unit	1
Princess Margaret Hospital - Interim Holding Works at Existing PMH Site	0
BreastScreen WA - Digital Mammography Technology	0
Strengthening Cancer Services in Regional WA - Albany, Northam, Narrogin, Geraldton, Kalgoorlie	723
Karratha Health Campus	80,649
Remote Indigenous Health Infrastructure	0
QEIIMC - New Central Plant Facility	0
NPA - Improving Public Hospital Services	8,108
District Hospital Investment Program (ex-SIHI)	86,035
Primary Health Centres Demonstration Program (ex-SIHI)	10,459
Small Hospital and Nursing Post Refurbishment Program (ex-SIHI)	31,378
Digital Innovation - Capital (ex-SIHI Telehealth)	478
RPH Redevelopment Stage 1	3,799
Strengthening Cancer Services in Regional WA - Northam Cancer Centre	500
Strengthening Cancer Services in Regional WA - Narrogin Cancer Centre	250
Strengthening Cancer Services in Regional WA - Geraldton Cancer Centre	75
Osborne Park Hospital additional parking facility	6
Joondalup Health Campus Telethon Paediatric Ward	0
Perth Children's Hospital Information Communication Technology	8,763
Fiona Stanley Hospital ICT Commissioning	1,106
Replacement of PathWest's Laboratory Information Systems (LISs)	5,175
FSH ICT - Intensive Care Clinical Information Systems (ICCIS)	0
FSH ICT - Pharmacy Automation	0
Renal Dialysis - Capital (ex-Wheatbelt Renal)	200
Renal Dialysis and Support Services	5,678

Bunbury, Narrogin and Collie Hospitals Redevelopment	82
Health and Hospitals Fund - Point of Care Network for Pathology Testing	209
PathWest - Laboratory Equipment and Asset Replacement/Maintenance	650
Infection Prevention and Control System	34
Onslow Hospital	19,084
SCGH Catheter Laboratory 2 Upgrade	0
Fremantle Hospital and Health Service Reconfiguration	3
Upgrade of PABX infrastructure at SCGH and KEMH	0
Newman Health Service Redevelopment Project	1,498
Ipharmacy	165
ICT Minor Works	1,336
King's Park Link Bridge	0
MODDS	10
Joondalup MHOA	442
Quadriplegic Centre Redevelopment	151
Epilepsy	0
PACS-RIS	753
TKI	3
Albany Hospice Car Park	0
Carnarvon Residential Aged Care Facility	593
Sarich Neuroscience Research Institute	385
Auspman	175
QEIIMC Hospital Avenue	341
RPH Helipad	128
Medical Accounts Assessment System	0
FSH - Critical ICT Requirements and Infrastructure Upgrades	1,882
FSH - da Vinci System	0
Joondalup Health Campus Mental Health Unit Anti-Ligature Point Rectification	865
NWHI - Tom Price Hospital Redevelopment	0
NWHI - Derby Community Health Service	8
Kalamunda District Community Hospital Infrastructure Upgrade	914
Carnarvon Hospital Redevelopment	0
Fremantle General Dental	129
Adult Mental Health Unit Overrun	2,882
Continued rollout of the Patient Administration System (PAS)	3,413
Expand the Earbus Program	0
KEMH - Neo-natal Intensive Care Unit	987
Graylands Hospital Redevelopment – High Priority Ligature Risk Remediation (HPLRR)	0
Government Office Accommodation Reform Package	0
Joondalup Health Campus Redevelopment Stage 2	117
RPH MHOA	0
PSOLIS	0
Actual amount spent on capital project listed in the 2018-19 Budget asset investment program	**335,214**

Government of **Western Australia**
Department of **Health**

Submission to the Under Treasurer, Department of Treasury

Proposed Amendments to the WA Health Outcome Based Management Framework

2017-2018 Reporting Period Onwards

September 2016

Contents

Abbreviations

Abbreviation	Meaning
ABF	Activity Based Funding
ABM	Activity Based Management
Accountability Framework	National Health Reform Agreement Performance and Accountability Framework
ACEM	Australasian College of Emergency Medicine
ARDT Policy	The Admission, Readmission, Discharge and Transfer Policy for WA Health Services 2015-2016
CAHS	Child and Adolescent Health Service Provider
COAG	Council of Australian Governments
CPNWAU	Cost per National Weighted Activity Unit
Department	The Western Australian Department of Health
DAMA	Discharged Against Medical Advice
EMHS	East Metropolitan Health Service Provider
Executive Committee	The OBSS Reform Project Executive Committee
Framework	The WA Health Outcome Based Service Structure Performance Framework
GBS	Government Budget Statements
HITH	Hospital in the Home Programs
HPV	Human Papilloma Virus
HSMR	Hospital standardised mortality ratios
HSPs	Health Service Providers
HSPR	Health Service Performance Report
HSA	*Health Services Act 2016* (WA)
HSS	Health Support Services
IHPA	Independent Hospital Pricing Authority
KPIs	Key Performance Indicators
Letter	Letter of 18 June 2014 from Michael Barnes, Acting Under Treasurer to Professor Stokes, Acting Director General of Health
MBI	Modified Barthel Index
NEP	National Efficient Price
NEST	National Elective Surgery Target
NHA	National Healthcare Agreement
NHCDC	National Hospital Cost Data Collection
NHS	Non Hospital Services
NHRA	National Health Reform Agreement National Health Reform Agreement 2011
NMHS	North Metropolitan Health Service Provider
NPA	National Performance Agreement
NSW	The State of New South Wales
NWAU	National Weighted Activity Unit
OAG	The Western Australian Office of the Auditor General
OBM	Outcome Based Management

Abbreviation	Meaning
OBM Guidelines	Outcome Based Management: Guidelines for use in the Western Australian Public Sector, Department of Treasury and Finance, November 2004.
OHHS	Our Hospitals and Health Services online report
PAF	National Health Reform Performance and Accountability Framework
PATS	Patient Assisted Travel Scheme
PHE	Public Health Establishment
Project	The Outcome Based Service Structure Reform Project
RFDS	Royal Flying Doctor Service
ROGS	Report on Government Services
SAB	Staphylococcus aureus bacteraemia
SA Health	South Australia Health
SJAA	St. Johns Ambulance Australia
SMHS	South Metropolitan Health Service Provider
Strategic Intent	WA Health Strategic Intent 2015-2020
Treasury	Department of Treasury
TI	Treasurer's Instruction
WA	The State of Western Australia
WACHS	WA Country Health Service Provider
WEST	WA Elective Surgery Target
QLD	The State of Queensland

Glossary

Term	Definition
Activity Based Funding	A system for funding public hospital services based on the actual number of services provided to patients and the efficient cost of delivering those services. Activity based funding uses national classifications, cost weights and nationally efficient prices to determine the amount of funding for each activity or service.
Activity Based Management	Activity Based Management is a management approach used by WA Health (and other jurisdictions) to plan, budget, allocate and manage activity and financial resources to ensure delivery of safe, high-quality health services.
Agency	Agency has the same meaning as given to it by the *Financial Management Act 2006 WA* "agency means a department, a sub-department or a statutory authority".
Block Funding	A system of funding public hospital functions and services as a fixed amount based on population and previous funding. Under National Health Reform, block funding will be provided to states and territories to support teaching and research undertaken in public hospitals and for some public hospital services where it is more appropriate, particularly smaller rural and regional hospitals
CFSA	WA Health Current and Future State Assessment – Outcome Based Service Structure Project
Effectiveness indicator	Indicators that provide information that assists with the assessment of the extent to which government desired outcomes have been achieved through resourcing and delivery of services to the community.
Efficiency indicator	Indicators that monitor the relationship between the services delivered and the resources used to produce the service or good.
Health Service Provider	A separate, board- or Chief Executive- governed statutory authority, legally responsible and accountable for the delivery of health services for their local areas and communities. Established under section 32(2) of the HSA.
Independent Hospital Pricing Authority	An independent statutory authority established under the *National Health Reform Act 2011* (Commonwealth) responsible for determining the national efficient price (NEP) for public hospital services.
National Efficient Price	A base price calculated by the Independent Hospital Pricing Authority as a benchmark to guide governments about the level of funding which would meet the average cost of providing acute care (admitted, emergency and outpatient) services in public hospitals across Australia. The national efficient price is based on the projected average cost of a National Weighted Activity Unit (NWAU) after the deduction of specified Commonwealth funded programs.
National Weighted Activity Unit	An NWAU is a measure of health service activity expressed as a common unit, against which the NEP is paid. It provides a way of comparing and valuing each public hospital service (whether it is an admission, emergency department presentations or outpatient episode), by weighting it for its clinical complexity. The average hospital service is worth one NWAU – the most intensive and expensive activities are worth multiple NWAUs, the simplest and least expensive are worth fractions of an NWAU. The NWAU will be updated annually.
Outcomes	Effects, impacts or results on or consequences for the community/target clients of services delivered by Agencies.
Programs	Are services that deliver continuous or non-standard units rather than discrete, measureable units of output.
Services	Activities and goods that agencies deliver to external users in order to achieve Outcomes. They can be in the nature of outputs or programs.
Service Agreement	The Director General and a Health Service Provider must enter into a service agreement for the provision of health services by the health service provider as mandated by section 46(2) of the HSA.

Term	Definition
Sub-Services	A service that can be aggregated up into a continuous standard Service unit.
System Manager	Defined in section 19(2) of the HSA as the System Manager role held by the Department CEO, currently the Director General of the Department of Health, and means responsibility for the overall management of the WA health system.
WA health system	The meaning given in section 19(1) of the HSA. Comprises of the Department, Health Service Providers and to the extent that contracted health entities provide health services to the State, the contracted health entities

Table of Tables

Table of Figures

A revised Outcome Based Management Framework for WA Health

This submission provides an overview of the proposed amendments to the WA Health Outcome Based Management Framework (**OBM Framework**). We have drawn on the intellect of the system to develop a contemporary and meaningful OBM Framework that is forward thinking in its design and application.

The WA Health OBM Framework is a consolidation of, and advancement on, recent governance, performance and financial reforms. The main intent is to improve the accountability of the WA health system in providing information to the public and Parliament on the services that are delivered, the funds used to deliver these services, and the performance of these services. It is intended to facilitate further improvements in WA Health service and program delivery through two broad mechanisms.

Firstly, the OBM Framework is intended to facilitate a more effective budget process, through utilising a revised and relevant service structure that describes the delivery of health services and the public funds that are used to deliver these services. Alignment of funds (through mechanisms such as Service Agreements between the Department of Health (as System Manager) and the Health Service Providers) to these categories of Services provides transparency and improves the efficiency and effectiveness of the resource allocation process.

Secondly, the OBM Framework is intended to facilitate improvements in the management of WA Health's resource and asset base, to ensure that the resources applied to Service and Program delivery are managed in a way which will maximise their delivery capacity, through more accurate and timely performance management monitoring and reporting (aligned to existing internal, State and National reporting obligations).

The OBM Framework will encompass a suite of interrelated policy documents and technical mapping. It is envisaged that the implementation of the OBM Framework will begin with the 2017/2018 financial year budget submission, and will be reported against in full in the 2017/2018 financial year Annual Reports of both the Department of Health (**Department**) and Health Service Provider Entities (**HSPs**).

The OBM Framework aligns to the *WA Health Strategic Intent 2015-2020* (**Strategic Intent**) which aims to ensure 'healthier, longer and better lives for all West Australians', and to 'improve and protect the health of our community by providing a safe, high-quality, accountable and sustainable healthcare system, through increased and accurate performance management'.

This submission will be followed by a second submission from WA Health to the Under Treasurer, that will detail the WA Health Annual Report Key Performance Indicators (**KPIs**) for the 2016/2017 annual reporting period.

Dr D J Russell-Weisz

DIRECTOR GENERAL

14 September 2016

1. Executive Summary

WA Health's submission is framed around:

- Providing the evidence base and rationale to the Department of Treasury (**Treasury**) and Under Treasurer for the wholesale change to WA Health's OBM Framework;
- Detailing the interaction between the WA Health Reform Program (**Reform Program**) and the design of the revised OBM Framework;
- Aligning the increased focus of WA Health on all aspects of performance to a revised OBM Framework that delivers accountability and integrity of the Services delivered to the WA public; and
- Demonstrating the link between the submitted OBM Framework, improved transparency and increased performance management capability and the end result of a more sustainable and responsive WA health system.

A Revised OBM Framework for WA Health

WA Health operates under an OBM Framework, pursuant to its legislative obligation as a WA Government Agency under section 61 of the *Financial Management Act 2006* and *Treasurer's Instruction 904*. Alignment with the OBM Framework ensures that WA Health's agency performance is measured using the same performance management framework employed by all other WA Government Agencies. The OBM Framework describes how Outcomes, Services and Key Performance Indicators (KPIs) are used to measure WA Health's performance towards achieving the relevant overarching whole-of-government goal(s). WA Health's KPIs measure the effectiveness and efficiency of the Services provided by WA Health in achieving the stated desired Outcomes.

The current OBM Framework has been in place for approximately 15 years, with minor amendments being made to the KPIs in order to reflect improvements in performance monitoring processes. Although these amendments have updated the OBM Framework to a certain extent, the WA Health system has changed, increasing in its size and service delivery configuration. This change and subsequent growth has exceeded other Australian jurisdictions and is reflective of a national change in the health landscape, an outcome of the introduction of Activity Based Funding (**ABF**) arrangements in 2013-2014.

WA Health acknowledges that it is time for a wholesale change of the current OBM Framework, in order to more accurately describe and reflect its status as a modern health agency. We know our business well, understanding both frontline operational service delivery and state-wide and national policy trends, and have worked hard to reflect this in our OBM Framework. This submission provides the details of the revisions to the WA Health OBM Framework, to be implemented during the 2017/2018 budget submission, Budget Papers, revenue and resource allocation-and performance reporting and the Annual Reports. The revised WA Health OBM Framework detailed in this submission is comprised of:

- A new Agency Goal;
- 3 new Outcome Statements;
- A revised Service Structure comprising of 8 Services (including two new Services to capture the roles of the Department and Health Support Services (**HSS**));
- 26 effectiveness KPIs used to measure progress of the Department and HSPs towards achieving the Outcomes; and

- 23 efficiency KPIs that measure the efficiency of the Services delivered by the Department and HSPs.

The revisions to the OBM Framework detailed in this submission are an outcome of the instructions received from the Under Treasurer in June 2014, and the subsequent Outcome Based Service Structure Reform Project (**Project**) November 2014 - August 2016, conducted as part of the broader Reform Program detailed below and at Appendix 1 of this submission.

The proposed amendments to the OBM Framework align to the strategic goals and intentions of the WA health system; have synergy to the ABF and Activity Based Management (**ABM**) health provision environment and the central principles of transparency of WA Health's business inclusive of accurate and timely performance reporting which enables business integrity. The revised OBM Framework development process has been guided by extensive consultation with a broad range of stakeholders detailed throughout this submission, inclusive of the feedback provided by key external stakeholders such as the Department of Treasury (**Treasury**), the Office of the Auditor General (**OAG**) and the Mental Health Commission (**MHC**).

The response of WA Health to specific feedback provided by Treasury and OAG and its incorporation where appropriate into the revised OBM Framework can be viewed at Appendix 2.

WA Health Reform Program 2015-2020

WA Health is committed to improving budget performance and improving the efficiency and effectiveness of the health system. Recognising that wholesale reform is fundamental to the continued delivery of a safe, high-quality and sustainable health system in WA, the ongoing work under the Reform Program will deliver a range of benefits that provide a strong foundation to drive system efficiencies and health system sustainability. The Reform Program is focused on leading the health system to better performance by leveraging on the systems' strengths and addressing challenges.

The Reform Program comprises of a number of work-streams, with the revision of WA Health's OBM Framework, a core reform project to improve accountability. In addition to reform of the OBM Framework, other complementary and connected performance and financial reforms include improving ABM, integrating system performance management into business-as-usual processes, transparent budget and resource allocation, and improved financial monitoring through cost centre reform. It is within this context of reform and system change that the WA Health OBM Framework has been developed.

Changes to WA Health's Governance Framework

Similarly to other Australian jurisdictions, WA has introduced new governance arrangements through board-governed health services and setting the role and responsibility of the Department as the System Manager. The revisions have been implemented through the *Health Services Act 2016* (**HSA**), which from 1 July 2016 replaced the outdated *Hospital and Health Services Act 1927.*

The HSA provides contemporary governance for WA Health and prescribes clear roles, responsibilities, accountabilities at all levels of the system. The revised HSA allows for decision-making closer to service delivery and patient care as well as supporting WA Health's vision 'to deliver a safe, high quality, sustainable health system for all Western Australians'.

The legislation dictates the following key roles, responsibilities and accountabilities for the WA health system, all of which have been incorporated into the development of the submitted OBM Framework:

- The Department led by the Director General, as System Manager responsible for overall management, performance, strategic direction of WA Health.
- Health Services as HSPs that are separate, board-governed statutory authorities, legally accountable for the delivery of health services.
- HSS as a HSP that is a chief executive-governed statutory authority accountable for delivery of support services.

The new governance structure for the WA Health System is outlined below in Table 1:

Table 1: WA Health Governance and Entity structure

Statutory Board Governed Health Service Providers	
1.	North Metropolitan Health Service
2.	East Metropolitan Health Service
3.	Child and Adolescent Health Service
4.	South Metropolitan Health Service
5.	WA Country Health Service
6.	The WA Quadriplegic Centre
Chief Executive Governed Health Service Providers	
7.	Health Support Services
The System Manager	
8.	The Department has been realigned to new System Manager functions.
Trusts	
9.	Queen Elizabeth II Medical Centre Trust

Pursuant to section 61 of the *Financial Management Act 2006*, Annual Reports are required to be produced for an Agency that is a department or statutory authority (including any affiliated or related body). Accordingly, the amendments to the governance structure for WA Health as a result of the HSA will mean that from 1 July 2016 there will be seven statutory entities and the Department with the Director General as System Manager. The Department, North Metropolitan Health Service (**NMHS**), South Metropolitan Health Service (**SMHS**), East Metropolitan Health Service (**EMHS**), Child and Adolescent Health Service (**CAHS**), WA Country Health Service (**WACHS**), The WA Quadriplegic Centre (**Quadriplegic Centre**) and Health Support Services (**HSS**) will provide Annual Reports against the revised OBM Framework. Queen Elizabeth II Medical Centre Trust (**QEII**) has historically reported against its own OBM Framework, and will

continue to do so, given the distinct and separate nature of the business undertaken by this related body.

These amendments will clarify roles and responsibilities at all levels across the system. Clear roles and responsibilities across all areas of WA Health will assist with improved performance and reduced duplication of resources. It will also lead to a health system that is more balanced between short-term imperatives and medium- to longer-term objectives through better system-wide policy and planning. Strong governance foundations will support system operation and risk management, resulting in a more sustainable and responsive WA health system.

The revised OBM Framework will deliver a number of benefits to the WA Health system (discussed in more detail at section 2.2 of this submission) inclusive of increased transparency of public reporting and a connected budget submission and resource allocation process.

2. Background

2.1. Setting the Scene - Rationale for OBM Reform

The state of WA has a good public healthcare system by national and international standards. However, similarly to all other Australian jurisdictions, the WA health system must work smarter to meet the changing health needs of the population and ensure the best value possible for our investments and the hard work of our dedicated staff. Health expenditure growth over the past decade has averaged 9.8% per annum. Health expenditure as a proportion of total general government expenditure has increased to 29% in 2014-15, an increase of 5 percentage points ($4.93 billion) since 2004-05. Achieving productive efficiency is fundamental to informing public discussion and debate on the allocative efficiency of this level of health spending.

It is within the above context that the Project was tasked with undertaking a wholesale review and reform of WA Health's current OBM Framework, as part of the wider Reform Program. Further detail on the Project objectives, scope, benefits and Terms of Reference can be viewed at Appendix 3, Appendix 4 and Appendix 5 of this submission.

WA Health has not completed a wholesale agency review of its OBM Framework for over 15 years, and the opportunity has been taken as part of the broader Reform Program to develop a revised OBM Framework that reflects the contemporary nature of health service provision in Western Australia. The impetus for this reform is to address and rectify what the current WA Health OBM Framework is not able to deliver:

1. Adequate information to the public on the Services delivered by WA Health;
2. Reflect roles and Services provided by the System Manager and HSPs;
3. Synergy with ABF products as defined in the ABF rules;
4. Align with the structures used for the purposes of the budgeting; resource allocation; revenue alignment and the financial and performance reporting and management; or
5. A suite of meaningful and strategically aligned KPIs.

The review of the current WA Health OBM Framework has addressed the above listed issues and has enabled the revised OBM Framework to align with budget and annual reporting cycle requirements, national health reform initiatives and WA Health's Strategic Intent as a whole and a sustainable approach to whole of government appropriation.

2.2. Benefits of the OBM Framework to the WA Health System

The overall purpose of the submitted OBM Framework is to improve the outcomes of WA Health's service delivery through a revised financial and performance management framework, facilitated through an OBM structure that aligns with the way in which WA Health operates and manages its business.

The development of an improved OBM Framework that is connected and utilised across the budget, resource allocation, performance management and reporting cycle will deliver the following benefits to the WA health system:

Transparency

- Development of an OBM Framework that reflects the Services that WA Health actually delivers, achieving improved public accountability for WA Health.
- Increased visibility of the Services provided by the Department and HSPs, through the creation of a suite of Sub-Services with related business rules that allows for greater accuracy and transparency of the Services reported in the Government Budget Statements (**GBS**) and WA Health Annual Reports.
- Creation of a common language and terminology for the use of ABF-aligned Services and other funded health Services across the WA Health system.
- Adoption of a single OBM Framework by all WA Health entities, facilitating benchmarking and aiding convergence to the national efficient price.
- Alignment of the Services provided by WA Health and community expectations regarding healthcare provision within the one OBM Framework.

Connection

- A single OBM Framework that will be implemented throughout the WA Health budget, resource allocation and performance reporting cycles.
- The connection of the OBM Framework throughout both Department and HSP financial practices will support the streamlining, accuracy and effectiveness of the WA Health budget, allocation, performance management and reporting processes.
- Facilitate the development and communication of budget proposals in a timely and non-contradictory manner.
- This connection will in turn align the information provided to the public, parliament and WA Health on the delivery of WA Health Services. In essence ensuring that the proposal made to Government and Treasury at the beginning of the budget submission and GBS process is reflected in the Annual Reports and parliamentary hearings.

Synergy with ABF/ABM

- Ensure that the submitted OBM Framework has synergies with ABF Service categories and Non Hospital and block funded Services.
- Facilitate service provision within the context of ABM, enhancing the implementation of ABF and ABM by HSPs and the Department. This in turn will assist with the regular engagement and discussion that occurs between the Department and Treasury.
- This alignment ties in with the launch of the *WA Health ABM Strategy 2015* that outlines the work-stream-specific mechanisms that underpin the implementation of ABM across the WA health system.

Clarity of Non Hospital and Block Funded Services

- Provide information on the Services and the funds for the Non Hospital and Block Funded Services, traditionally referred to internally as the Non Hospital products.
- Standardise and create internal consistency of Non Hospital and Block Funded Services across the WA health system.
- Improve external reporting alignment of Non Hospital and Block Funded Services to national collections such as National Hospital Cost Data Collections (**NHCDC**).

Strategically Aligned Key Performance Indicators:

- Consistent approach and clarity around KPI measurement and use.
- KPIs that are strategically aligned to national reporting requirements, reflective of revised Services and Outcomes and are meaningful to the public and parliament.
- Facilitate effective and consistent reporting and accounting for the effectiveness and efficiency of the health system.

2.3. Evidence Base for Proposed OBM Framework

The revised OBM Framework is the culmination of an 18-month process of research and analysis to create a robust evidence base and rationale for each component of the OBM Framework. Surmised below and throughout this submission is the body of research and work for the WA Health OBM Framework.

2.3.1. Current and Future State Assessment

The revised OBM Framework is built on the evidence gathered in through a current and future state assessment process. The Project Current and Future State Assessment (**CFSA**)[1] was a detailed review of:

- Current state of the WA Health OBM and KPIs;
- Comparison of the Budget Papers and Annual Reports of selected WA Government Agencies to identify learnings on other OBM models;
- An environmental scan of Budget Papers and Annual Reports of Health Agencies in other jurisdictions for considerations that may be applicable to WA Health; and
- Department of Health survey that assessed the current state of the WA Health OBM, the issues perceived and improvements desired for the future state of the WA Health OBM and feedback from key stakeholder consultations.

2.3.2. Changes to the Governance of WA Health Governance

The revised OBM Framework is reflective of the changes to WA Health's governance structure, with a new third Outcome Statement and related Service line Seven, developed to capture the role of the 'System Manager' and the services it provides at a system-wide level. The future-focused design of the submitted OBM Framework incorporates, and has been based on, the new governance structure and contemporary view of the WA health system.

[1] A copy of the CFSA can be obtained upon request from the Director, Reform Office, Purchasing and System Performance Division, Department of Health.

2.3.3. Alignment to strategic policy documents

The revised OBM Framework has been developed with reference to a number of key strategic policies and documents to ensure that it is reflective of contemporary state and national health policy and reform. Numerous sources were reviewed (the complete list is provided on page 79) however an overview of some of these documents is provided below:

- *WA Health Strategic Intent 2015-2020*;
- *WA Health Clinical Services Framework 2014-2024*;
- *Admission, Readmission, Discharge and Transfer Policy for WA Health Services 2015-2016* (**ARDT Policy**);
- The National Health Reform Agreement 2011;
- Alignment with the ABF classifications provided by The Independent Hospital Pricing Authority;
- *National Health Data Dictionary* version 12 housed within the Australian Institute of Health and Welfare METeOR Metadata Online Registry;
- *Report on Government Services 2015*, Volume A: Approach to Performance reporting; Volume D Emergency Management; Volume E Health; Volume F Aged Care and Disability (Australian Productivity Commission);
- *Aboriginal and Torres Strait Islander Health Performance Framework*;
- *End of Life Framework* (WA Health, 2016);
- *Performance Policy Framework*;
- National Partnership Agreement on Essential Vaccines;
- *Clinical Indicator User Manual*, Oral Health version three (Australian Council on Healthcare Standards, 2012);
- *BreastScreen Australia National Accreditation Standards*; and
- *National Health Reform Performance and Accountability Framework* (National Health Performance Authority, 2011).

2.3.4. Detailed consultation process with internal and external stakeholders

The revised OBM Framework is a result of a comprehensive consultation process with a broad range of stakeholders, inclusive of the following key stakeholders:

- Finance Executives from all HSPs[2] (and their related team members);
- Finance Executives from the Department and HSS (and their related team members);
- Performance Projects Board;
- Departmental Executive Committee;
- State Health Executive Forum;
- Representatives from Treasury;
- Representatives from the OAG; and
- Representatives from the MHC.

A copy of the complete Project Stakeholder Consultation Log can be viewed at Appendix 12 of this submission.

[2] Excluding EMHS which did not exist at the time of the OBM Framework development. Representatives from SMHS were able to provide input on behalf of EMHS.

2.3.5. Mapping Process and Business Rules

The feasibility of the revised OBM Framework was tested and confirmed by the mapping of the approximately 10,000 active WA Health cost centres to the Services, Sub-Services and Programs. This mapping process tested the feasibility of the new Service Structure, including back casting two years and forecasting four years in line with forward estimates. The mapping process was reviewed and verified through consultation with HSPs, and endorsed by each HSP Chief Executive.

This cost centre mapping is the main mechanism to ensure the integrity and application of the Framework through the budget, resource allocation and performance cycle, which are fundamental statutory requirements of HSPs. The mapping will be utilised for a number of internal business as usual process including budget submission, mid-year review, performance planning and management as well as tracking expenditure and performance against the OBM Framework from a system perspective on a monthly to quarterly basis.

It is critical to note that the cost centre mapping enables the OBM Framework to be linked to the WA Health General Ledger. All transactions recorded within the General Ledger require a cost centre to be recorded; therefore the cost centre mapping processes undertaken provides a link between the General Ledger and the OBM Framework. This is a critical step in realising the benefits of the revised OBM Framework across the business.

2.3.6. Key Performance Indicators

KPIs assist each WA Government Agency to define and measure progress toward Agency Goals and Outcomes, providing a measurement tool to monitor Agency progress towards those Goals and Outcomes. Accordingly, the development of the OBM Framework KPIs occurred within the context of the following three considerations:

1. S.M.A.R.T Criteria[3];
2. Transparency of reporting; and
3. Ensuring business integrity.

KPIs for the revised OBM Framework have been rigorously reviewed and developed. The evidence base for the chosen KPIs is inclusive of the following:

- Review of national reporting requirements and associated indicators that were reported nationally comparing jurisdictions;
- Review of the WA Government Agency KPIs with an additional emphasis on select Agencies with a System Manger function;
- Jurisdictional review of KPIs, noting that WA is the only jurisdiction where KPIs are audited;
- Information and expertise of subject-matter experts and data custodians across WA Health; and
- Advice and information from HSPs.

This extensive review and alignment has not been undertaken previously by WA Health. The robust evidence base utilised for the development of KPIs (the development process can be viewed at paragraph 7.3 of this submission)

[3] Internationally known as the Specific, Measurable, Achievable, Relevant and Time-bound criteria.

incorporated a broad approach to review the existing KPIs and development of new KPIs ensuring WA Health's business, functions and strategic initiatives were integrated.

2.4. Evaluation Principles

A suite of evaluation principles for the design of the revised OBM Framework were applied to the decision-making process in relation to the Outcome Statements and Services, and are detailed at Appendix 6 of this submission. The evaluation principles used in determining the final Outcomes and Services are listed in below in Table 2.

Table 2: WA Health OBM Framework Evaluation Principles

Evaluation Principles	
1.	**Transparency of Public Reporting** • To improve the accuracy of public reporting (through GBS and Annual Reports); • To provide information of interest to the public/community on WA Health service delivery; and • A structure that can accommodate reporting/acquittal by budget holder or entity.
2.	**Ensuring Business Integrity** • To improve alignment with the WA Health resource acquisition, allocation, performance management cycle and to improve alignment with ABF/ABM; • To provide information that is material financially; and • A structure that aligns with WA Health's *Strategic Intent* and operational processes.

3. A new OBM Framework - WA Health Submission to the Under Treasurer

The submission up until this point this point has provided an overview of the background, evidence base and rationale for the revised OBM Framework. Detailed from this section onwards is WA Health's formal submission to the Under Treasurer for the proposed amendments relating to its current OBM Framework (sections 4 to 7) and summarised in section 9.

The revised WA Health OBM Framework detailed in this submission will be implemented for the 2017/2018 budget cycle and will then be implemented across the business and reported in the 2017/2018 Annual Reports. Provided below is an overview of the revised WA Health OBM Framework that has been developed as a result of a detailed development process, and tested with all relevant stakeholders. The detail of the process, research and analysis behind each component of the revised OBM Framework is provided in the succeeding sections of this submission.

Outlined in Figure 1 on the following page is WA Health's submitted OBM Framework and Figure 2 provides a comparison of the amendments between the current and revised OBM Frameworks. Section Four details the amendments to the current two Outcomes and the rationale for the addition of a third Outcome to align to the roles of the Department and HSS. Section Five captures the evidence base and rationale for the redesign of the Services, including a streamlining of ten to eight Services in order to accurately reflect the contemporary nature and business of WA Health. Section Six provides the detail behind the creation of a new level of Sub-Service detail within the OBM Framework and the benefits this will bring to both financial and performance management of the WA health system. Section Seven contains the information of the revised suite of WA Health KPIs (what has been retained, added and removed) and the process used to develop the KPIs in line with a number of evaluation criteria. Section Eight details the scope and application of the OBM Framework and Section Nine provides a summary of WA Health's request for change to Treasury.

Figure 1: WA Health Revised Outcome Based Management Framework

WA Strategic Outcome (Whole of Government)

Results Based Service Delivery: Greater focus on achieving results in key service delivery areas for the benefit of all Western Australians.

WA Health Agency Goal

Delivery of safe, quality, financially sustainable and accountable healthcare for all Western Australians

Outcome 1: Public hospital based services that enable effective treatment and restorative healthcare for Western Australians.

Key effectiveness indicators contributing to Outcome 1

1. Unplanned hospital readmission rates (Unplanned hospital readmissions of public hospital patients within 28 days for selected surgical procedures: (a) knee replacement; (b) hip replacement;(c) tonsillectomy & adenoidectomy; (d) hysterectomy; (e) prostatectomy; (f) cataract surgery; g) appendicectomy)
2. Waiting times for emergency hospital care (Proportion of emergency department patients seen within recommended times: (a) % Triage Category 1 (2 minutes); (b) % Triage Category 2 (10 minutes); (c) % Triage Category 3 (30 minutes); (d) % Triage Category 4 (60 minutes);(e) % Triage Category 5 (2 hours))
3. Elective surgery waiting times (Proportion of all elective patients on the wait list whose waiting time is over the clinically recommended time for their urgency category at census date, reported by urgency category and reportable status)
4. Percent of contacts with community-based public mental health non-admitted services within seven days post discharge from public mental health inpatient units
5. Hospital infection rates (Healthcare-associated *Staphylococcus aureus* bloodstream infections (HA-SABSI) per 10,000 occupied bed-days in public hospitals)
6. Hospital standardised mortality ratio (Percentage of WA public hospitals who are rated as performing or highly performing in comparison to their national peers for the ratio of observed and expected numbers of hospital separations that result in the patient's death)
7. The rate of total hospital readmissions within 28 days to an acute designated mental health inpatient unit
8. The percentage of admitted Aboriginal and Non-Aboriginal patients who left against medical advice

Services delivered to achieve Outcome 1

1. Public hospital admitted services
2. Public hospital emergency services
3. Public hospital non-admitted services
4. Mental health services

Key efficiency indicators within Outcome 1

9. Average admitted cost per weighted activity unit
10. Average emergency department cost per weighted activity unit
11. Average non-admitted cost per weighted activity unit
12. Average cost per bed-day in specialised mental health inpatient units
13. Average cost per treatment day of non-admitted care provided by public clinical mental health services

Outcome 2: Prevention, health promotion and aged and continuing care services that help Western Australians to live healthy and safe lives.

Key effectiveness indicators contributing to Outcome 2

14. Percentage of transition care clients whose functional ability was either maintained or improved during their utilisation of the Transition Care Program
15. Childhood immunisation (Percentage of children fully immunised at 12-15 months: a) Aboriginal; b) Total)
16. Loss of life from premature death due to identifiable causes of preventable disease or injury: (a) Lung cancer; (b) Ischaemic heart disease; (c) Falls; (d) Melanoma
17. The percentage of clients who are discharged from the WA Quadriplegic Centre back into the community
18. The percentage of active clients with pressure areas / burns treated by the WA Quadriplegic Centre's Community Nursing Service
19. Response times for patient transport services delivered by St John Ambulance (Percentage of priority 1 calls attended to within 15 minutes in the metropolitan area by St John Ambulance Western Australia Ltd)
20. Response times for patient transport services delivered by the Royal Flying Doctor Service (Percentage of Royal Flying Doctor Service (Western Operations) inter-hospital transfers meeting the state-wide contract target response time for priority 1 calls)
21. The percentage of people accessing community-based palliative care to assist them to die at home
22. Participation rate of women aged 50 – 69 years who participate in breast screening: (a) Indigenous women; (b) Non-Indigenous women
23. The percentage of Western Australian year 8 students that complete their HPV vaccination series
24. The percentage of (a) adults and (b) children who have a tooth retreated within six months of receiving initial restorative dental treatment
25. The percentage of patients who access emergency services at a small rural or remote Western Australian hospital and are subsequently discharged home

Services delivered to achieve Outcome 2

5. Aged and continuing care services
6. Public and community health services

Key efficiency indicators within Outcome 2

26. Average cost of a transition care day provided by contracted non-government organisations/service providers
27. Average cost per bed-day for specified residential care facilities, flexible care (hostels) and nursing home type residents
28. Average cost per bed-day for WA Quadriplegic Centre inpatient services
29. Average cost per WA Quadriplegic Centre community client for clinical and related services
30. Average cost per client who receives support services from the Home and Community Care Program
31. Average cost per person of delivering population health programs by population health units
32. Cost per person of providing preventative interventions, health promotion and health protection activities that reduce the incidence of disease or injury
33. Cost per capita for patient transport provided by St John Ambulance Western Australia Ltd, based on the total accrued costs of these services for the estimated total population of Western Australia
34. Cost per capita for patient transport provided by the Royal Flying Doctor Service (Western Operations), based on the total accrued costs of these services for the estimated total population of Western Australia
35. The average cost of WA Health provided dental health programs for (a) enrolled school children and (b) socio-economically disadvantaged adult patients

Outcome 3: Strategic leadership, planning and support services that enable a safe, high quality and sustainable WA health system.

Key effectiveness indicators contributing to Outcome 3

36. The percentage of Policy Frameworks and associated documents reviewed within the specified time period
37. The percentage of Health Service Performance Reports completed by the 17th working day of each month
38. Clinical Incidents (Proportion of all notified clinical incidents where the patient outcome was death)
39. The percentage of system-wide, key budget forecasts produced by the Department of Health within agreed client timeframes
40. Public Health Regulation (The percentage of regulations, policy and other supporting documents in the Annual Public Health Division Operational Plans which were completed)
41. The percentage of responses from WA Health Service Providers and Department of Health who are satisfied or highly satisfied with the overall service provided by Health Support Services

Services delivered to achieve Outcome 3

7. Health System Management - Policy and Corporate Services
8. Health Support Services

Key efficiency indicators within Outcome 3

42. Average cost of Public Health Regulatory Services per head of population
43. Average percentage on time production of key system-wide financial reports released by the WA Department of Health to internal, State and Commonwealth stakeholders
44. The total cost per full time equivalent worker to undertake the System Manager role of providing strategic leadership, planning and support services to Health Service Providers
45. Average cost of Accounts Payable services per transaction
46. Average cost of Accounts Receivable services per transaction
47. Average cost of payroll and support services per WA Health employee
48. Average cost of Supply Services by purchasing transaction
49. Average cost of supporting a WA health personal computer (PC)

Figure 2: Summary of the Proposed Changes to the Outcomes and Services contained in the WA Health OBM Framework

WA Health Outcome Based Management Framework – Current and Proposed

WA Government Goal: Greater focus on achieving results in key service delivery areas for the benefit of all Western Australians

WA Health Agency Goal: Delivery of safe, quality, financially sustainable and accountable healthcare for all Western Australians

Outcomes

Current (2015-16)

Outcome 1: Restoration of patients' health, provision of maternity care to women and newborns, and support for patients and families during terminal illness.

Outcome 2: Enhance health and wellbeing of Western Australians through health promotion, illness and injury prevention and appropriate continuing care.

Nil

Proposed (2017-18)

Outcome 1: Public hospital-based services that enable effective treatment and restorative healthcare for Western Australians.

Outcome 2: Prevention, health promotion and aged and continuing care services that help Western Australians to live healthy and safe lives.

Outcome 3: Strategic leadership, planning and support services that enable a safe, high-quality and sustainable WA health system.

Services

Current (2015-16)

1. Public hospital admitted patients
2. Home based hospital programs
3. Palliative care
4. Emergency Department
5. Public hospital non-admitted patients
6. Patient transport

7. Prevention, promotion and protection
8. Dental health
9. Continuing care
10. Contracted mental health

Nil

Proposed (2017-18)

1. Public hospital admitted services
2. Public hospital emergency services
3. Public hospital non-admitted services
4. Mental health services

5. Aged and continuing care services
6. Public and community health services

7. Health System Management - Policy and Corporate Services
8. Health support services

Key Performance Indicators

Current (2015-16)

Metropolitan Health Service
Effectiveness: 5 Efficiency: 9

Metropolitan Health service
Effectiveness: 10 Efficiency: 6

Metropolitan Health service
Effectiveness: 0 Efficiency: 0

Proposed (2017-18)

NMHS
Effectiveness: 8
Efficiency: 5

SMHS
Effectiveness: 8
Efficiency: 5

NMHS
Effectiveness: 2
Efficiency: 2

SMHS
Effectiveness: 0
Efficiency: 1

NMHS
Effectiveness: 0
Efficiency: 0

SMHS
Effectiveness: 0
Efficiency: 0

EMHS
Effectiveness: 8
Efficiency: 5

CAHS
Effectiveness: 7
Efficiency: 5

EMHS
Effectiveness: 0
Efficiency: 1

CAHS
Effectiveness: 0
Efficiency: 1

EMHS
Effectiveness: 0
Efficiency: 0

CAHS
Effectiveness: 0
Efficiency: 0

Current (2015-16)

WA Country Health Service
Effectiveness: 5 Efficiency: 6

WA Country Health Service
Effectiveness: 5 Efficiency: 4

WA Country Health Service
Effectiveness: 0 Efficiency: 0

Proposed (2017-18)

WA Country Health Service
Effectiveness: 8 Efficiency: 5

WA Country Health Service
Effectiveness: 2 Efficiency: 3

WA Country Health Service
Effectiveness: 0 Efficiency: 0

Current (2015-16)

Department of Health
Effectiveness: 3 Efficiency: 4

Department of Health
Effectiveness: 7 Efficiency: 6

Department of Health
Effectiveness: 0 Efficiency: 0

Proposed (2017-18)

DoH
Effectiveness: 0
Efficiency: 0

HSS
Effectiveness: 0
Efficiency: 0

DoH
Effectiveness: 6
Efficiency: 4

HSS
Effectiveness: 0
Efficiency: 0

DoH
Effectiveness: 5
Efficiency: 3

HSS
Effectiveness: 1
Efficiency: 5

Note: Prior to 2017-18, the Quad Centre Annual Reports were not required to report against the WA Health Outcome Based Management Framework. From 2017-18, the Quad Centre will be reporting against Outcome 2 in their Annual Report as a Health Service Provider in alignment with the *Health Services Act 2016.*

4. Outcomes and Agency Goal

The desired Outcomes of WA Health state why it exists as an Agency. Outcomes are defined as the effects, impacts, results on or consequences for the community/target clients of Services delivered by Agencies, and describe why Services are delivered rather than how Services are delivered.

4.1. Agency Goal

As part of the development of a revised OBM Framework, it was determined that a new Agency Goal for WA Health was required to be added in order to set the overall strategic direction for the system at a level higher than that of Outcome.

The development and addition of an Agency Goal is in line with other WA Government Agencies who have a System Manager component of service delivery such as the WA Department of Premier and Cabinet who has five Agency Goals.

The Agency Goal links directly to the WA Health's Strategic Intent "to deliver a safe, high quality, sustainable health system for all Western Australians". The Strategic Intent is supported by seven key enablers and the proposed Agency Goal links directly with enabler two; "accountability" and enabler three; "financial management". A long term WA Health Agency Goal improves accountability to the WA public, and can be used to improve effectiveness and efficiency in the delivery of healthcare services. The WA Health Agency Goal, which although not directly measurable through KPIs, reflects the overall implied outcome of each of the three distinct Outcomes; "Delivery of safe, quality, financial sustainable and accountable healthcare for all Western Australians".

4.2. Overview of Current and Proposed Outcome Statements

WA Health currently reports against two Outcomes as part of its annual and performance reporting processes. The revised WA Health OBM Framework will include three Outcomes, as prescribed in Table 3 below.

Table 3: Current and Proposed WA Health Outcome Statements

#	Current	Proposed
1.	Restoration of patients' health, provision of maternity care to women and newborns, and support for patients and families during terminal illness.	Public hospital based services that enable effective treatment and restorative health care for Western Australians.
2.	Enhance health and wellbeing of Western Australians through health promotion, illness and injury prevention and appropriate continuing care.	Prevention, health promotion and aged and continuing care services that help Western Australians to live healthy and safe lives.
3.		Strategic leadership, planning and support services that enable a safe, high quality and sustainable WA Health System.

4.3. Proposed Revised Outcomes

WA Health, in line with the complex and ever changing nature of healthcare delivery, has changed significantly since the last revision of its OBM Framework. As a result, the two existing Outcomes have been revised and a new third Outcome has been created.

The first two revised Outcomes are reflective of a continuum of care approach and the split between delivering Services in both a hospital and community based setting. However, in line with the new governance structure that came into effect as of 1 July 2016 for the WA health system, a third Outcome has been developed. The third Outcome is reflective of the role of the Department as System Manager, with an accompanying Service Seven that only captures the Department's budget and some other Department-related corporate services and Service Eight to capture HSS.

The third Outcome Statement has been developed from a systems perspective, and has been created to capture the Services provided at a system-wide level by the Department and HSS. Both the Department and HSS do not require their own OBM Framework, as the activities it undertakes contribute either directly or indirectly to the provision of healthcare or prevention management initiatives that are consistent with the intent of the revised Outcome statements. Service delivery to the system as a whole will be captured and measured in Outcome Three and Services Seven and Eight. However, it is not expected that all entities will report against all Outcomes.

The proposed Outcomes are more strategic than the two Outcomes in the Current OBM, and cover the objectives of the number of separate statutory entities within WA Health, whilst at the same time remaining substantially granular to allow for measurement by effectiveness KPIs. The proposed Outcomes have been developed in alignment with WA Health's *Strategic Intent* as well as incorporating the key elements prescribed under TI's and the *OBM Guidelines*[4] In totality, the revised Outcomes result in a more concise and accurate definition of the impact of the Services delivered by WA Health with public monies. The new Agency Goal and proposed Outcomes, to be reported in the suite of WA Health Annual Reports are depicted below in Table 4.

Table 4: WA Health revised Agency Goal and Outcome Statements

Proposed		
WA Government Goal: Greater focus on achieving results in key service delivery areas for the benefit of all Western Australians.		
WA Health Agency Goal: Delivery of safe, quality, financial sustainable and accountable healthcare for all Western Australians.		
Outcome 1: Public hospital based services that enable effective treatment and restorative health care for Western Australians.	**Outcome 2:** Prevention, health promotion and aged and continuing care services that help Western Australians to live healthy and safe lives.	**Outcome 3:** Strategic leadership, planning and support services that enable a safe, high quality and sustainable WA Health System.

[4] Department of Treasury, Western Australia, 2004 *Outcome Based Management Guidelines,* Perth Western Australia. Available online from: https://www.treasury.wa.gov.au/uploadedFiles/_Treasury/Publications/Outcome_Based_Management.pdf

4.4. Research and Analysis

The starting point for the review of the current Outcomes was to ensure that the Services delivered by WA Health were reflected in the statements. WA Health's vision is clear, 'to deliver a safe, high-quality, sustainable health system'. As outlined above, WA Health's Strategic Intent is focused on a continuum of care. These include prevention and community care services, more effective and efficient hospital services, chronic disease services, and Aboriginal health services. Continuum of care is a concept involving a system that guides and tracks patients over time through a comprehensive array of health services spanning all levels and intensity of care. The Continuum of care covers the delivery of healthcare over a period of time, and may refer to care provided from birth to end of life. Healthcare services are provided for all levels and stages of care.[5]

The first two proposed Outcomes reflect the continuum of care approach to healthcare delivery. However, the third proposed Outcome was created in order to provide greater transparency to the public as to the function of the Department as System Manager and the Services provided by the statutory entity HSS. In researching the feasibility of a third Outcome statement, the CFSA identified both state and jurisdictional Government Agencies that had a System Manager component of their organisational structure. Two of the state Government Agencies reviewed and all of the jurisdictional public health systems operated with the state health department acting in a 'System Manager' capacity (responsible for planning, policy, purchase, regulation and state-wide service delivery). However use of Budget Papers and Annual Reports varied based on each jurisdictions' governance arrangements and reporting requirements. Further research and analysis with respect to the development of WA Health Outcomes can be viewed at Appendix 6, Appendix 7 and Appendix 8 of this submission.

[5] Healthcare Information and Management Systems Society HIE Committee Continuity of Care Workgroup, "*Definition: Continuum of Care*" (2014). A copy of the paper can be accessed here: http://s3.amazonaws.com/rdcms-himss/files/production/public/2014-05-14-DefinitionContinuumofCare.pdf

5. Services

Services within the OBM Framework are defined as the Services that WA Health delivers to achieve the WA Health desired Outcomes. Under each Service sits a range of Sub-Services and Programs, which all roll up to one of the eight Services and three Outcomes. Service descriptors have been developed for the first time, to provide clear direction on inclusions and to bring consistency and understanding across WA Health as to the Services it delivers to the WA public.

5.1. Overview of Current and Proposed Services

WA Health currently has ten Services, reported against two Outcome Statements in the Department, Metropolitan Health Service and WA Country Health Service Annual Reports. The revised OBM Framework will reduce the number of Services from ten to eight. Table 5 below provides a view of the current and proposed Services pursuant to the submitted OBM Framework, inclusive of the materiality of each Service against the 2015/2016 and 2016/2017 budget allocation (noting that the 2016/2017 information is not yet available for the proposed OBM Framework).

Note: The figures in the table below have been calculated using the following methodology: The percentages were derived from the 2015/2016 WA Health Budget and represent the percentage of the total budget allocated to each OBM Framework Service. Percentages for the submitted OBM Framework have been calculated based on the budget allocated to each Service with Financial Products allocated across Services one to four according to the materiality of the OBM Framework components and based on a percentage of the budget allocated.

Table 5: Current and Proposed Services

Current	% of 15/16 Budget Allocation	% of 16/17 Budget Allocation	Proposed	% of 15/16 Budget Allocation
1. Public Hospital Admitted Patients	53.6%	55.2%	1. Public Hospital Admitted Services	43.3%
2. Home Based Hospital Programs	0.6%	0.4%		
3. Emergency Department	9.1%	9.0%	2. Public Hospital Emergency Services	9.4%
4. Public Hospital Non-Admitted Patients	11.5%	11.1%	3. Public Hospital Non-Admitted Services	9.4%
5. Contracted Mental Health	7.5%	7.5%	4. Mental Health Services	8.7%
6. Continuing Care	6.0%	5.6%	5. Aged and Continuing Care Services	6.4%
7. Palliative Care	0.4%	0.4%		
8. Prevention, Promotion and Protection	7.3%	7.0%	6. Public and Community Health Services	16.6%
9. Dental Health	1.4%	1.2%		
10. Patient Transport	2.6%	2.5%		
			7. Health System Management - Policy and Corporate Services	3.5%
			8. Health Support Services	2.7%

5.2. Rationale for Submitted Services

Outlined below is the rationale for the Services contained within the submitted OBM Framework, and the basis of their development. The reduction of Services from ten to eight is a more appropriate reflection of the Services delivered by WA Health now and into the future, and mirrors the WA Government investment in Services that are clear and understandable to the public and Parliament. There is also no overlap of Services as there has been in the current OBM, such as was the case with public hospital admitted patients and home based hospital programs. Rather there is now a clear delineation between Services, which remain mutually exclusive. For internal management purpose, WA Health has also mapped Sub-Services against these eight Services to allow WA Health to provide more detailed information to both internal and external stakeholders as well as Parliament on Services, if and when requested. Detail regarding these Sub-Services can be viewed at section 6 of this submission.

The Services discussed below account for the largest parts of the budget and the expenditure in WA Health and effort has been made to ensure that materiality of the selected Services was one of the driving factors in the decision making process. The proposed Services are closely aligned with the revised Outcomes and Agency Goal. The amendments to the Services will achieve a more consistent approach in terms of the level of Service delivered, alignment to material significance in terms of expenditure and are reflective of the business of WA Health. The Service design has also incorporated the future purchasing intentions of WA Health, described in more detail below as the split between hospital and public health settings.

Materiality Principle

The design of the revised Services for WA Health incorporated consideration of a 'materiality principle'. Each Service was considered both for its financial materiality from a budget perspective (as detailed in Table 5 above) as well as its relevance or significance from both the internal management and clinical point of view and an external public perspective. It is acknowledged that striking this balance can be complex, however the design of the below Services reflects the best possible mix of both materiality and public expectation from WA Health's perspective.

Visibility of Hospital and Public Health Settings

WA Health delivers healthcare Services that provide emergency, surgical, medical and other treatments as well as Programs to prevent ill health. These Services enable WA Health to deliver a safe, high quality, sustainable health system for all Western Australians. Health Services provided by WA Health are focused on a continuum of care to support and guide health care through integrated service delivery from prevention and health promotion, early intervention, primary care through to diagnosis, treatment, rehabilitation and palliation.

The design of the Services has encapsulated the above split; hospital-based treatment and community-based Service and Program delivery. The first four Services focus on hospital-based services, which account for approximately 70% of WA Health's budget. Services Five and Six are reflective of the community-based services provided to prevention of disease and injury (subsequently reducing the need for hospitalisation) and enhancing the health and wellbeing of Western Australians, which accounts for approximately 23% of WA Health's budget.

System Manger and Health Support Services

Services Seven and Eight have been created to capture the services delivered by both the Department and HSS and together equate to approximately 6.2% of WA Health's budget. Addition of these two Service lines will capture the true service delivery of the Department to both HSPs and the State as a whole. Thus in the proposed Service Structure, services provided by HSS to the system have been presented publically and will not treated as an overhead for the first time.

5.3. Service Descriptors

Service descriptors have been developed for each of the eight Services. Detailed service descriptors did not exist for the previous OBM (although a version of descriptors were included in the KPIs manuals and Budget Papers) and this additional level of information assists with providing the public with a greater understanding of the Services delivered by WA Health as well as creating a consistent approach to how Services and their related expenditure are captured (through cost centres) across all HSPs and the Department.

The Service descriptors have been developed based on desktop research and in consultation with the OBSS Project Executive Committee to ensure that they adequately and directly captured the related Sub-Service lines. The one-to-one alignment between the Service descriptors and the Sub-Services is discussed in further detail at section 6 of this submission.

Service Line 1: Public Hospital Admitted Services

Admitted Services are a substantial service delivery area, with the materiality of this service against the overall budget for WA Health high accounting for approximately 43% of the overall WA Health budget. Service One in the current OBM 'Public Hospital Admitted Patients' has been retained and has largely been treated the same as prior years under the revised OBM Framework. This Service captures both acute and sub-acute service provision, exclusive of specialised mental health which is captured under Service Four. To reflect this inclusion, the word 'patients' has been replaced with the term 'Services' to more accurately reflect the service delivery nature of WA Health. Table 6 below presents the comparison between the previous and current Service lines.

Table 6: Public Hospital Admitted Services

Current	Proposed Service with Related Service Descriptor
Public Hospital Admitted Patients	**Public Hospital Admitted Services** The provision of healthcare services to patients in metropolitan and major rural hospitals that meet the criteria for admission and receive treatment and/or care for a period of time, including public patients treated in private facilities under contract to WA Health. Admission to hospital and the treatment provided may include access to acute and/or subacute inpatient services, as well as hospital in the home services. Public Hospital Admitted Services includes teaching, training and research activities provided by the public health service to facilitate development of skills and acquisition or advancement of knowledge related to admitted services. This Service does not include any component of the Mental Health Services reported under Service four "Mental Health Services".
Home Based Hospital Programs	

As presented in Table 6, the only significant amendment has been that the previous Service 'Home Based Hospital Programs' has been combined into 'Public Hospital Admitted Patients

Services', in line with both the ARDT Policy and the materiality principle as it was only allocated 0.6% of the 2015/2016 budget. Home-based hospital services are viewed by WA Health as a component of 'Public Hospital Admitted Service' rather than a standalone discreet Service, as the initiative focusses on hospital clinical care that can be delivered safely in a home environment. The Hospital in the Home (**HITH**) Programs (the major component of 'Home Based Hospital Programs') provides short-term acute care in the patient's home for conditions that traditionally required hospital admission and inpatient treatment, thus reducing the burden on the WA public hospital system. HITH is treated from both a cost and data perspective as 'admitted patient' care, when a patient is transferred to HITH from in-hospital based care, this is considered continuous care. The criteria for admission that applies to the hospital component of their stay also applies to the HITH component. Based on the above rationale and alignment the decision was made to merge 'Home Based Hospital Programs' into 'Public Hospital Admitted Patients Services'.

Design of Service One is similar in nature to the jurisdiction of New South Wales (**NSW**) in particular (as well as Queensland (**QLD**) and Victoria (**VIC**)) who have a Service titled 'Inpatient Hospital Services' which covers the provision of healthcare to patients admitted to hospitals including elective surgery and maternity services.

Service Line 2: Public Hospital Emergency Services

The existing 'Emergency Department' Service has been retained, with a minor amendment to the wording of the Service to 'Public Hospital Emergency Services' in line with the amendment to Service One and to aide with providing greater clarity and transparency around this Service to the public. This Service also aligns to the jurisdictions of NSW and QLD, which both have separate Service lines for emergency care. Table 7 below presents the service descriptor for the current Service 'Emergency Department' that will be retained in the proposed Service Structure.

Table 7: Public Hospital Emergency Services

Current	Proposed Service with Related Service Descriptor
Emergency Department	**Public Hospital Emergency Services** The provision of services for the treatment of patients in emergency departments of metropolitan and major rural hospitals, inclusive of public patients treated in private facilities under contract to WA Health. The services provided to patients are specifically designed to provide emergency care, including a range of pre-admission, post-acute and other specialist medical, allied health, nursing and ancillary services. Public Hospital Emergency Services includes teaching, training and research activities provided by the public health service to facilitate development of skills and acquisition or advancement of knowledge related to emergency services. This Service does not include any component of the Mental Health Services reported under Service four "Mental Health Services".

Emergency Services equated to 9.4% of WA Health's 2015/2016 budget and are a critical component of the hospital-based Services delivered by WA Health to the public. There was clear rationale and support to continue to isolate Emergency Services as a standalone component of the OBM Framework, and with the ever increasing demand on emergency departments and health services, it is imperative that health service provision is continually monitored to ensure the effective and efficient delivery of safe and high-quality care.

Service Line 3: Public Hospital Non-Admitted Services

The existing Service of 'Public Hospital Non-Admitted Patients' remains the same, with the replacement of the term 'patients' with 'Services', in line with the design of the revised Service Structure. 'Public Hospital Non-Admitted Services' comprised 9.4% of WA Health's 2015/2016 budget and are a critical component of the hospital-based Services delivered by WA Health to the public. There is clear rationale to continue to isolate non-admitted services as a standalone Service in the OBM Framework. Table 8 below presents the Service descriptor for 'Public Hospital Non-Admitted Services'.

Table 8: Public Hospital Non-Admitted Services

Current	Proposed Service with Related Service Descriptor
Public Hospital Non-Admitted Patients	**Public Hospital Non-Admitted Services** The provision of metropolitan and major rural hospital services to patients who do not undergo a formal admission process, inclusive of public patients treated by private facilities under contract to WA Health. This Service includes services provided to patients in outpatient clinics, community-based clinics or in the home, procedures, medical consultation, allied health or treatment provided by clinical nurse specialists. Public Hospital Non-Admitted Services includes teaching, training and research activities provided by the public health service to facilitate development of skills and acquisition or advancement of knowledge related to non-admitted services. This Service does not include any component of the Mental Health Services reported under Service four "Mental Health Services".

Service Line 4: Mental Health Services

The previous Service of 'Contracted Mental Health' has been retained and broadened in scope to include all mental health services(not just the contracted components) as such, the Service has also been retitled as 'Mental Health Services'. The revised Mental Health Service Four is now inclusive of a mix of both community-based services, acute inpatient services and outpatient treatment services. This Service includes both ABF funded and non-ABF funded services and will be above the threshold funding amount received by WA Health from the MHC. A deliberate decision was made to incorporate both hospital-based and community-based mental health services in order to provide a complete picture of mental health service delivery by WA Government, acknowledging that this would be broader in scope than what is reported as 'purchased' by the MHC. The revised scope of the Service line 'Mental Health Services' is captured in the Service descriptor below (Table 9).

Table 9: Mental Health Services

Current	Proposed Service with Related Service Descriptor
Contracted mental health	**Mental Health Services** The provision of inpatient services where an admitted patient occupies a bed in a designated mental health facility or a designated mental health unit in a hospital setting; and the provision of non-admitted services inclusive of community and ambulatory specialised mental health programs such as prevention and promotion, community support services, community treatment services, community bed based services and forensic services. This Service includes the provision of state-wide mental health services such as perinatal mental health and eating disorder outreach programs as well as the provision of assessment, treatment, management, care or rehabilitation of persons experiencing alcohol or other drug use problems or co-occurring health issues. Mental Health Services includes teaching, training and

Current	Proposed Service with Related Service Descriptor
	research activities provided by the public health service to facilitate development of skills and acquisition or advancement of knowledge related to mental health or alcohol and drug services. This service includes public patients treated in private facilities under contract to WA Health.

The continued inclusion of a standalone Service for mental health is reflective of the importance the public of Western Australia places on this critical service delivered for the community, and its materiality of 8.7% of the 2015/2016. This Service is in line with other jurisdictions such as Victoria, NSW and QLD who have 'Mental Health', 'Mental Health Services' and 'Integrated Mental Health Services' respectively.

Service Line 5: Aged and Continuing Care Services

'Aged and Continuing Care Services' is a new Service that encompasses the previous Services of 'Aged Care' and 'Palliative Care'. Service Five captures aged care and continuing care provided to people with long-term disability and palliative care services. This combination of Services has been made in order to capture the revisions to the organisational structure of WA Health since the last review of the OBM Framework, which includes the creation of an Aged and Continuing Care Directorate within the Department.

There is also jurisdictional support for the combination of aged and continuing care into one Service from Victoria, and QLD and NSW, respectively. Victoria has a Service titled 'Ageing, Aged and Home Care' and both QLD and NSW combine "Rehabilitation and Extended Care". Table 10 below presents the integration of the two Services into one with the accompanying Service descriptor.

Table 10: Aged and Continuing Care Services

Current	Proposed Service with Related Service Descriptor
Continuing care	**Aged and Continuing Care Services** The provision of aged and continuing care services and community based palliative care services. Aged and continuing care services include programs that assess the care needs of older people, provide functional interim care or support for older, frail, aged and younger people with disabilities to continue living independently in the community and maintain independence, inclusive of the services provided by the WA Quadriplegic Centre. Aged and Continuing Care Services is inclusive of community based palliative care services that are delivered by private facilities under contract to WA Health, which focus on the prevention and relief of suffering, quality of life and the choice of care close to home for patients.
Palliative care	

Service Five includes all aged care services including home and community care (excluding the admitted care service component which is captured under Service One) and residential aged care. Continuing care services are services that assist with the functional status of people with impairment and disability, as well as services that slow the progression of impairment. This includes services for younger people with disabilities living in the community and those people who require palliative care services.

Palliative care services are inclusive of community-based multidisciplinary care and support for terminally ill people and their families/carers. 'Palliative Care' has been removed from being a

standalone Service as it was only allocated 0.4% of the 2015/2016 budget. In line with the materiality of Service principle, it was decided that Palliative Care Services should be integrated into Service Five due to its alignment with continuing care services. Further, there is no jurisdictional support for a standalone 'palliative care' Service. To retain the visibility to the public in this area of interest, KPIs have been used to capture and provide information against Outcome Two to reassure the public of the effective delivery of palliative care services.

Service Line 6: Public and Community Health Services

The previous Service of 'Prevention, Promotion and Protection' has been retained under the OBM Framework and expanded to capture 'Public and Community Health Services'. Service Six captures the broad range of public and community health services that are provided to the Western Australian public outside of a hospital-setting. Public health services are programs and services that prevent disease, promote health and prolong life among the population as a whole and accordingly reflect the previous Service 'Prevention, Promotion and Protection'.

Services provided by the Public Health Division within the Department and Health Services Providers that are captured under this Service are varied in nature, and include programs such as:

- Data and Statistics inclusive of epidemiology;
- Disaster Management – community advice, fires and floods, local government, medical management, risk management, training and development;
- Environmental health, flood, water and hazards – health hazards, insects, emerging community issues, food;
- Genomics;
- Healthy lifestyles – tobacco, nutrition, obesity and healthy weight, injury prevention;
- Healthy planning and development – aboriginal health, climate change, environmental health; and
- Infectious diseases, sexual health and immunisation.

Also included in this Service are the previous Services of 'Patient Transport Services' and 'Dental Health Services', as these are Services delivered in the community outside of the hospital-setting. The revised OBM provides a strong distinction between services provided in hospital settings and services provided outside the hospital setting and this is reflected in the realignment of 'Patient Transport Services' and 'Dental Health Services' into Service Six. Table 11 presents the expanded Service descriptor for the proposed Service 'Public and Community Health Services' and the alignment of the Services from the current Service Structure into this new Service.

Table 11: Public and Community Health Services

Current	Proposed Service with Related Service Descriptor
Prevention, Promotion and Protection	**Public and Community Health Services** The provision of healthcare services and programs delivered to increase optimal health and wellbeing, encourage healthy lifestyles, reduce the onset of disease and disability, reduce the risk of long-term illness as well as detect, protect and monitor the incidence of disease in the population. Public and Community Health Services includes public health programs, Aboriginal health programs, environmental health, community-based dental services, the provision of grants to non-government
Patient Transport	
Dental Health	

Current	Proposed Service with Related Service Descriptor
	organisations for public and community health purposes, emergency road and air ambulance services, services to assist rural-based patients travel to receive care, state-wide pathology services provided to external WA Agencies and the services provided by small rural hospitals.

The WA Health *Patient Transport Strategy* describes a range of services provided in the community that transport patients to hospital or provide patients with a cost subsidy for transporting themselves to hospital. The *Patient Transport Strategy* also captures services provided by the Royal Flying Doctor Service (**RFDS**) and St. Johns Ambulance Australia (**SJAA**) as well as the Patient Assisted Travel Scheme (**PATS**), a subsidy to the patient to assist their own transport to a hospital or health service. These Services assist people in need of urgent medical treatment to reach the nearest appropriate medical facility or assist people living in rural or remote locations to access specialist Services. The inclusion of these Services into this Service Six reflects the community setting where the Service is delivered.

Funding for 'Patient transport' is primarily for the contracted Services provided by RFDS and SJAA. Patient transport is not a core business function of WA Health and it can be regarded as operational expenditures of WA Health's business rather necessitate the characteristic of an individualised standalone Service. The re-alignment of this Service is part of a "best-fit" approach employed as part of the redesign of WA Health's OBM Framework. To ensure transparency of the service delivery the OBM Framework has included effectiveness and efficiency indicators for patient transport and these are discussed at section 7.7.3 of this submission.

The existing 'Dental Health Service' has been aggregated into Service Six and captures the provision of community dental health service only, as it is a service provided to and in the community. To ensure transparency of 'Dental Health Services', the OBM Framework has included effectiveness and efficiency indicators to capture this and these are discussed at section 7.7.4 of this submission. The combination of community healthcare services and dental services is in line with the jurisdiction of Victoria who have one Service titled "Primary, Community and Dental Health".

Service Line 7: Health System Management - Policy and Corporate Services

In line with recent reform to the governance structure of WA Health, the Department, led by the Director General, will be established as the System Manager responsible for the overall management, performance and strategic direction of WA Health, ensuring the delivery of high-quality, safe and timely health Services. A new service line has been added and reflects the role of the Department of Health in the revised OBM Framework. Table 12 outlines the proposed Service Seven and its descriptor.

Table 12: Health System Management - Policy and Corporate Services

Current	Proposed Service with Related Service Descriptor
No current Service	**Health System Management - Policy and Corporate Services** The provision of strategic leadership, policy and planning services, system performance management and purchasing linked to the state-wide planning, budgeting and regulation processes. This Service includes the public health regulator role of the Department and further development, implementation and

Current	Proposed Service with Related Service Descriptor
	monitoring of state-wide public health, emergency management and medicines policies and standards. Health System Management - Policy and Corporate Services includes corporate services inclusive of statutory financial reporting requirements, overseeing, monitoring and promoting improvements in the safety and quality of health services and system wide infrastructure and asset management services.

This Service captures the functions provided by the Department as System Manger to the whole WA health system (inclusive of HSPs) as detailed in the related descriptor. As this is a new Service line for WA Health, new KPIs have been developed to measure the provision of this Service line, and are discussed at section 7.7.7 of this submission.

Service Line 8: Health Support Services

HSS is now a separate statutory authority that is legally responsible for its employees and the services it delivers from 1 July 2016. Accordingly, Service Eight has been created as a new Service addition to WA Health's OBM Framework. Service Eight will capture the Services provided by the statutory authority HSS to both the Department and HSPs inclusive of ICT, HR and payroll as well as the system-wide services provided by the Project Management Office and the Office of the Chief Procurement Officer. The full scope of the HSS as Service Eight is presented in Table 13 below.

Table 13: Health Support Services

Current	Proposed with Related Service Descriptor
No current Service	**Health Support Services** The provision of purchased health support services to WA Health entities inclusive of corporate recruitment and appointment, employee data management, payroll services, workers compensation calculation and payments and processing of termination and severance payments. Health Support Services includes finance and business systems services, IT and ICT services, workforce services, project management of system wide projects and programs and the management of the supply chain and whole of health contracts.

This will provide better alignment with the broader WA Health governance changes and ensure HSS is legally accountable for its management and delivery of Services. It will also provide clarity in roles and responsibilities of the Department as System Manager and funder of Services, and HSS as a provider of Services. As this is a new Service line for WA Health, new KPIs have been developed to measure the provision of this Service line, and are discussed at section 7.7.7 of this submission.

5.3.1. Improved Strategic Alignment

The revised OBM Framework improves the strategic alignment of Services to current national and state policies. The service descriptors have been developed with reference to the following strategic policy sources:

- *WA Health Clinical Services Framework 2014-2024;*
- *Strategic Intent 2015-2020;*
- Activity Based Funding Definitions;

- *Australian National Health Data Dictionary*; and
- Australian Refined Diagnosis Related Group classification system.

A detailed evidence matrix of the research related to the service descriptors can be viewed at Appendix 9 and Appendix 10 of this submission.

***Strategic Intent 2015-2020* – Priorities**

The revised Services are aligned to the following priorities identified in the Strategic Intent:

1. Prevention and Community Care Services
   - Support the Western Australian community to become healthier. Focus on promoting healthy habits and behaviours. Support people to make healthy lifestyle choices for mind and body.
   - Work with primary health providers and carers to provide integrated and more accessible services to reduce the occurrence of acute illness and improve patient outcomes.

2. Health Services
   - Provide more effective and efficient hospital services through: Improving clinical and non-clinical processes across health services, and implementing and reporting on common efficiency and benchmarking standards.
   - Reduce demand on traditional hospital services through:
     - Increasing non-hospital ambulatory care services; and
     - Preventing patient readmissions to hospital through improved care coordination.

3. Chronic Disease Services
   - Increase awareness of chronic disease and long-term conditions of mind and body.
   - Improve early detection and intervention of chronic diseases.
   - Reduce the number of people living with chronic disease by supporting healthier lifestyles.

4. Aboriginal Health Services
   - Strengthen and embed the approach to improving the health and wellbeing of Aboriginal people living in Western Australia.
   - Increase Aboriginal consumer, carer and community involvement to enhance access to and delivery of culturally appropriate health services.
   - Create and develop strategic partnerships to improve the development and management of health Services for Aboriginal people.

5.3.2. Transparency of Activity Based Funding

The first three revised Services (Public Hospital Admitted Services; Public Hospital Emergency Services; Public Hospital Non-Admitted Services) of the OBM Framework are aligned and capture the nature of ABF funding. This assists with more accurate cost of service information, and consequently, increased transparency of the cost of providing hospital services to the WA public.

ABF has directly underpinned hospital funding arrangements, or contributed to the derivation of hospital budgets, in most Australian jurisdictions for a number of years.[6] ABF is a critical

[6] Ernst and Young, *State Price Analysis Report* (July 2014) p 1.

element of the funding arrangements that allow the provision of health services to the public at both a state and national level, and WA Health began its implementation of Activity Based Funding and Management in the 2010/11 financial year. The greater alignment of the proposed Services to ABF funding will allow for a robust cost per national weighted activity unit (**NWAU**) calculation.

There are five main ABF funding streams, and the first four OBM Framework Services mirror these:[7]

1) Emergency department;
2) Acute admitted care;
3) Subacute;
4) Non-admitted outpatient care; and
5) Mental healthcare.

The benefits to the WA health system as a whole of the proposed OBM Framework alignment to ABF funding include:

- More detailed and accurate information as to the utilisation of ABF funding by Health Services Providers;
- A consistent system of costing for both ABF and non-ABF funded Services; and
- Tracking and measurement of variances in a more effective manner.

5.3.3. Clarity of Non-Hospital Services

The annual budget submission made by the Department on behalf of the WA health system is framed from the perspective of ABF services, which by default isolates the remaining Non-ABF services. As a result, the first three Services (Public Hospital Admitted Services; Public Hospital Emergency Services; Public Hospital Non-Admitted Services) have been aligned to ABF funding categories. Services Five, Six, Seven and Eight (Aged and Continuing Care; Public and Community Health Services, Health System Policy and Corporate Services; and Health Support Services) can be classified as Non-Hospital Services (**NHS**). Service Four is both mixture of ABF and NHS funding sources, given the mixture and interconnected nature of mental health service delivery within the WA health system.

NHS complement and support the hospital system and provide critical services to Western Australians. The demand for these services continues to increase with a growing and ageing population and the growing burden of chronic illness. These services are necessary to maintain and improve health outcomes and prevent the transfer of costs and demand into the hospital system, hence supporting the overall health system. Since 2013-14 WA Health's budget settings have been set in expenditure categories of Hospital and Non-Hospital Services. Performance reporting against these budget categories has been difficult as the Department does not have an effective timely and accurate reporting mechanism.

The NHS Categories identified as part of the OBM Framework development process have been captured within the internal management view through the Sub-Services (see paragraph 6 below) and a mapping has been completed to align OBM Framework NHS categories with existing external reporting requirements for both the Public Health Establishment (**PHE**) annual process and the NHCDC.

[7] *National Pricing Model Technical Specifications* Version 1.0, IHPA, Canberra, 2013.

Now, with the revised OBM Framework, and for the first time, WA Health will have the ability to track its NHS expenditure at a system-wide level, with an accuracy that has not been possible under previous OBM Frameworks. This will facilitate the development of a NHS costing model and provide a strong evidence base to assist with understanding the costs of delivering these services. The intention of this design is to standardise and improve alignment of NHS within the WA Health budget submission process to existing NHS external reporting requirements. Table 14 on the following pages captures the 11 NHS categories that will be utilised by the WA health system, and incorporated into the *WA Health Clinical Costing Standards*.

Table 14: WA Health Non Hospital Service Categories

Item	NHS Category	OBM Framework	NHCDC	PHE
1.	**Abnormal Items**	N/A	01 Abnormal Items	Abnormal Items
			14 New Hospital Start-up costs	
2.	**Community & Residential Mental Health**	Service 4. Mental Health Services	23 – OP Aggregate	Residential Mental Health
		Sub-Service 8. Non-Admitted Patients - Mental Health	02 Community Mental Health	Community Mental Health (Non-Patients only)
		Sub-Service 10. Mental Health Programs	23 – OP Aggregate	
3.	**Other Community Health**	Service 5. Aged and Continuing Care Services	03 Community Health	Other Community Health
		Sub-Service 11. Aged and Continuing Care Services		
		Sub-Service 12. Palliative & Cancer Care Services		
		Service 5. Aged and Continuing Care Services	N/A	Rehabilitation Care Services
		Sub-Service 11. Aged and Continuing Care Services		
4.	**Home Care Programs**	Service 5. Aged and Continuing Care Services	HACC Components only of: 06 Domiciliary Care Services 07 Continuing Care Program 11 Out of Scope 16 Non ABF	Domiciliary Care Services
		Sub-Service 11. Aged and Continuing Care Services		
5.	**Residential Care Programs**	Service 5. Aged and Continuing Care Services	21 Residential Aged Care	Residential Care Program
		Sub-Service 11. Aged and Continuing Care Services		
6.	**Public Health**	Service 6. Public and Community Health Services	04 Public Health 22 Small Hospitals	Public Health
		Sub-Service 13. Public Health Services		
		Sub-Service 14. Special Purpose Programs		
		Sub-Service 16 Aboriginal Health Programs		
		Sub-Service 17. Community Dental Health		
		Sub-Service 18. Small Rural		

Item	NHS Category	OBM Framework	NHCDC	PHE
		Hospitals		
7.	**Commercial Activities**	N/A	09 Commercial activities	Commercial Activities
8.	**Special Purpose Accounts (Mental Health Only only)**	N/A	10 SPA type [actually GEN]	Special Purpose Accounts (MHS only)
9.	**Patient Transport (non –ABF)**	Service 6. Public and Community Health Services	18 PATS 19 RFDS	Out of Scope
		Sub-Service 15. Patient Transport Services		
10.	**Out of Scope Services**	N/A	11 Out of Scope	Out of Scope Corporate Type Services
		N/A	20 Capital (Expensed)	
		N/A	Services to Other Organisations	
		7. Health System Policy and Corporate Support Services 20. Policy Services	Excluded from NHCDC	
		8. Health Support Services 21. Health Support Services		
11.	**Teaching, Training and Research**	1. Public Hospital Admitted Services	12.5 Direct TTR	Teaching, Training and Research
		2. Public Hospital Emergency Services		
		3. Public Hospital Non-Admitted Services		
		4. Mental Health Services		

6. Sub-Services

6.1. Internal Management of the WA Health OBM Framework

Information is central to an efficient and effective health system. It shines a light on good and bad performance, helps the community and governments to hold healthcare providers to account, facilitates good patient care, and forms part of the evidence base on health interventions.[8] In undertaking a review of the current WA Health OBM Framework, it was determined that the information reported about the Services provided by WA Health was more accurate. Accordingly, an additional level of detail not required by the OBM Guidelines has been created at a Sub-Service level to assist with the provision of information for Services and Outcomes.

There will be two views maintained by WA Health regarding its OBM Framework:

1. **External Government Budget Statement and Annual Report View** – This is the view that will be provided in and reported against in the Government Budget Statement and Annual Reports. It does not contain Sub-Service or Program information and once finalised it will list the selected suite of KPIs aligned to the relevant Outcome and Service.
2. **Internal Management View** – This is the more granular view of the OBM Framework that can be used for internal system management purposes by both HSPs and the Department. It contains both Sub-Service and Program level detail, and will eventually contain both an expenditure and budget view gathered and maintained through the cost centre mapping.

Provided in Figure 1 (page 20) and Figure 3 on the following page are the two OBM Framework views. The first view highlighted in Figure 1 is reflective of the OBM Framework as it will appear in the GBS (in a consolidated form) as well as the Annual Reports.

The second view at Figure 3 represents an internal management view, which will be maintained by the Department as System Manager and each HSP as a mechanism to provide more accurate information on the Services and subsequent Outcomes as part of the OBM Framework.

This internal management view is a first for WA Health, and its consistent application and maintenance across the whole of WA Health through a related OBM Framework Policy will create a level of granularity regarding the OBM Framework that has not been possible in previous years. It is important to note the following caveats when utilising the internal management view of the OBM Framework:

- Financial products, savings and corrective measures are treated differently in the Service Agreement view to the OBM Framework view;
- Reconciliation will not be possible between the ‘mapped cost centre view’ and the ‘SA view’ for each of the Services. This is due to the management of financial products, savings and corrective measures;
- Material cost centres have been split between the different functions/services undertaken by the cost centre, based upon information provided by HSPs; and
- The internal management view is representative of a point in time and will need to be reviewed regularly by cost centre managers to reflect the correct alignment of budget allocation and expenditure to the OBM Framework Services.

[8] *Efficiency in Health*, Productivity Commission Research Paper, Australian Productivity Commission (April 2015) p 73.

Figure 3: WA Health OBM Framework – Internal Management Sub-Service and Program View

Key:

	ABF Funded Services
	Non Hospital and Block Funded Services

WA Government Goal:
Greater focus on achieving results in key service delivery areas for the benefit of Western Australians

WA Health Agency Goal:
Delivery of safe, quality, financial sustainable and accountable healthcare for all Western Australians

Outcomes	Service	Sub-Services	SLA Budget 15/16 ($)	Programs
Outcome 1: Public hospital based services that enable effective treatment and restorative health care for Western Australians	**1. Public Hospital Admitted Services (Approximately $3209M)** The provision of healthcare services to patients in metropolitan and major rural hospitals that meet the criteria for admission and receive treatment and/or care for a period of time, including public patients treated in private facilities under contract to WA Health. Admission to hospital and the treatment provided may include access to acute and/or subacute inpatient services, as well as hospital in the home services. Public Hospital Admitted Services includes teaching, training and research activities provided by the public health service to facilitate development of skills and acquisition or advancement of knowledge related to admitted services. This Service does not include any component of the Mental Health Services reported under Service four "Mental Health Services".	01. Public Hospital Admitted Services	2,809,327,864	01. Acute Inpatient Activity
				02. Sub-acute Inpatient Activity
				03. Teaching, Training and Research Funding - Inpatient
		02. Public, Private Partnership - Admitted Services	399,847,724	04. Public, Private Partnership - Inpatient Activity
				05. PPP- Teaching, Training and Research - Inpatient
	2. Public Hospital Emergency Services (Approximately $699M) The provision of services for the treatment of patients in emergency departments of metropolitan and major rural hospitals, inclusive of public patients treated in private facilities under contract to WA Health. The services provided to patients are specifically designed to provide emergency care, including a range of pre-admission, post-acute and other specialist medical, allied health, nursing and ancillary services. Public Hospital Emergency Services includes teaching, training and research activities provided by the public health service to facilitate development of skills and acquisition or advancement of knowledge related to emergency services. This Service does not include any component of the Mental Health Services reported under Service four "Mental Health Services".	03. Public Hospital Emergency Department Services	572,009,126	06. Emergency Department Activity
				07. Teaching, Training and Research - Emergency Department
		04. Public, Private Partnership - Emergency Department Services	126,808,226	08. Public, Private Partnership - Emergency Department Activity
				09. PPP- Teaching, Training and Research - Emergency Department
	3. Public Hospital Non-Admitted Services (Approximately $695M) The provision of metropolitan and major rural hospital services to patients who do not undergo a formal admission process, inclusive of public patients treated by private facilities under contract to WA Health. This Service includes services provided to patients in outpatient clinics, community based clinics or in the home, procedures, medical consultation, allied health or treatment provided by clinical nurse specialists. Public Hospital Non-Admitted Services includes teaching, training and research activities provided by the public health service to facilitate development of skills and acquisition or advancement of knowledge related to non-admitted services. This Service does not include any component of the Mental Health Services reported under Service four "Mental Health Services".	05. Public Hospital - Non-admitted Services	656,016,445	10. Non-admitted Activity
				11. Teaching, Training and Research - Non-admitted
		06. Public, Private Partnership - Non-admitted Services	39,002,649	12. Public, Private Partnership - Non-admitted Activity
				13. PPP - Teaching, Training and Research - Non-admitted Activity
	4. Mental Health Services (Approximately $648M) The provision of inpatient services where an admitted patient occupies a bed in a designated mental health facility or a designated mental health unit in a hospital setting; and the provision of non-admitted services inclusive of community and ambulatory specialised mental health programs such as prevention and promotion, community support services, community treatment services, community bed based services and forensic services. This Service includes the provision of state-wide mental health services such as perinatal mental health and eating disorder outreach programs as well as the provision of assessment, treatment, management, care or rehabilitation of persons experiencing alcohol or other drug use problems or co-occurring health issues. Mental Health Services includes teaching, training and research activities provided by the public health service to facilitate development of skills and acquisition or advancement of knowledge related to mental health or alcohol and drug services. This service includes public patients treated in private facilities under contract to WA Health.	07. Public Hospital - Inpatient Mental Health Services	294,438,783	14. Acute Inpatient Mental Health
				15. Sub-acute Inpatient - Mental Health
				16. Teaching, Training and Research - Mental Health Inpatient
		08. Public, Private Partnership - Inpatient Mental Health Services	36,567,530	17. Public, Private Partnership - Inpatient Mental Health
				18. PPP - Teaching, Training and Research - Mental Health Inpatient
		09. Public Hospital - Non-Admitted Mental Health Services	295,455,000	19. Non-Admitted Patients - Mental Health
		10. Mental Health Specific Services	21,325,165	20. Mental Health Specific Programs
Outcome 2: Prevention, health promotion and aged and continuing care services that help Western Australians to live healthy and safe lives	**5. Aged and Continuing Care Services (Approximately $527M)** The provision of aged and continuing care services and community based palliative care services. Aged and continuing care services include programs that assess the care needs of older people, provide functional interim care or support for older, frail, aged and younger people with disabilities to continue living independently in the community and maintain independence, inclusive of the services provided by the WA Quadriplegic Centre. Aged and Continuing Care Services is inclusive of community based palliative care services that are delivered by private facilities under contract to WA Health, which focus on the prevention and relief of suffering, quality of life and the choice of care close to home for patients.	11. Aged and Continuing Care Services	479,373,077	21. Aged Care Assessment Teams (ACAT)
				22. Home and Community Care (HACC)
				23. Transitional and Home Care Programs
				24. Residential and respite care
				25. Private & NGO Aged Care Contracts
				26. Complex and Long Stay Programs
				27. Quadriplegic Centre
		12. Palliative & Cancer Care Services	47,789,162	28. Palliative & Cancer Care Services
	6. Public and Community Health Services (Approximately $1354M) The provision of healthcare services and programs delivered to increase optimal health and wellbeing, encourage healthy lifestyles, reduce the onset of disease and disability, reduce the risk of long-term illness as well as detect, protect and monitor the incidence of disease in the population. Public and Community Health Services includes public health programs, Aboriginal health programs, environmental health, community based dental services, the provision of grants to non-government organisations for public and community health purposes, emergency road and air ambulance services, services to assist rural based patients travel to receive care, statewide pathology services provided to external WA Agencies and the services provided by small rural hospitals.	13. Public Health Services	435,629,622	29. Health Promotion, Primary Care, Education and Research
				30. Health Protection and Screening Services
		14. Special Purpose Services	109,562,306	31. Renal Programs
				32. Blood Contract Programs
				33. FINE - ED
				34. Other non-admitted programs
		15. Patient Transport Services	209,011,679	35. Emergency Road Based Ambulance Services
				36. Emergency Air Based Services
				37. Patient Assisted Transport Service (PATS)
				38. Other transport services
		16. Aboriginal Health Services	61,428,008	39. Aboriginal Health
		17. Community Dental Health Services	97,361,003	40. Oral Health Care WA
				41. Community Dental Health
		18. Block Funded Small Rural Hospital Services	182,107,000	42. Block Funded Small Rural Hospitals
			69,420,000	43. RFR and Other Commonwealth Funding
		19. Pathology Services for Customers External to WA Health	189,577,946	44. PathWest
Outcome 3: Strategic leadership, planning and support services that enable a safe, high quality and sustainable WA Health System	**7. Health System Management - Policy and Corporate Services (Approximately $288M)** The provision of strategic leadership, policy and planning services, system performance management and purchasing linked to the state-wide planning, budgeting and regulation processes. Health System Policy and Corporate Services includes corporate services inclusive of statutory financial reporting requirements, overseeing, monitoring and promoting improvements in the safety and quality of health services and system wide infrastructure and asset management services.	20. Policy Services	288,000,882	45. Budget for Royal St
	8. Health Support Services (Approximately $220M) The provision of purchased health support services to WA Health entities inclusive of corporate recruitment and appointment, employee data management, payroll services, workers compensation calculation and payments and processing of termination and severance payments. Health Support Services includes finance and business systems services, IT and ICT services, workforce services, project management of system wide projects and programs and the management of the supply chain and whole of health contracts.	21. Health Support Services	80,989,050	46. HCN
			139,477,052	47. HIN

Financial Products - Approx $466M district allowance depreciation, expensed capital, district allowance, recoups, SPA's, other financial products	466,095,507
Savings and Corrective Measures - Approx $70M	69,821,559
Total WA Health OBM	**8176,342,365**
QEII	7,365,146
Total WA Health	**8,183,707,511**

3

6.1. Creation of Sub-Services

As demonstrated in Table 15 (spread across the following pages) WA Health has not previously maintained data sets about its OBM Framework at Sub-Service and Program level prior to this submission. The internal management view discussed above will enable this granularity of information to be maintained for the first time on a more formal basis.

Under the revised OBM Framework, WA Health will have 21 Sub-Services (with a fluent level of program information underneath that will be updated with each annual budget submission and Service Agreement process) that will roll up into the eight Services. This information will be available to Treasury (or other external stakeholders) upon request, they will not appear in WA Health Annual Reports. The maintenance of the information contained at the Sub-Service level is important for the budget submission process and will be used to assist alignment between external reporting and internal processes such as allocation and performance management.

Datasets, through a cost centre mapping outside of the General Ledger in the short-term future, we be maintained for all reporting entities at Sub-Service and Program level to assist with the internal management of Services reported against in the WA GBS and Annual Reports. The Sub-Services are one of the key input resources required to provide information on the delivery of Services to the WA public.

6.2. Research and Analysis

Descriptors for each Sub-Service have been developed, incorporating a review of the following related strategic instruments and policies:

- *Clinical Services Framework 2014-2024*;
- *Admission, Readmission, Discharge and Transfer Policy for WA Health Services 2014-2015*;
- Alignment with the ABF classifications provided by The Independent Hospital Pricing Authority;
- *National Health Data Dictionary* version 12; and
- The Australian Institute of Health and Welfare METeOR Metadata Online Registry.

An evidence matrix demonstrating the strategic alignment of each Sub-Service Descriptor can be viewed at 0 of this submission. Each Sub-Service has been cross referenced and reflects the activity that is captured within the cost centres mapped to each Sub-Service and Program. This process provides and increased level of internal consistency, reduces definitional issues, and increases understanding of Sub-Services in WA Health. The Sub-Services with related descriptors are listed in Table 15.

Table 15: Sub-Service Descriptors

Proposed Sub-Service	Proposed Sub-Service Descriptor
Outcome 1 Service 1: Public Hospital Admitted Services	
1. Public Hospital Admitted Services	The provision of acute and sub-acute (admitted patient) care services in which the clinical intent or treatment goal is to: manage labour (obstetric); cure illness or provide definitive treatment of injury; perform surgery; relieve symptoms of illness or injury (including inpatient palliative care); reduce severity of an illness or injury; provision of specialised multidisciplinary care in which the primary need for care is optimisation of the patient's functioning and quality of life (including inpatient palliative care); protect against exacerbation and/or complication of an illness and/or injury which could threaten life or normal function, including involuntary psychiatric patients or perform diagnostic or therapeutic procedures. This Sub-Service includes some forms of rehabilitation care as well as a component of Teaching, Training and Research activity to facilitate the acquisition of knowledge, or development of skills related to the provision of Admitted Services to the public. This Sub-Service does not include any component of the Mental Health Services reported under Service four "Mental Health Services".
2. Public, Private Partnership – Admitted Services	The provision of acute and subacute admitted services to public patients, by private providers under contract to WA Health. This Sub-Service includes a component of Teaching, Training and Research activity to facilitate the acquisition of knowledge, or development of skills related to the provision of Admitted Services to the public. This Sub-Service does not include any component of the Mental Health Services reported under Service four "Mental Health Services".
Outcome 1 Service 2: Public Hospital Emergency Services	
3. Public Hospital Emergency Department Services	The provision of dedicated hospital based emergency services, inclusive of the diagnosis and treatment of acute and urgent illnesses and injuries. Patients being treated in emergency services/urgent care centres may subsequently become admitted. Care provided to patients in General Practitioner co-located units is excluded from the scope of this Sub-Service. This Sub-Service does not include any component of the Mental Health Services reported under Service four "Mental Health Services".
4. Public, Private Partnership – Emergency Services	The provision of emergency services to public patients, by private providers under contract to WA Health. This Sub-Service includes a component of Teaching, Training and Research activity to facilitate the acquisition of knowledge, or development of skills related to the provision of Emergency Services to the public. This Sub-Service does not include any component of the Mental Health Services reported under Service four "Mental Health Services".
Outcome 1 Service 3: Public Hospital Non-Admitted Services	
5. Public Hospital Non-admitted Services	The provision of services related to specialist outpatient clinics or other non-admitted patient services and non-medical specialist outpatient clinics. Categories of outpatient services include: procedures; medical consultation; standalone diagnostic and allied health and/or clinical nurse and/or midwife specialist intervention. This Sub-Service includes a component of Teaching, Training and Research activity to facilitate the acquisition of knowledge, or development of skills related to the provision of Non-admitted Services to the public. This Sub-Service does not include any component of the Mental Health Services reported under Service four "Mental Health Services".

Proposed Sub-Service	Proposed Sub-Service Descriptor
6. Public, Private Partnership - Non-admitted Services	The provision of non-admitted services to public patients, by private providers under contract to WA Health. This Sub-Service includes a component of Teaching, Training and Research activity to facilitate the acquisition of knowledge, or development of skills related to the provision of Non-admitted Services to the public. This Sub-Service does not include any component of the Mental Health Services reported under Service four "Mental Health Services".
Outcome 1 Service 4: Mental Health Services	
7. Public Hospital - Inpatient Mental Health Services	The provision of acute and sub-acute inpatient services within a specialised mental health unit, inclusive of specialised mental health services that provide overnight care in a psychiatric hospital or a specialised mental health unit in an acute hospital. People with mental health problems can also be admitted to other areas where health care workers are not specifically trained to care for the mentally ill. This Sub-Service includes a component of Teaching, Training and Research activity to facilitate the acquisition of knowledge, or development of skills related to the provision of Inpatient Mental Health Services to the public.
8. Public Hospital - Non-Admitted Mental Health Services	The provision of non-admitted patient mental health services within a specialised mental health unit or community based mental health services delivered either in the community or in the home.
9. Public, Private Partnership - Inpatient Mental Health Services	The provision of inpatient mental health services to public patients, by private providers under contract to WA Health, inclusive of specialised mental health services that provide overnight care or a specialised mental health unit in an acute hospital. This Sub-Service includes a component of Teaching, Training and Research activity to facilitate the acquisition of knowledge, or development of skills related to the provision of Mental Health Services to the public.
10. Mental Health Specific Programs	The provision of community based mental health specific programs purchased by the WA Mental Health Commission including suicide prevention, Aboriginal mental health, drug and alcohol, youth community treatment, court diversion, community living and domestic violence programs.
Outcome 2 Service 5: Aged and Continuing Care Services	
11. Aged and Home Care Services	The provision of continuing care services for WA's ageing population, embedded in major health programs in a number of settings inclusive of community care (including the Home and Community Care Program); residential care (including Commonwealth funded high and low care residential facilities as well as the nursing home type patient units in the State's country hospitals); High Dependency Units in residential aged care facilities for people with behavioural problems associated with chronic mental disorders and/or advanced dementia and residential rehabilitation care programs for both the older population and younger individuals with disabilities to continue living independently in the community and maintain independence.
12. Palliative & Cancer Care Services	Palliative Care specialist services are for patients who have progressive, life limiting or life threatening malignant and/or non-malignant disease. The focus of care is on the prevention and relief of suffering, quality of life and the choice of care close to home. Palliative care services can be delivered in any setting, such as home, residential care or in palliative care units. Specialist services provide consultancy, advice and support to the primary care providers; assessment/management of symptoms which are beyond the capacity of the primary care team to manage optimally; specialist assessment/ management of the patient and their families' psychological, social or spiritual needs; and direct patient care in an inpatient hospice/palliative care. This Sub-Service is inclusive of contracted palliative and

Proposed Sub-Service	Proposed Sub-Service Descriptor
	cancer care services provided in partnership with GPs, NGOs, Medicare Locals, Private providers and State Government.
Outcome 2 Service 6: Public and Community Health Services	
13. Public Health Services	Provision of primary, community, promotion and protection health care services, inclusive of environmental health education, monitoring and regulation programs; disaster preparedness and management services; immunisation clinics; maternity clinics and allied health care across the full continuum of wellness and disease/injury.
14. Special Purpose Programs	The provision of special purpose programs inclusive of blood contract programs (such as the $30 millon dollar blood contract managed by the Department, and other long stay patient care programs such as Lady Lawley, Catch program and Renal programs and community midwifery programs). This Sub-Service recognises that some health service programs have a specific purpose with a distinct expenditure profile.
15. Patient Transport Services	This item comprises transportation in a specially-equipped surface vehicle or in a designated air ambulance to and from facilities for the purposes of receiving medical and surgical care. Includes all government ambulance services and transport provided by the Royal Flying Doctors Service, care flight and similar services, emergency transport services of public fire rescue departments or defence that operate on a regular basis for civilian emergency services (not only for catastrophe medicine). Includes transport between hospitals or other medical facilities and transport to or from a hospital or other medical facility and a private residence or other non-hospital/medical services location. The provider of this service could be a public or private. This Sub-Service does not include inter-hospital patient transport services, which are captured under Sub-Service 1 above.
16. Aboriginal Health Programs	Provision of services targeted at improving the provision of health and medical services for Aboriginal people while ensuring services are provided in a culturally appropriate manner and work collaboratively with; Aboriginal communities, Aboriginal Community Controlled Health Organisations, General Practitioners, hospitals and NGOs. Includes various high priority projects that are aimed at improving the life expectancy for the WA Aboriginal population, these include prevention and management of chronic disease; maternal and child health; social and emotional wellbeing and mental health, and substance abuse.
17. Community Dental Health	Dental health services include the school dental service, providing dental health assessment and treatment for school children, the adult dental service for financially and/or geographically disadvantaged people, specialist and general dental, as well as oral health care provided by the Oral Health Centre of Western Australia to holders of a Health Care Card. Services are provided through government funded dental clinics, itinerant services and private dental practitioners participating in the metropolitan, country and orthodontic patient dental subsidy schemes.
18. Block Funded Small Rural Hospitals	The provision of emergency care services and limited acute medical and minor surgical services in locations ‘close to home’ for country residents and the many visitors to the regions, by small and rural hospitals classified as block funded. The Services provided by small rural hospitals include community care services which align closely with the needs of local communities.
19. Pathology Services for Customers External to WA	The provision of state-wide external diagnostic services across the full range of pathology disciplines, inclusive of forensic biology and pathology services to other WA Government Agencies and services provided to the public by PathWest. This

Proposed Sub-Service	Proposed Sub-Service Descriptor
Health	Sub-Service also includes the operational costs of Pathwest in delivering services to both Health Service Providers and the public, that are not charged out on a fee for service basis.
Outcome 3 Service 7: Health System Management - Policy and Corporate Services	
20. Policy Services	The provision of strategic leadership, policy and planning services, system performance management and purchasing linked to the state-wide planning, budgeting and regulation processes. Health System Policy and Corporate Services includes corporate services inclusive of statutory financial reporting requirements, overseeing, monitoring and promoting improvements in the safety and quality of health services and system wide infrastructure and asset management services.
Outcome 3 Service 8: Health Support Services	
21. Health Support Services	The provision of purchased health support services to WA Health entities inclusive of corporate recruitment and appointment, employee data management, payroll services, workers compensation calculation and payments and processing of termination and severance payments. Health Support Services includes finance and business systems services, IT and ICT services, workforce services, project management of system wide projects and programs and the management of the supply chain and whole of health contracts.

6.3. Program level information

As discussed above at section 6.1, the internal management view of the revised WA Health OBM Framework, contains program level detail linked (but not on a one-to-one basis) to the line items in the Service Agreements between the Department and HSPs.

Programs are a more granular view of a Sub-Service, grouped into like Services with an overall view of materiality to that Sub-Service. Based on this view, the Department and HSPs have the ability to integrate both budget and expenditure at the Service, Sub-Service and Program levels. This analytical capability of the system has not been possible under the previous OBM Framework, and will bring a greater level of accountability and transparency to the financial and performance management processes of WA Health.

6.4. Maintenance of Mapping at Sub-Service and Program Level

As with the datasets required to be maintained for OBM Services, datasets will be maintained for Sub-Services and Programs increasing internal transparency across the system and create a level of assurance for internal management reporting purposes. The mapping between hospital and NHS, and the Sub-Services and Programs that roll up to the Services will provide a refined and more accurate estimate of the actual spending within these categories.

This allows the development of an evidence based cost model for NHS as the alignment and mapping of prior year actuals for over 600 funded line items in the Service Agreements or projects, processed in over approximately 10,000 cost centres, to a defined program structure has been completed as part of the revised OBM Framework. A suite of business rules are in development to assist with the maintenance of this datasets to which both the System Manager and HSPs will be able to access.

7. Key Performance Indicators

Under Section 61 of the *Financial Management Act 2006* and Treasurers Instructions 903 and 904, WA Health is required to report annual indicators on its effectiveness and efficiency. The effectiveness indicators inform how well WA Health achieves its Outcomes while efficiency indicators show accountability for funds and the management of these funds spent in the delivery of the Services or programs. KPIs contained in WA Health's Annual Reports provide a performance summary of the delivery of Services that are either managed directly by WA Health or for which WA Health provides funding through contractual arrangements with private or not-for-profit service providers.

7.1. Factors, events and trends influencing our performance

Spending on health services for the Western Australian public represents a significant portion of the WA Government's budget. As the Western Australian population continues to grow and age, the need to access quality healthcare will increase. With this in mind, the creation of a revised suite of KPIs that align to the revised OBM Framework has been undertaken to ensure alignment to an increasing amount of ABF, take advantage of increasing data and analytical capabilities of our health system and increase the meaningfulness of KPIs to both the Western Australian public and parliament.

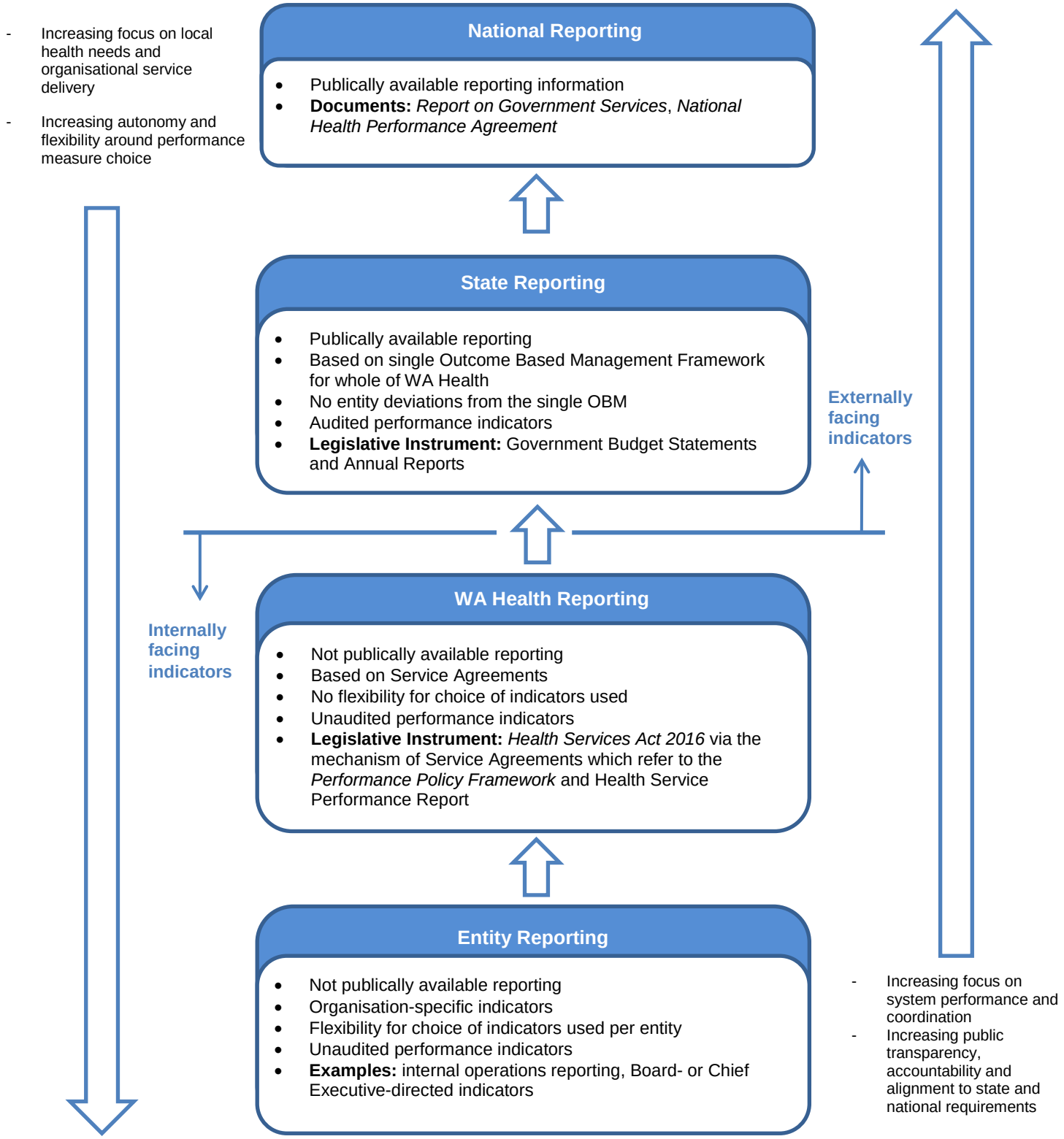
Over the last few years significant progress has been made on reporting many indicators of performance in WA public hospitals. Members of the public have access to the performance of each WA Health public hospital through the Our Hospital indicators.[9] The Performance at a Glance section of Our Hospitals and Health Services presents information on public hospitals throughout WA and how they compare against National Targets (where possible) including: waiting times for emergency departments and elective surgery, mental health, safety and quality, patient satisfaction and finance. Building upon this increased transparency and accountability relating to WA public hospital performance, the development of a revised suite of KPIs to capture WA Health's performance against the OBM Framework incorporated an alignment (where possible) to other existing performance information reporting obligations at national, state and internal levels.

This alignment to existing performance reporting mechanisms will reduce the duplication of existing reporting obligations across the WA health system, in turn ensuring effective and efficient service delivery through streamlined reporting arrangements and increased benchmarking capability within a national context. Benchmarking the performance of both individual entities as well as the WA health system at a national level provides an important insight that allows for continuous performance improvement.

Outlined in Figure 4 below is a diagram of how the OBM Framework KPIs align to existing externally-facing national and state-based performance reporting obligations, as well as internally-facing performance reporting obligations.

[9] Further information on these indicators can be accessed here: http://www.health.wa.gov.au/OurHospitalsandHealthServices/home/.

Figure 4: WA Health Performance Reporting Obligations



7.2. Evaluation Principles

Similarly to evaluation principles detailed at section 2.4 of this submission, a review of state, national and international sources regarding development of health-related KPIs was conducted and used to inform the creation of evaluation principles that were used throughout the development and review of the submitted KPIs.

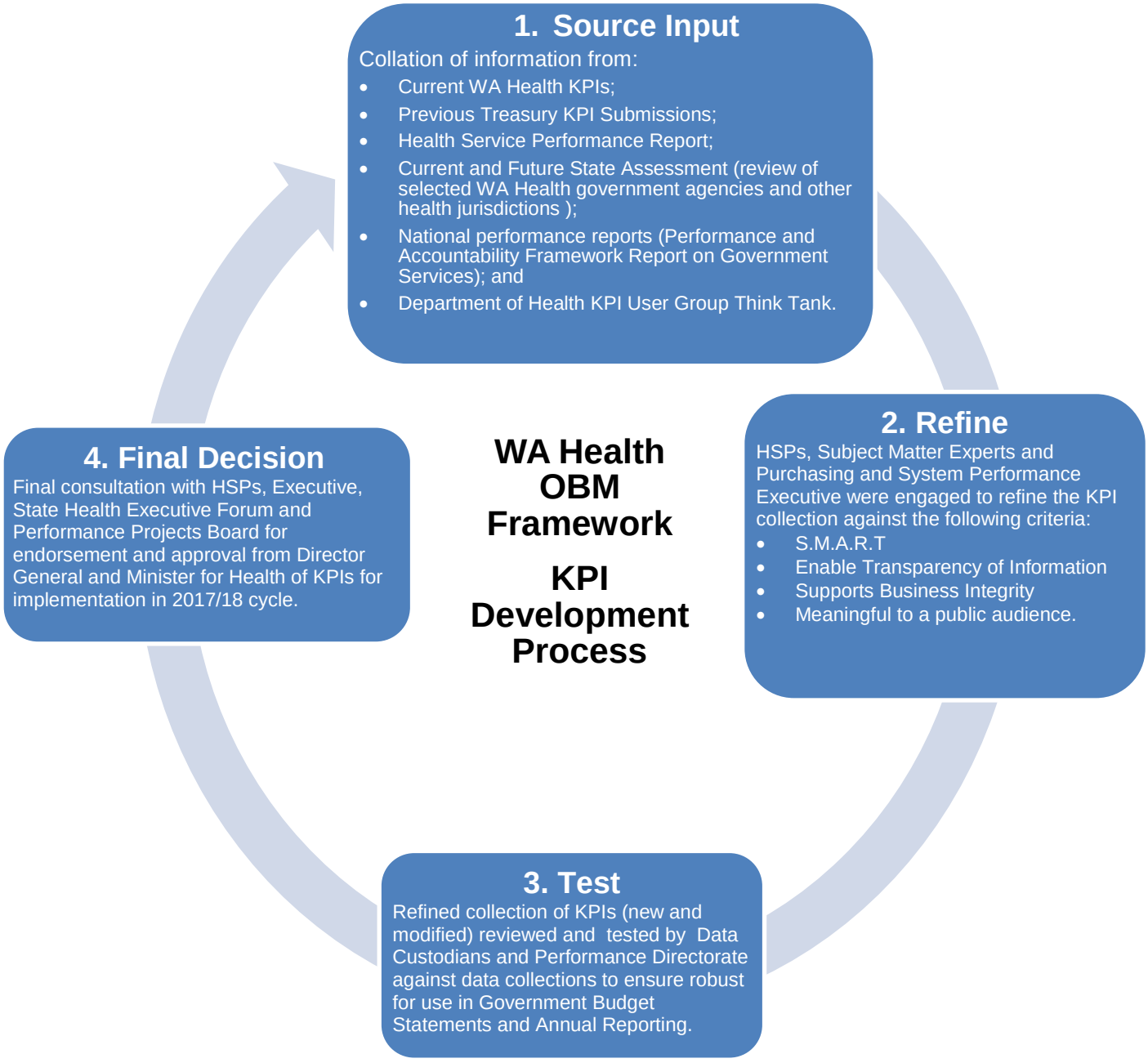
The S.M.A.R.T. criteria were used in addition to the evaluation principles of ‘transparency of reporting’ and ‘ensuring business integrity’. The KPI considerations for decision making were based on developing a suite of KPIs that would deliver the following benefits:

- Establish baseline information (i.e. the current state of performance).
- Set performance standards and targets to motivate continuous improvement of the WA health system as a whole and from a separate entity perspective.
- Measure and report improvements in service delivery over time.
- Compare performance were appropriate across relevant HSPs where appropriate.
- Benchmark performance against regional and international peers or norms
- Allow external stakeholders (such as the public, parliament and Treasury) to independently judge health sector performance.

7.3. Key Performance Indicator Development Process

An extensive list of KPIs was compiled from existing Annual Reports, appraisal of jurisdictional and national indicators, as well as from consultations with stakeholders and subject matter experts. A review of these indicators was completed to align KPIs with the considerations for decision-making outlined above. This alignment review, consultation feedback and data information was utilised to reduce the potential list of KPIs into a smaller collection for consideration. Figure 5 provides a high-level view of the KPI development process. Additional information on the desktop review related to the KPI development process can be viewed at Appendix 11 of this submission.

Figure 5: WA Health OBM Framework – KPI Development Process



7.4. Evidence base

The KPI development process was supported by robust and existing data and performance management processes, and this initial evidence base was built upon in order to determine the final OBM Framework KPIs. In addition, initial mapping and review of our KPIs within the OBM Framework was undertaken, along with associated measurement methodologies, data and information.

7.4.1. Strategic Alignment

Each of the KPIs detailed in this submission underwent a review process to ensure there was an alignment to at least one of the four following priorities identified in the Strategic Intent

1. Prevention and Community Care Services;
2. Health Services;
3. Chronic Disease Services; and
4. Aboriginal Health Services.

The five of the seven enablers of 'Workforce', 'Financial Management', 'Partnerships', 'ICT' and 'Research and Innovation' were also considered as part of the review process.

7.5. Proposed Key Performance Indicators

The revised OBM Framework includes both effectiveness KPIs that measure the three Outcomes and revised efficiency KPIs that measure the eight Services. Listed on the following pages in Table 17 are the selected KPIs for the revised WA Health OBM Framework, with related status ('to be continued', 'to be added' or 'to be removed'), KPI title, measure, target and rationale for inclusion in the final KPI suite. All of these KPIs have been provided to both Treasury and OAG for informal feedback and amendments have been made where necessary based on this feedback.

The selected KPIs are strategically aligned and reflect existing reporting requirements on internal, state and national levels as outlined in Figure 4. Consideration was given to each KPIs utility for regular reporting purposes. The suite of KPIs has also been chosen to ensure that meaningful performance can be captured, even when the KPI is disaggregated across five HSPs.

7.6. Proposed Key Performance Indicators by Entity

The recent changes to the organisational structure of WA Health (discussed at item 2.3.2) have necessitated amendments to the previous Annual Reporting format of the Metropolitan Health Service, WA Country Health Service, the Quadriplegic Centre and the Department of Health Annual Reports.

As outlined in Table 16 whilst this submission is made for one OBM Framework designed for the WA health system in its entirety, the disaggregation of HSPs annual reports from 2016/2017 onwards requires that some of the KPIs be entity-specific as not all KPIs are relevant to the services delivered by all HSPs. Each of the KPIs within the OBM Framework suite have been aligned as detailed below to the relevant reporting entity for Annual Reporting purposes.

Table 16: Suite of WA Health Outcome Based Management Framework Key Performance Indicators

Key: **Red** text indicates new indicators (not currently reported in Annual Reports). **Black** text indicates existing indicators in the Annual Reports. ✓ indicates the entity will report this KPI in their Annual Report.

Outcomes	Type	Alignment to Outcomes and Service Lines	KPI	NMHS	SMHS	EMHS	CAHS	WACHS	Quad Centre	HSS	DoH
1. Public hospital based services that enable effective treatment and restorative healthcare for Western Australians	Effectiveness KPIs	Outcome 1 – Public hospital based services that enable effective treatment and restorative healthcare for Western Australians	1. Unplanned hospital readmission rates (Unplanned hospital readmissions of public hospital patients within 28 days of selected surgical procedures: (a) knee replacement; (b) hip replacement; (c) tonsillectomy & adenoidectomy; (d) hysterectomy; (e) prostatectomy; (f) cataract surgery; (g) appendicectomy)	✓	✓	✓	✓	✓			
			2. Waiting times for emergency hospital care (Proportion of emergency department patients seen within recommended times: (a) % Triage Category 1 (2 minutes); (b) % Triage Category 2 (10 minutes); (c) % Triage Category 3 (30 minutes); (d) % Triage Category 4 (60 minutes); (e) % Triage Category 5 (2 hours))	✓	✓	✓	✓	✓			
			3. Elective surgery waiting times (Proportion of all elective patients on the wait list whose waiting time is over the clinically recommended time for their urgency category at census date, reported by urgency category and reportable status)	✓	✓	✓	✓	✓			
			4. Percent of contacts with community-based public mental health non-admitted services within seven days post discharge from public mental health inpatient units	✓	✓	✓	✓	✓			
			5. Hospital infection rates (Healthcare-associated *Staphylococcus aureus* bloodstream infections (HA-SABSI) per 10,000 occupied bed-days in public hospitals)	✓	✓	✓	✓	✓			
			6. Hospital standardised mortality ratio (Percentage of WA public hospitals who are rated as performing or highly performing in comparison to their national peers for the ratio of observed and expected numbers of hospital separations that result in the patient's death)	✓	✓	✓		✓			
			7. The rate of total hospital readmissions within 28 days to an acute designated mental health inpatient unit	✓	✓	✓	✓	✓			
			8. The percentage of admitted Aboriginal and Non-Aboriginal patients who left against medical advice	✓	✓	✓	✓	✓			
			Outcome 1 Total Effectiveness KPIs	8	8	8	7	8	0	0	0
	Efficiency KPIs	Service 1 – Public Hospital Admitted Services	9. Average admitted cost per weighted activity unit	✓	✓	✓	✓	✓			
			Service Line 1 Total Efficiency KPIs	1	1	1	1	1	0	0	0
		Service 2 – Public Hospital Emergency Services	10. Average emergency department cost per weighted activity unit	✓	✓	✓	✓	✓			
			Service Line 2 Total Efficiency KPIs	1	1	1	1	1	0	0	0
		Service 3 – Public Hospital Non-Admitted Services	11. Average non-admitted cost per weighted activity unit	✓	✓	✓	✓	✓			
			Service Line 3 Total Efficiency KPIs	1	1	1	1	1	0	0	0
		Service 4 – Mental Health Services	12. Average cost per bed-day in specialised mental health inpatient units	✓	✓	✓	✓	✓			
			13. Average cost per treatment day of non-admitted care provided by public clinical mental health services	✓	✓	✓	✓	✓			
			Service Line 4 Total Efficiency KPIs	2	2	2	2	2	0	0	0
			Outcome 1 Total KPIs	13	13	13	12	13	0	0	0
2. Prevention, health promotion and aged and continuing care services that help Western Australians to live healthy and safe lives	Effectiveness KPIs	Outcome 2 – Prevention, health promotion and aged and continuing care services that help Western Australians to live healthy and safe lives.	14. Percentage of transition care clients whose functional ability was either maintained or improved during their utilisation of the Transition Care Program								✓
			15. Childhood immunisation (Percentage of children fully immunised at 12-15 months: a) Aboriginal; b) Total)								✓
			16. Loss of life from premature death due to identifiable causes of preventable disease or injury: (a) Lung cancer; (b) Ischaemic heart disease; (c) Falls; (d) Melanoma								✓
			17. The percentage of clients who are discharged from the WA Quadriplegic Centre back into the community						✓		
			18. The percentage of active clients with pressure areas / burns treated by the WA Quadriplegic Centre's Community Nursing Service						✓		
			19. Response times for patient transport services delivered by St John Ambulance (Percentage of priority 1 calls attended to within 15 minutes in the metropolitan area by St John Ambulance Western Australia Ltd)								✓
			20. Response times for patient transport services delivered by the Royal Flying Doctor Service (Percentage of Royal Flying Doctor Service (Western Operations) inter-hospital transfers meeting the state-wide contract target response time for priority 1 calls)					✓			
			21. The percentage of people accessing community-based palliative care to assist them to die at home								✓
			22. Participation rate of women aged 50 – 69 years who participate in breast screening ((a) Indigenous women; (b) Non-Indigenous women)	✓							
			23. The percentage of Western Australian year 8 students that complete their HPV vaccination series								✓
			24. The percentage of (a) adults and (b) children who have a tooth retreated within six months of receiving initial restorative dental treatment	✓							
			25. The percentage of patients who access emergency services at a small rural or remote Western Australian hospital and are subsequently discharged home					✓			
			Outcome 2 Total Effectiveness KPIs	2	0	0	0	2	2	0	6
	Efficiency KPIs	Service 5 – Aged and Continuing Care Services	26. Average cost of a transition care day provided by contracted non-government organisations/service providers								✓
			27. Average cost per bed-day for specified residential care facilities, flexible care (hostels) and nursing home type residents					✓			
			28. Average cost per bed-day for WA Quadriplegic Centre inpatient services						✓		
			29. Average cost per WA Quadriplegic Centre community client for clinical and related services						✓		
			30. Average cost per client who receives support services from the Home and Community Care Program								✓
			Service Line 5 Total Efficiency KPIs	0	0	0	0	1	2	0	2
		Service 6 – Public and Community Health Services	31. Average cost per person of delivering population health programs by population health units	✓	✓	✓	✓	✓			
			32. Cost per person of providing preventative interventions, health promotion and health protection activities that reduce the incidence of disease or injury								✓
			33. Cost per capita for patient transport provided by St John Ambulance Western Australia Ltd, based on the total accrued costs of these services for the estimated total population of Western Australia								✓
			34. Cost per capita for patient transport provided by the Royal Flying Doctor Service (Western Operations), based on the total accrued costs of these services for the estimated total population of Western Australia					✓			
			35. The average cost of WA Health provided dental health programs for (a) enrolled school children and (b) socio-economically disadvantaged adult patients	✓							
			Service Line 6 Total Efficiency KPIs	2	1	1	1	2	0	0	2
			Outcome 2 Total KPIs	4	1	1	1	5	4	0	10
3. Strategic leadership, planning and support services that enable a safe, high quality and sustainable WA health system.	Effectiveness KPIs	Outcome 3 – Strategic leadership, planning and support services that enable a safe, high quality and sustainable WA health system.	36. The percentage of Policy Frameworks and associated documents reviewed within the specified time period								✓
			37. The percentage of Health Service Performance Reports completed by the 17th working day of each month								✓
			38. Clinical Incidents (Proportion of all notified clinical incidents where the patient outcome was death)								✓
			39. The percentage of system-wide, key budget forecasts produced by the Department of Health within agreed client timeframes								✓
			40. Public Health Regulation (The percentage of regulations, policy and other supporting documents in the Annual Public Health Division Operational Plans which were completed)								✓
			41. The percentage of responses from WA Health Service Providers and Department of Health who are satisfied or highly satisfied with the overall service provided by Health Support Services							✓	
			Outcome 3 Total Effectiveness KPIs	0	0	0	0	0	0	1	5
	Efficiency KPIs	Service 7 – Health System Management - Policy and Corporate Services	42. Average cost of Public Health Regulatory services per head of population								✓
			43. Average percentage on time production of key system-wide financial reports released by the WA Department of Health to internal, State and Commonwealth stakeholders								✓
			44. The total cost per full time equivalent worker to undertake the System Manager role of providing strategic leadership, planning and support services to Health Service Providers								✓
			Service Line 7 Total Efficiency KPIs	0	0	0	0	0	0	0	3
		Service 8 – Health Support Services	45. Average cost of Accounts Payable services per transaction							✓	
			46. Average cost of Accounts Receivable services per transaction							✓	
			47. Average cost of payroll and support services per WA Health employee							✓	
			48. Average cost of Supply Services by purchasing transaction							✓	
			49. Average cost of supporting a WA Health personal computer (PC)							✓	
			Service Line 8 Total Efficiency KPIs	0	0	0	0	0	0	5	0
			Outcome 3 Total KPIs	0	0	0	0	0	0	6	8
			Total KPIs	17	14	14	13	18	4	6	18
			Overall Total of KPI Suite								49

7.7. Rationale for proposed new KPIs

Of the 49 KPIs listed above in Table 16, 29 are new and have not been reported in WA Health's Annual Reports prior to this submission. Outlined below is further detail on a select group of the new KPIs, mainly focusing on the transparency that has been provided through KPIs for existing Services that have been devolved into a new Service or new KPIs. Importantly, and demonstrated through the discussion in this section, each of the current Services that have not been picked up in the revised OBM Framework (Palliative Care, Patient Transport and Dental Health Services) remain transparent to the public through the inclusion of corresponding indicator/s for each Service.

7.7.1. New suite of efficiency Indicators to capture cost of weighted activity unit

As part of the development of a revised WA Health OBM, and opportunity was presented to create three new key efficiency indicators that would replace the previous cost per case mix adjusted separation indicators:

- Average admitted cost per weighted activity unit
- Average emergency department cost per weighted activity unit
- Average non-admitted cost per weighted activity unit.

This new suite of indicators provides a more accurate measure that allows for a reasonable comparison of hospital cost efficiency between WA public hospitals and other jurisdictions.

7.7.2. Palliative Care Services

The previous Service 'Palliative Care' has been incorporated into Service Six 'Public and Community Health'. However, transparency of this service has been maintained through the following effectiveness KPI:

- Effectiveness KPI "The percentage of palliative care Silver Chain patients that die at home".

Further detail on the rationale for this palliative care service KPI has been provided in Table 17 below.

7.7.3. Patient Transport Services

The previous Service 'Patient Transport' has been incorporated into Service Six 'Public and Community Health'. However, visibility and transparency of patient transport services has remained through the continuation of the following effectiveness and efficiency KPIs:

- Effectiveness KPIs:
    - Response times for patient transport services delivered by St John's Ambulance (Percentage of priority 1 calls attended to within 15 minutes in the metropolitan area by St John's Ambulance Western Australia Ltd); and
    - Response times for patient transport services delivered by the Royal Flying Doctor Service (Percentage of Royal Flying Doctor Service (Western Operations) inter-hospital transfers meeting the state-wide contract target response time for priority 1 calls).

- Efficiency KPIs:
    - Cost per capita for patient transport provided by St John Ambulance Western Australia Ltd, based on the total accrued costs of these services for the estimated total population of Western Australia; and
    - Cost per capita for patient transport provided by the Royal Flying Doctor Service (Western Operations), based on the total accrued costs of these services for the estimated total population of Western Australia.

Both the effectiveness and efficiency KPIs have been previously reported as combined KPIs, however these have now been split into correspondence sets of separate KPIs to provide greater transparency with respect to the two different types of patient transport Services: Road Ambulance and Flying Doctor. Further details on the rationale for each of these patient transport service KPIs have been provided in Table 17 below.

7.7.4. Dental Health Services

Similarly to patient transport services above; the previous Service 'Dental Health Service' has been incorporated into Service Six 'Public and Community Health'. A concerted effort has been made to capture the statewide dental Services provided by WA Health to the public through the inclusion of OBM Framework KPIs that capture and measure the performance of the delivery of this key community-based service:

- Effectiveness KPI "The percentage of (a) adults and (b) children who have a tooth retreated within six months of receiving initial restorative dental treatment"; and
- Efficiency KPI "The average cost of WA Health provided dental health programs for (a) enrolled school children and (b) socio-economically disadvantaged adult patients".

Further detail on the rationale for each of these 'Dental Health Service' KPIs has been provided in Table 17.

7.7.5. Block Funded Small Rural Hospital Services

As a result of consultation with Treasury, a new effectiveness KPI to capture the diverse nature of Services delivered by small rural hospitals has been developed:

- "The percentage of patients who access emergency services at a small rural or remote Western Australian hospital and are subsequently discharged home".

This KPI will only be reported in the WACHS Annual Report. Further detail on the rationale for this KPI has been provided in Table 17 below.

7.7.6. System Manager KPIs

The revised WA Health OBM Framework includes Outcome Three and Service line Seven, both of which are new and capture the role of the Department as System Manager. As a result, all of the KPIs aligned to this Outcome and Service are new, and have not been submitted to Treasury previously.

A WA Agency, jurisdictional and international review was undertaken to determine a selection of potential System Manager KPIs for selection, aligned to the roles of the System Manager identified in the HSA. Notably, the Jurisdictional review and review of other WA Government Agencies with a System Manager role (largely central agencies) identified that the majority have workload based KPIs, which are not particularly meaningful to the public and parliament. WA Health has endeavoured to develop some higher level KPIs, and this has required consideration

of international jurisdictions such as the UK Department of Health and private health organisations such as St John of God and Ramsay healthcare.

In addition to the WA Agency, jurisdictional and international review, representatives from each of the Department work streams related to the role of the System Manager were consulted, and their views and feedback incorporated into the final suite of KPIs for the Department to report against its Annual Report.

It is envisaged that a review of the System Manager KPIs will occur at the close of the Reform Program 2015-2020, where a revised Strategic Intent and other key future state planning documents can be drawn upon.

7.7.7. Health Support Services KPIs

Aligned to the development of the revised OBM Framework, was the decision of Government through the mechanism of the HSA, that HSS would become its own entity as a separate statutory authority that is legally responsible for its employees and services it delivers from 1 July 2016. This amendment in legal status will provide better alignment with the broader WA Health governance changes and ensure HSS is legally accountable for its management and delivery of services. It will also provide clarity in roles and responsibilities of the Department as System Manager and funder of services, and HSS as a provider of services.

This change in the status of HSS created the need to have a separate Service Eight within the OBM Framework that captured the support services provided by HSS to the WA health system. The KPIs developed to measure the performance of HSS from both an effectiveness and efficiency perspective were drawn from existing internal performance measures, as well as a review of other support service-type Government Agencies. Alignment were possible has been made to the performance indicators contained in the Service Agreements between HSS and HSPs which broadly demonstrate HSS efficiency and the extent to which it is meeting service commitments to clients.

7.8. WA Health OBM Framework Key Performance Indicator Suite – KPIs to be continued, added and removed

Listed below in Table 17 is the detail behind each of the WA Health OBM Framework Key Performance Indicators, including which of the KPIs have been continued, added or removed. Additional information has been included for each KPI, including measurement, target, rationale and strategic alignment information.

It is critical to note that the targets for the KPIs are estimates only, and further work will be progressed internally to finalise the targets for the suite of 2017/2018 efficiency KPIs following the 2017/2018 GBS process and further engagement with the relevant data custodians for the effectiveness KPIs.

Table 17: WA Health OBM Framework Key Performance Indicator Suite – KPIs to be continued, added and removed

How to use this table:

- The numbering of the KPIs in the table below is based on the KPI numbering applied above in Figure 1 and Table 16 above, to ensure ease of use and consistency throughout this submission.
- A key is provided below to assist with terms used specifically within Table 17.
- KPIs in **black text** are existing annual report KPIs and KPIs in red text are indicators that are either completely new or are currently reported through other mechanisms but not in WA Health Annual Reports.

Key:

HSPR Health Service Performance Report
ROGS Report on Government Services
ACEM Australasian College of Emergency Medicine
PAF National Health Reform Performance and Accountability Framework
NHA National Healthcare Reform Agreement 2011

Indicator Title	Indicator Measure	Estimated Indicator Target	Indicator Rationale	Reporting Entities	Indicator Alignment
Key Effectiveness Indicators					
To be **continued:**					
1. Unplanned hospital readmission rates (Unplanned hospital readmissions of public hospital patients within 28 days for selected surgical procedures: (a) knee replacement; (b) hip replacement; (c) tonsillectomy & adenoidectomy; (d) hysterectomy; (e) prostatectomy; (f) cataract surgery; g) appendicectomy)		The target is based on the best result achieved within the previous five years. • Knee replacement: 2.5% • Hip replacement: 1.8% • Tonsillectomy & adenoidectomy: 5.5% • Hysterectomy: 3.0% • Prostatectomy: 3.2% • Cataract surgery: 0.3% • Appendicectomy: 3.3%	After a successful hospital stay, the most important task for WA public hospital patients and staff is preparing for a successful discharge home. Tracking the number of patients who experience unplanned readmissions to WA public hospitals within 28 days of selected surgical procedures, assists in assessing the quality of hospital services provided to the community. Unplanned readmissions are those readmissions where the principal diagnosis and readmission interval indicate that the readmission may be related to the care provided by the hospital in an index surgical episode of care. This indicator measures readmissions to any public hospital. Readmission rate is considered a global performance measure, as it potentially points to deficiencies in the functioning of the overall healthcare system. Good intervention, appropriate treatment together with good discharge planning will decrease the likelihood of unplanned hospital readmissions. A low unplanned readmission rate suggests that good clinical practice is in operation within our health system, and lessons can be learnt from a higher than target unplanned readmission rate through the creation of a variety of improvement strategies. The surgeries selected to be measured by this KPI have a risk associated with post-surgery complications. Good discharge plans can help to decrease the likelihood of unplanned hospital readmissions, by providing patients with the care instructions they need after a hospital stay and by helping patients recognise symptoms that may require immediate medical attention. However, it is important to note that unplanned hospital readmissions may or may not be related to the previous visit, and some unplanned readmissions are not preventable. **Note:** CAHS are only able to report tonsillectomy and adenoidectomy, cataract surgery and appendicectomy. This is due to the remaining indicators (knee replacement, hip replacement, hysterectomy and prostatectomy) are exceedingly rare (zero cases in more than 10 years). This will be noted within the CAHS annual report.	NMHS SMHS EMHS CAHS WACHS.	**OBM Outcome and Strategic Intent Alignment:** This KPI aligns to the components of Outcome 1 particularly the outcomes of access to public hospital based services and restorative health care. It also aligns to the Strategic Intent priority of Health Services. **State; National; International Alignment:** This indicator is reported by WA HSPs in the HSPR on a monthly basis through indicator "P2-7a-g: Unplanned hospital readmissions of patients discharged following management of: (a) knee replacement; (b) hip replacement; (c) tonsillectomy & adenoidectomy; (d) hysterectomy; (e) prostatectomy; (f) cataract surgery; (g) Appendicectomy". This KPI also has a strong alignment to the following national reported performance indicators: • PAF Safety & Quality: 6.2.1.4 Unplanned hospital readmission rates for patients discharged following management of: o Acute Myocardial Infarction; o Heart failure; o Knee and hip replacements; o Depression; o Schizophrenia; and o Paediatric tonsillectomy and adenoidectomy. • ROGS Safety and Quality indicator Table 11A.50: Unplanned hospital readmissions within 28 days of selected surgical admissions, 2012-13: o Knee replacement; o Hip replacement; o Tonsillectomy & Adenoidectomy; o Hysterectomy; o Prostatectomy; o Cataract surgery; and o Appendicectomy. • NHA Indicator P123: Unplanned hospital readmission rates (Unplanned and unexpected hospital readmissions to the same public hospitals within 28 days for selected surgical procedures).
2. Waiting times for emergency hospital care (Proportion of emergency	HSP performance against the Australasian College of Emergency Medicine (**ACEM**) recommendation	The following Australasian College of Emergency Medicine Triage category times are used for the calculation and reporting of emergency department wait	This indicator measures how effective WA public hospital emergency departments are at the starting point of the patient care journey. It captures the percentage of patients treated within the timeframes recommended by the Australasian College for Emergency Medicine.	NMHS SMHS EMHS	**OBM Outcome and Strategic Intent Alignment:** The proposed KPI aligns to the components of Outcome 1, particularly with respect to the ability to access public hospital based services. It also aligns to the Strategic Intent priority of

Indicator Title	Indicator Measure	Estimated Indicator Target	Indicator Rationale	Reporting Entities	Indicator Alignment
department patients seen within recommended times: (a) % Triage Category 1 (2 minutes); (b) % Triage Category 2 (10 minutes); (c) % Triage Category 3 (30 minutes); (d) % Triage Category 4 (60 minutes); (e) % Triage Category 5 (2 hours))	that all patients are seen within the benchmarked time for Triage 1, 2, 3, 4 & 5. Emergency department waiting times by triage category is calculated by subtracting the time at which the patient presents at the emergency department (that is, the time at which the patient is clerically registered or triaged, whichever occurs earlier) from the time of commencement of service by a treating medical officer or nurse. Patients who do not wait for care after being triaged or clerically registered are excluded from the data.	times and seen within recommended times performance indicators by the Department of Health, Western Australia, locally and by the Department of Health and Ageing (DOHA) and the Australian Institute of Health and Welfare (AIHW) nationally: • 100% of all Triage 1 patients should be seen immediately (within seconds) (a time interval of less than or equal to 2 minutes is used to identify those Triage 1 patients seen within time) • 80% of all Triage 2 patients should be seen within 10 minutes • 75% of all Triage 3 patients should be seen within 30 minutes • 70% of all Triage 4 patients should be seen within 60 minutes • 70% of all Triage 5 patients should be seen within 120 minutes.	The higher the percentage, the better the performance; timely treatment in emergency department appropriate to triage category ensures patients receive appropriate further treatment and restorative care in WA public hospital emergency departments. The performance of each HSP against this KPI will assist in monitoring and driving improvements in patient access to emergency department treatment within clinically recommended treatment times. It is acknowledged that this KPI is unlikely to be accepted by the OAG as an auditable effectiveness KPI. However WA Health believes that this indictor represents information that is of great public interest both within WA and on a national level, therefore this indicator will be included in Annual Reports as additional performance information if it cannot be considered to be an auditable KPI.	CAHS WACHS.	Health Services. **State; National; International Alignment:** A similar indicator to this proposed KPI is reported to the WA public through the "our hospitals and health services performance indicators (**OHHS**): "Emergency department waiting times - the percentage of patients seen within recommended times within a given triage category compared to the National Target". The exact same indicator is also reported by HSPs on a monthly basis through the internal performance mechanism of the HSPR: "P2-3a-e: Proportion of emergency department patients seen within recommended times a) % Triage Cat 1 – 2 mins; b) % Triage Cat 2- 10min; c) % Triage Cat 3- 30 min; d) % Triage Cat 4- 60 min; e) % Triage Cat 5- 2 hours. The information captured by this KPI is also reported at a national level through the following mechanisms: • PAF Equity and Effectiveness Indicator: 6.2.3.3 Percentage of Emergency Department patients transferred to a ward or discharged within four hours, by triage category; and ROGS Access Indicator Table 11.2: Emergency department waiting times - Proportion of patients seen on time (per cent). • NHA Indicator PI 21a–Waiting times for emergency hospital care: Proportion seen on time (Percentage of patients who are treated within national benchmarks for waiting times for each triage category in public hospital emergency departments).
3. Elective surgery waiting times (Proportion of all elective patients on the wait list whose waiting time is over the clinically recommended time for their urgency category at census date, reported by urgency category and reportable status)		The target was set by WA Health (approved by SHEF 29 January 2016). The targets are: • Reportable cases 0% • Non-Reportable cases 15%	Reportable status is defined as: • Reportable cases, namely all waiting list cases that are not listed on the Elective Surgery Wait List excluded procedures list. This list is consistent with the Australian Institute of Health and Welfare (AIHW) excluded procedures list. It also includes additional procedure codes that are intended to better reflect the procedures identified in the AIHW excluded procedures list. • Non-reportable cases, namely all cases that are on the Elective Surgery Wait List excluded procedures list. Including both reportable and non-reportable cases is important as it: • Ensures the reportable status of the procedure does not confer advantage to either type, e.g. that non-reportable procedures are not postponed to facilitate completion of reportable procedures that would otherwise go over-boundary. • Gives greater coverage to rural areas of WA, where regional and district hospitals provide a significant number of diagnostic scope procedures that are classified as non-reportable. A number of these are diagnostic procedures that are essential to identifying health conditions that may go on to be reportable procedures (e.g. bowel resection for cancer). On 1st April 2016, WA Health introduced a new statewide performance target for the provision of elective services. The State Health Executive Forum (SHEF) approved the target on 29 January 2016. The new target requires no patients (0%) on the elective waiting lists wait longer than the clinically recommended time for their procedure, according to their urgency category. For non-reportable wait listed procedures, the target is incremental, with the aim of	NMHS SMHS EMHS CAHS WACHS.	**OBM Outcome and Strategic Intent Alignment:** This KPI aligns to all of the components of Outcome 1; particularly with respect to outcome of all Western Australians have access to services. It also aligns to the Strategic Intent priority of Health Services. **State; National; International Alignment:** This indicator is reported publically through the following OHHS indicator: WEST – the percentage of elective surgery patients treated within recommended times within a given urgency category. In addition, HSPs already capture and report this performance information on a monthly basis to the Department through the HSPR P2-2a through to c "Elective surgery patients treated within boundary times a) % Cat 1 < 30 days; b) % Cat 2 < 90 days; c) % Cat 3 <365 days". From 2017/2018 onwards HSPs will report this exact KPI in the HSPR, creating a one to one reporting alignment. This KPI also aligns to the following nationally reported indicators: • PAF Equity and Effectiveness: 6.2.3.4 Elective surgery patient waiting times by urgency category. • ROGS Access Indicator Table 11.3: Elective surgery waiting times: Number of days waited. • NHA Indicator PI 20b: Waiting times for elective surgery: proportion seen on time (The percentage of patients removed from elective surgery waiting lists who received

Indicator Title	Indicator Measure	Estimated Indicator Target	Indicator Rationale	Reporting Entities	Indicator Alignment
			achieving 0% over boundary cases on waiting lists by 2018. **Note:** This KPI will be included as new in WA Health's 2016/2017 KPI submission to Treasury, and this is why it has been treated as being continued for the purposes of this submission for 2017/2018 KPIs.		surgery within the clinically recommended time, by urgency category).
4. Percent of contacts with community-based public mental health non-admitted services within seven days post discharge from public mental health inpatient units		In May 2011 a target of 75% achievement was endorsed by the Australian Health Ministers' Advisory Council (AHMAC) Mental Health Standing Committee and has been adopted by WA Health.[10] This target will be subject to periodic review and will be further informed by analysis of the data. A higher percent of contacts would be an indication of good performance, as this would result in a reduced likelihood of avoidable readmissions.	The 2007 National Survey of Mental Health and Wellbeing found that an estimated 3.2 million Australians aged between 16 and 85 years had a mental disorder. Therefore, it is crucial to ensure effective and appropriate care is provided not only in a hospital setting but also in the community. Discharge from hospital is a critical transition point in the delivery of mental health care. People leaving hospital after an admission for an episode of mental illness have heightened levels of vulnerability and, without adequate follow up, may relapse or be readmitted. This KPI measures the performance of the overall health system in providing continuity of mental health care. A responsive community support system for persons who have experienced a psychiatric episode requiring hospitalisation is essential to maintain their clinical and functional stability and to minimise the need for hospital readmissions. Patients leaving hospital after a psychiatric admission with a formal discharge plan, involving linkages with public community based services and support, are less likely to need avoidable readmission. The standard underlying the measure is that continuity of care involves prompt community follow up in the vulnerable period following discharge from hospital. Overall, the variation in post-discharge follow up rates suggests important differences between mental health systems in terms of their practices.	NMHS SMHS EMHS CAHS WACHS.	**OBM Outcome and Strategic Intent Alignment:** Outcome 1 **-** Western Australians have access to public hospital based services that enable treatment and restorative health care. It also aligns to the Strategic Intent priority of Health Services via the mental health stream. **State; National; International Alignment:** This exact KPI is also reported by the MHC in its Annual Reports, however performance differs as this is from a purchaser perspective, whereas the WA Health KPI is from a provider perspective. From a national perspective, this KPI aligns to the following indicator which was highlighted in the National Mental Health Report 2013 as a key indicator[11] and aligns to National Health Agreement Indicator 25 "Rate of community follow up within first seven days of discharge from a psychiatric admission". There is also a strong alignment to PAF Safety & Quality indicator: 6.2.1.7 Rate of community follow up within the first seven days of discharge from a psychiatric admission. Additionally, this indicator was adopted as a national KPI for Australian public mental health services in 2005, incorporated in the COAG Action Plan as a 'progress measure' for monitoring outcomes of the Plan and, with some modification to the specifications, continued as an indicator under the 4th National Mental Health Plan.
14. Percentage of transition care clients whose functional ability was either maintained or improved during their utilisation of the Transition Care Program	This KPI compares admission and discharge results from the Modified Barthel Index (**MBI**) (used to assess changes in self-are and mobility activities of daily living) and determines the percentage of discharges where clients demonstrate maintained or improved MBI results.	There is currently no existing national target for this indicator. As such, a target of 65% has been set by the Subacute, Community and Aged Care Directorate, Department of Health WA. The target of 65% is based upon historical data trends. A greater percentage of transition care clients with stable or improved functional ability than the target would indicate good performance.	The wording of this current KPI has been slightly amending from the current title of "Percentage of clients maintaining or improving functional ability while in transition care". The amendment to the title has been to increase its meaningfulness and readability for end users of annual reports. The Transition Care Program is a joint Federal, State and Territory initiative that aims to optimise the functioning and independence of older people after a hospital stay and enable them to return home rather than prematurely enter residential care. TCP services take place in either a residential or a community setting, including in a client's home. A number of care options are available, designed to be flexible in helping meet each person's needs. Services may include: • case management, including establishing community support and services and, where required, identifying residential care options • medical services provided by a GP • low intensity therapy such as physiotherapy and occupational therapy • emotional support and future care planning via a social	DoH	**OBM Outcome and Strategic Intent Alignment:** This KPI aligns to the components of Outcome 2: Western Australians have access to prevention, health promotion and aged and continuing care services to live healthy and safe lives. It also aligns to the Strategic Intent priority of Prevention and Community Care Services and enabler of Partnerships. **State; National; International Alignment:** N/A

[10] More information can be accessed at this link: http://www.health.gov.au/internet/main/publishing.nsf/content/1ED20240320A3A11CA257D9B007B31C6/$File/mea333.pdf

[11] Australian Government Department of Health, National mental health report 2013, section 3.4.

Indicator Title	Indicator Measure	Estimated Indicator Target	Indicator Rationale	Reporting Entities	Indicator Alignment
			worker • nursing support • personal care • domestic help • other therapies as required. This KPI measures the effectiveness of the Transition Care program through measuring functional ability improvements in clients utilising the Transition Care program. Monitoring the success of this KPI can enable improvements in service planning and the development of targeted strategies and interventions that focus on improving the program's effectiveness, and ensuring the provision of the most appropriate care to those in need. This enhances the health and wellbeing of elderly Western Australians.		
15. Childhood immunisation (Percentage of children fully immunised at 12-15 months: a) Aboriginal; b) Total)	This indicator is a population based measure used to assess the immunisation coverage among children of a particular age cohort: 12-15, months as registered in the Australian Childhood Immunisation Register who have received age appropriate immunisations. One age cohort is chosen to represent overall coverage among children. A child is assessed as fully immunised at 12 months of age (12-15 months) if they have received age appropriate immunisations against diphtheria, tetanus, pertussis, polio, pneumococcal, haemophilus influenza B and hepatitis B.	The target for this KPI is 90%. This target is established on the National Partnership Agreement on Essential Vaccines.[12] A target of 90% is set in the agreement through review of the following sources: • Australian Childhood Immunisation Register; • The States Immunisation registers; and • National Centre for Immunisation, Research and Surveillance Coverage Reports.	This KPI links to WA Health's commitment to the National Partnership Agreement on Essential Vaccines, which aims to minimise the incidence of major vaccine preventable diseases in Australia. The KPI measures the percentage of fully immunised children that have received age appropriate immunisations in order to facilitate the effectiveness of health promotion strategies that aim to reduce the overall incidence of potentially serious disease. One age cohort is chosen to represent overall coverage among children. Immunisation is a simple, safe and effective way of protecting people against harmful diseases before they come into contact with them in the community. Immunisation not only protects individuals, but also others in the community, by reducing the spread of disease. Without access to immunisation, the consequences of any illness or disability are likely to be more disabling and more likely to contribute to a premature death. CAHS does not report this indicator, as it is based on the child's residential postcode rather than the provider. CAHS by definition, services a prescribed cohort of the WA population (i.e. children and adolescents). Unlike the other HSPs, the scope of CAHS activities is not prescribed on the basis of geographical regions.	DoH	**OBM Outcome and Strategic Intent Alignment:** This KPI aligns to the components of Outcome 2: Western Australians have access to prevention, health promotion and aged and continuing care services to live healthy and safe lives. It also aligns to the Strategic Intent priority of Prevention and Community Care Services and Aboriginal Health Services. **State; National; International Alignment:** This indicator is reported by HSPs through HSPR indicator "P1-2a&b "Childhood immunisation: percentage of children fully immunised at 12-15 months: a) Aboriginal b) Total"." This KPI aligns to the strategic policy document of the *WA Health Immunisation Strategy 2016-2020* and its related Key Performance Indicator of "Vaccination coverage rates in WA children 12–15 months old consistently". At a national level this information is reported as part of the Intergovernmental National Partnership Agreement on Essential Vaccines between the Commonwealth and all Australian States.
16. Loss of life from premature death due to identifiable causes of preventable disease or injury: (a) Lung cancer; (b) Ischaemic heart disease; (c) Falls; (d) Melanoma	Potential Years of Life Lost per 1,000 head of population for selected preventable diseases and injury. The formula is calculated via sum of the years from age of death to age 74 years and adjusted by all-cause deaths for the likelihood of death from another cause during this period for each death identified for each condition, per 1,000 head of population and age-standardised.	There is currently no existing national target for this indicator. As such, the targets are set by the Epidemiology Branch, Public Health Department of Health WA. Targets are based on national figures from the most recent and complete National Potential Years of Life Lost per 1,000 population estimates, derived from data provided by the ABS.	This KPI measures the potential years of life lost for the most common causes of these premature deaths, which is one of the most important means of monitoring and evaluating the effectiveness, quality and productivity of health systems. WA Health aims to reduce the loss of life from preventable disease or injury, through the application of existing public health or medical interventions. The potential years of life lost from premature death are measured for falls, ischaemic heart disease, melanoma and lung cancer. These conditions contribute significantly to the burden of disease and injury within the community and are considered National Health Priority Areas. The data obtained from this KPI assists health system managers to best determine effective and quality targeted promotion and prevention initiatives, which in turn reduce the loss of life from these preventable conditions.	DoH	**OBM Outcome and Strategic Intent Alignment:** This KPI aligns to the components of Outcome 2: Western Australians have access to prevention, health promotion and aged and continuing care services to live healthy and safe lives. It also aligns to the Strategic Intent priority of Prevention and Community Care Services and Chronic Disease Services. **State; National; International Alignment:** N/A

[12] More information on this agreement can be accessed here: http://www.federalfinancialrelations.gov.au/content/npa/health_payments/essential_vaccines/national_partnership.pdf

Indicator Title	Indicator Measure	Estimated Indicator Target	Indicator Rationale	Reporting Entities	Indicator Alignment
17. The percentage of clients who are discharged from the WA Quadriplegic Centre back into the community		The target for this KPI is 50%. This target is based on historical data.	There is increased emphasis on the WA Quadriplegic Centre to provide transitional care for patients from the State Spinal Unit to: • Facilitate the early discharge of patients from the Tertiary Hospital. • Continue clinical management and post-acute rehabilitation. • Prepare patients for community integration whilst awaiting funding applications for community care. This KPI reflects the commitment and intent of the WA Quadriplegic Centre to ensure as many eligible clients as possible receive continuing care services the enable them to be discharged back home into the community.	QUAD	**OBM Outcome and Strategic Intent Alignment:** This KPI aligns to the components of Outcome 2; particularly Western Australians have access to continuing care services to live healthy and safe lives. It also aligns to the Strategic Intent priorities of Prevention and Community Care Services and Health Services. **State; National; International Alignment:** N/A
18. The percentage of active clients with pressure areas / burns treated by the WA Quadriplegic Centre's Community Nursing Service		The target for this KPI is 85%. This target is based on historical data.	The cost of treating pressure related ulcers/burns in tertiary settings are substantial each year. Early and timely community intervention, as provided by the WA Quadriplegic Centre's Community Nursing Service, reduces and in many cases negates the necessity for hospitalisation, thereby reducing the overall impact of a client's injury and the high preventable cost of care in a tertiary or sub-acute hospital. This KPI will measure the successful treatment and support of clients in the home, which in turn reduces both the incidence severity and cost associated with acute tertiary admissions.	QUAD	**OBM Outcome and Strategic Intent Alignment:** This KPI aligns to the components of Outcome 2; particularly Western Australians have access to continuing care services to live healthy and safe lives. It also aligns to the Strategic Intent priorities of Prevention and Community Care Services and Health Services. **State; National; International Alignment:** N/A
19. Response times for patient transport services delivered by St John Ambulance (Percentage of priority 1 calls attended to within 15 minutes in the metropolitan area by St John Ambulance Western Australia Ltd)	**Note:** This KPI was previously combined and reported as "a) Percentage of priority 1 calls attended to within 15 minutes in the metropolitan area by St John Ambulance Western Australia Ltd (SJA-WA) b) Percentage of Royal Flying Doctor Service (Western Operations) (RFDS) inter-hospital transfers meeting the statewide contract target response time for Priority 1 calls." This existing KPI has now been split out to isolate the two different Services and related performance.	The target for this KPI is 90% as this is the target defined in the WA Health Service Agreements with St John Ambulance Western Australia Ltd. Targets values are to be provided by the data providers (contract managers) each reporting year.	To ensure Western Australians receive the care and medical transport services they need, when they need it, the Department has entered into a contractual relationship with St John Ambulance Western Australia Ltd to deliver road based patient transport services to the WA public. This collaboration ensures that patients have access to an effective and rapid response ambulance service to ensure the best possible health outcome for patients requiring urgent medical treatment. Response times for patient transport services have a direct impact on the speed with which a patient receives appropriate medical care and provide a good indication of the effectiveness of road based patient transport services delivered to the WA public. It is understood that adverse effects on patients and the community are reduced if response times are decreased. This KPI measures the response of patient transport services provided within the metropolitan areas of WA to patients with the highest need (priority 1) of urgent medical treatment. Through surveillance of this measure over time, the effectiveness of patient transport services can be determined. This facilitates further development of targeted strategies and improvements to operational management practices aimed at ensuring optimal restoration to health for patients in need of urgent medical care. This KPI will only be reported in the DoH annual report as they are the budget holder and contract manager for St John Ambulance services.	DoH	**OBM Outcome and Strategic Intent Alignment:** This KPI aligns to the components of Outcome 2, particularly with respect to the ability of all Western Australians to have access to effective patient transport services. It also aligns to the Strategic Intent priority of Health Services and enablers of Partnerships and Accountability. **State; National; International Alignment:** There is a national alignment with the following related ROGS indicator "Urban centre response times". Response times are defined as the time taken between the arrival of the first responding ambulance resource at the scene of an emergency code 1 incident and the initial receipt of the call for an emergency ambulance at the communications centre. Urban centre response times applied for each jurisdiction's capital city – boundaries are based on the ABS Urban Centres Localities structure. Code 1 incidents are those requiring at least one immediate response under lights and sirens. Measures are provided for the 50th and 90th percentile. The proposed effectiveness indicator is different to the ROGS KPI in that it provides a percentage of all calls attended to, rather than 50th and 90th percentile measures.
20. Response times for patient transport services delivered by the Royal Flying Doctor Service (Percentage of Royal Flying Doctor Service (Western Operations) inter-hospital transfers meeting the state-wide contract target response time	**Note:** This KPI was previously combined and reported as "a) Percentage of priority 1 calls attended to within 15 minutes in the metropolitan area by St John Ambulance Western Australia Ltd (SJA-WA) b) Percentage of Royal Flying Doctor Service (Western Operations) (RFDS) inter-hospital	The target for this KPI is 80% as this is the target defined in the WA Health Service Agreements with Royal Flying Doctor Service (Western Operations).	To ensure Western Australians receive the care and medical transport services they need, when they need it, the Department has entered into a contractual relationship with Royal Flying Doctor Service (Western Operations) to deliver patient transport services to the WA public. This collaboration ensures that patients have access to an effective aeromedical and inter-hospital patient transfer service to ensure the best possible health outcomes for patients requiring urgent medical treatment through rapid response. Response times for patient transport services have a direct impact on the speed with which a patient receives appropriate medical care and provide a good indication of the efficiency and effectiveness of patient	WACHS	**OBM Outcome and Strategic Intent Alignment:** This KPI aligns to the components of Outcome 2: Western Australians have access to prevention, health promotion and aged and continuing care services to live healthy and safe lives. It also aligns to the Strategic Intent priority of Health Services and enabler of Partnerships and Accountability. **State; National; International Alignment:** N/A

Indicator Title	Indicator Measure	Estimated Indicator Target	Indicator Rationale	Reporting Entities	Indicator Alignment
for priority 1 calls)	transfers meeting the statewide contract target response time for Priority 1 calls." This existing KPI has now been split out to isolate the two different Services and related performance.		transport services. It is believed that adverse effects on patients and the community are reduced if response times are decreased. Through surveillance of this measure over time, the effectiveness of patient transport services can be determined. This facilitates further development of targeted strategies and improvements to operational management practices aimed at ensuring optimal restoration to health for patients in need of urgent medical care. This KPI captures all contracted RFDS services and excludes the patient assisted travel costs of airfares, car hire, taxis which are captured as part of intra-hospital transfers, and do not relate to this KPI. This KPI will only be reported in the WACHS annual report as they are the budget holder and contract manager for RFDS services.		
To be **added:**					
5. Hospital infection rates (Healthcare-associated *Staphylococcus aureus* bloodstream infection (HA-SABSI) per 10,000 occupied bed-days in public hospitals)	Rate of healthcare-associated Staphylococcus aureus (including methicillin-sensitive and methicillin-resistant Staphylococcus aureus (MSSA and MRSA)) bloodstream infection. This rate reflects both admitted and non-admitted patients. The scope of this KPI includes all metropolitan and rural acute care public hospitals including one acute care mental health hospital and excluding rural hospitals categorised as small hospitals. Private hospitals and private hospitals contracted to provide services to public patients are excluded.	The target for this KPI is <1.0 per 10,000 occupied bed days. The target has been set based on the WA Metropolitan tertiary hospital aggregate - Established for the HSPR 2014-15 in consultation with Communicable Disease Control.	*Staphylococcus aureus* bacteraemia (**SAB**) is a serious bloodstream infection (sometimes called 'golden staph') that may be associated with hospital care. SAB causes significant illness and serious complications which frequently result in prolonged hospital stays and increased healthcare costs. Individuals cannot be a long term carrier of SAB. SAB is a highly pathogenic organism even with advanced medical care, and once in your bloodstream it is associated with a marked increase in morbidity and mortality – mortality estimated at 20-25%. There are National definitions used to determine if a SAB event is healthcare or community acquired and they include criteria for patients who may be receiving care as an outpatient or hospital in the home or as a day case. These definitions will be utilised when calculating this KPI to isolate events of SAB within an admitted hospital setting. Once a patient acquires a SAB it would be extremely rare for them not to be admitted to hospital for care. This KPI has been selected for inclusion as it is a robust KPI of the safety and quality of WA public hospitals, and aligns to the principle of increased transparency and accountability of performance information provided to the public. A low or decreasing healthcare-associated infections rate is desirable.	NMHS SMHS EMHS CAHS WACHS.	**OBM Outcome and Strategic Intent Alignment:** This KPI aligns to all of the components of Outcome 1: Western Australians have access to public hospital based services that enable treatment and restorative health care. It also aligns to the Strategic Intent priority of Health Services. **State; National; International Alignment:** This KPI is reported publically on WA Health's OHSS website through the following OHHS indicator: SAB. Further, HSPs already capture and report this performance information on a monthly basis to the Department through the HSPR Indicator P2-4 Healthcare-associated *Staphylococcus aureus* bloodstream infections (HA-SABSI) per 10,000 occupied bed-days. This KPI also aligns to the following nationally reported indicators: • PAF Safety & Quality: 6.2.1.5 Healthcare-associated *Staphylococcus aureus* (including MRSA) bacteraemia. • ROGS Indicator Table 11A.53: Episodes of SAB (including MRSA) in acute care hospitals, by MRSA and MSSA. • NHA Indicator PI 22: Healthcare-associated infections: SAB associated with acute care public hospitals (excluding cases associated with private hospitals and non-hospital care)). • The Australian Government's MyHospitals website, which is managed by the National Health Performance Authority, reports SAB infections as counts and rates per 10 000 patient days under surveillance for most public hospitals and a number of private hospitals.
6. Hospital standardised mortality ratio (Percentage of WA public hospitals who are rated as performing or highly performing in	This KPI will measure the percentage of WA public hospitals that are considered performing or highly performing as determined by the ratio target.	The target for this KPI is 100% of facilities rated as Performing or Highly Performing. The hospital standardised mortality ratio (**HSMR**) facility target source is provided by the Australian Commission on Safety and Quality in Health Care	The HSMR indicator was recommended by the Australian Commission on Safety and Quality in Health Care for inclusion in a core set of national KPIs measuring the safety and quality of hospital care[13] (note that WA Health can only measure this KPI for WA public hospitals). HSMRs are intended as an overall measure of deaths in hospital, a proportion of which will be preventable. High ratios may suggest potential problems with quality of care.	NMHS SMHS EMHS WACHS.	**OBM Outcome and Strategic Intent Alignment:** This KPI aligns to all of the components of Outcome 1: Western Australians have access to public hospital based services that enable treatment and restorative health care. It is reflective of the overall Australian government objective that Australians are born and remain healthy. It also aligns to the Strategic Intent priority of Health Services.

[13] Australian Commission on Safety and Quality in Health Care. Update. Issue 10, Mar 2010. Sydney: ACSQHC, 2010. http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/C6E96E608654099 CCA257753001ECA1A/$File/Issue-10.pdf (accessed May 2011).

Indicator Title	Indicator Measure	Estimated Indicator Target	Indicator Rationale	Reporting Entities	Indicator Alignment
comparison to their national peers for the ratio of observed and expected numbers of hospital separations that result in the patient's death)	The ratio comparing the observed number of hospital separations that result in the patient's death, with the number of separations expected to result in death, based on the patients' risk profile and National all hospital (public and private) model. The size of hospital and the number of separations within the same peer group may vary. Smaller hospitals with fewer separations are more likely to have wider confidence intervals than larger hospitals. This may affect the precision of estimating the current thresholds.	(ACSQHC). National Hospital Morbidity Database is used by ACSQHC to derive national coefficients and national peer group means. National coefficients are then applied to WA Hospital Morbidity Data System Data by Epidemiology to create WA specific data as an equivalent measure of the National core hospital-level outcome indicator recommended by the ACSQHC. A Health Service performance score of 100% indicates that all of the Health Service Provider's facilities have a HSMR which is considered to be equivalent to or better than the relevant National Peer Rate. A Health Service performance score of less than 100% indicates that at least one of the Health Service provider's facilities has a HSMR which is considered higher than the relevant NPR. In these circumstances, the Facility level data should be examined to determine the facility/facilities in question.	It is important to understand that this KPI is utilised as a screening tool, rather than a definitive indication of poor safety and quality. Poor performance against this KPI by a HSP will prompt further investigation, whilst at the same time lessons may be learnt from good performance against this KPI. Comparing mortality and life expectancy data across populations, with consideration for factors such as cause, age, sex, population group and geographical distribution, can provide important insights into the overall health of Australians.[14] Trends over time in mortality and life expectancy data can signal changes in the health status of the population, as well as provide a baseline measurement of the effectiveness of the WA health system. CAHS will not be reporting this KPI as there is currently no established method (national or international) to calculate paediatric specific HSMR. This is an area of ongoing development by several Australian groups such as AIHW and the University of Melbourne.		**State; National; International Alignment:** HSPs already capture and report this performance information on a monthly basis to the Department through the HSPR indicator P2-11 "Hospital standardised mortality ratio". At a national level this KPI also aligns to the following indicators: • PAF Safety & Quality: 6.2.1.3 In hospital mortality rates for: o Acute myocardial infarction; o Heart failure; o Stroke; o Fractured neck of femur; and o Pneumonia. • ROGS Indicator Table E.3: Age-standardised mortality rates by major cause of death (deaths per 100 000 people). In the United Kingdom, Canada, the Netherlands and the United States, HSMRs have been used for several years within organisations to monitor performance and response to various quality and safety programs. In the UK and Canada HSMRs is also publicly reported and used to compare performance between hospitals.[15]
7. The rate of total hospital readmissions within 28 days to an acute designated mental health inpatient unit	The proportion of in-scope overnight public patient separations from the mental health service organisations' acute psychiatric inpatient units, which are followed by readmission to the same or to another designated acute psychiatric inpatient unit within 28 days of discharge. An acute psychiatric inpatient unit is defined as services that provide voluntary and involuntary short-term inpatient management and treatment during an acute phase of mental illness, until the person has recovered enough to be treated effectively and safely in the community.	The target for this indicator is 12%. The target comes from the Fourth National Mental Health Plan (May 2011) produced by the Mental Health Information Strategy Subcommittee, Australian Health Minister's Advisory Council (AHMAC), Mental Health Standing Committee. The scope of 28 days for this indicator has been set and endorsed by the AHMAC Mental Health Standing Committee (as at 24 March 2011).	Readmission rate is considered to be a global performance measure as it potentially points to deficiencies in the functioning of the overall mental health care system. While multiple hospital admissions over a lifetime may be necessary for someone with ongoing illness, a high proportion of unplanned readmissions shortly after discharge may indicate that inpatient treatment was either incomplete or ineffective, or that follow-up care was inadequate to maintain the person out of hospital. These readmissions necessitate patients spending additional time in hospital and utilise additional resources. A low unplanned readmission rate suggests that good clinical practice is in operation. This indicator is reported at the facility at which the initial admission occurred rather than the facility at which the patient was readmitted. By measuring and monitoring this indicator key areas for improvement can be identified. This in turn can facilitate the development and delivery of targeted care pathways and interventions, which can aim to improve mental health and quality of life of Western Australians.	NMHS SMHS EMHS CAHS WACHS.	**OBM Outcome and Strategic Intent Alignment:** This KPI aligns to all of the components of Outcome 1: Western Australians have access to public hospital based services that enable treatment and restorative health care. It also aligns to the Strategic Intent priority of Health Services. **State; National; International Alignment:** This exact KPI is also reported publically through the following OHHS indicator: Mental Health Readmissions within 28 days – the rate of total hospital readmissions within 28 days to an acute designated mental health inpatient unit. It also aligns with the MHC key effectiveness indicator "Readmission to hospital within 28 days of discharge" reported in its Annual Report. Through this alignment the WA public will have both a purchaser and provider viewpoint on the same KPI. Additionally, HSPs capture and report this performance information on a monthly basis to the Department through the HSPR indicator p2-12 "Rate of total hospital readmissions within 28 days to an acute designated mental health inpatient unit". Similar indicators are reported on a national level in: • PAF Safety & Quality Indicator: 6.2.1.4 "Unplanned hospital readmission rates for patients discharged following management of: [conditions including] depression; schizophrenia"; and • ROGS Indicator Volume E Health, Chapter 12 Mental Health Management, Indicator – "Readmissions to hospital within 28 days of discharge".
8. The percentage of	The percentage of	The target for this KPI is still under	WA Health public hospitals employ a range of initiatives to ensure the	NMHS	**OBM Outcome and Strategic Intent Alignment:**

[14] AIHW 2013d.
[15] Institute of Healthcare Improvement. Move your dot. Measuring, evaluating and reducing hospital mortality rates (Part 1). Boston: IHI, 2003; Canadian Patient Safety Institute. Targeted Interventions. Safer Healthcare Now! Edmonton: CPSI, 2006. http://www.saferhealthcarenow.ca/EN/Pages/default.aspx (accessed May 2011).

Indicator Title	Indicator Measure	Estimated Indicator Target	Indicator Rationale	Reporting Entities	Indicator Alignment
admitted Aboriginal and Non-Aboriginal patients who left against medical advice	admitted patients who ended in discharge against medical advice during the reporting period. This indicator is analysed and reported by: a) Percentage of all admitted separations for Aboriginal patients who were left against medical advice b) Percentage of all admitted separations for non-Aboriginal patients who were left against medical advice.	development. It will also be reported in the HSPR, and is due to start being reported by HSPs through the HSPR in September 2016. Accordingly a target will need to be finalised for the HSPR and then picked up by the Annual Report KPI by September, and this information can be provided upon request at this point in time.	delivery of culturally secure health services to Aboriginal people. The inclusion of this new KPI will assist in measuring the success of these initiatives. A high percentage reported for this KPI will reflect the need for improved responses by the health system to the needs of Aboriginal patients and provides a measure of the quality of the services provided. Discharge against medical advice has been found to cost the health system 50% more than the cost of patients who are discharged by physicians.[16] Published data contends that high DAMA rates reflect the need for improved responses by the health system to the needs of Aboriginal patients and provides a measure of the safety, quality and cultural security of the services provided. Monitoring this indicator will enable identification of performance improvement opportunities, as well as the collaborative and effective addressing of the underlying factors in achieving an equitable treatment outcome for Aboriginal patients.	SMHS EMHS CAHS WACHS.	This KPI aligns to all of the components of Outcome 1: Western Australians have access to public hospital based services that enable treatment and restorative healthcare. It also aligns to the Strategic Intent priority of Health Services. **State; National; International Alignment:** The information captured and measured by this indicator is also reported from an overall state perspective as part of the *Aboriginal and Torres Strait Islander Health Performance Framework 2014* which monitors progress in Aboriginal and Torres Strait Islander health outcomes, health system performance and the broader determinants of health.
21. The percentage of people accessing community-based palliative care to assist them to die at home		The target for this KPI is 68%, taken from the End of Life Framework WA Health 2016. The End of Life Framework states that "Dying in Australia is more institutionalised than in the rest of the world, with 50 percent of Australians dying in hospitals, despite 68% indicating a preference to die at home". The target for this KPI represents that the proportion of the Western Australian population who have a preference to die at home have been able to do so.	The wish of Australians to die in their home and not in a hospital has been well documented, with Seventy per cent of people want to die at home, yet only about 14 per cent do so.[17] Reflecting the wishes of the WA community, WA Health has developed an End of Life Framework which is a state-wide model for the provision of comprehensive, coordinated care at end-of-life in WA. There is a strong rationale for WA Health to assist people with their request to die at home as approximately one-third of all people who die in hospital will have only one admission – the one in which they die – at an estimated cost of $19,000 for those aged 50 and over. [18] This KPI will measure the WA Health systems implementation of the End of Life Framework and other initiative, which reflects the increasing importance of this issue, given the ageing demographic projected for WA.	DoH	**OBM Outcome and Strategic Intent Alignment:** This KPI aligns to the components of Outcome 2; particularly Western Australians have access to continuing care services to live healthy and safe lives. It also aligns to the Strategic Intent priority of Prevention and Community Care Services and enabler of Partnerships. **State; National; International Alignment:** N/A
22. Participation rate of women aged 50 – 69 years who participate in breast screening ((a) Indigenous women; (b) Non-Indigenous women)	The participation rate of women aged 50 – 69 years who participate in screening in the most recent 24-month period: a) Indigenous women; and b) Non-Indigenous women.	The target for this KPI is ≥70%. The source of this target is the National Accreditation Standards (NAS) Annual Data Report measure 1.1.1(b). This target is applicable for all women in the age cohort, regardless of indigenous, socio-economic or linguistic status.	BreastScreen Australia aims to reduce illness and death resulting from breast cancer through organised screening to detect cases of unsuspected breast cancer in women, thus enabling early intervention which leads to increased treatment options and improved survival. It has been estimated that breast cancer detected early is considerably less expensive than when the tumour is discovered at a later stage. Mass screening using mammography can improve early detection by as much as 15-35%.[19] High rates reported against this KPI will reflect the efficient use of the physical infrastructure and specialist staff resources required for the population based breast cancer screening program. High rates will also be an indication of a sustainable health system as early detection reduces the cost to hospital services at the later stages of a patient's journey. This KPI will be reported in the NMHS Annual Report only, as they receive the budget to provide this State wide service. Performance against this KPI is not able to be disaggregated by HSP entity.	NMHS	**OBM Outcome and Strategic Intent Alignment:** This KPI aligns to the components of Outcome 2; particularly Western Australians have access to prevention services to live healthy and safe lives. It also aligns to the Strategic Intent priority of Prevention and Community Care Services. **State; National; International Alignment:** N/A
23. The percentage of		The target for this KPI is ≥ 80% for both	This KPI measures the HPV vaccination, which is the approved public	DoH	**OBM Outcome and Strategic Intent Alignment:**

[16] Aliyu ZY. Discharge against medical advice: sociodemographic, clinical and financial perspectives. International journal of clinical practice 2002;56(5):325-27.
[17] *Dying Well*, Grattan Institute Report No. 2014-10, September 2014, 2.
[18] WA Health End of Life Framework (2016) 9; taken from the Swerissen H, Duckett S. Dying well: Grattan Institute Report No. 2014-10 [cited 2015 Nov 16]. Available from: http://grattan.edu.au/wp-content/uploads/2014/09/815-dying-well.pdf
[19] Elixhauser A, *Costs of breast cancer and the cost-effectiveness of breast cancer screening*, Int J Technol Assess Health Care. 1991;7(4):604-15. Review.

Indicator Title	Indicator Measure	Estimated Indicator Target	Indicator Rationale	Reporting Entities	Indicator Alignment
Western Australian year 8 students that complete their HPV vaccination series		females and males. There is no nationally agreed target for this KPI. This value was supplied by the Prevention and Control Program data custodian and represents a 94% completion rate amongst those who have consented to receive the vaccine (based on historical data indicating 85% of students in the School Based Immunisation Program (SBIP) database consent to receive HPV vaccination).	health intervention for reducing the risk of developing HPV-associated cancers at sites other than the cervix. The combination of HPV vaccination and cervical screening can provide the greatest protection against cervical cancer. It is important that as many people as possible get vaccinated. Not only does vaccination protect vaccinated individuals against infection by the HPV types targeted by the respective vaccine, but also vaccination of a significant proportion of the population can reduce the prevalence of the vaccine-targeted HPV types in the population, thereby providing some protection for individuals who are not vaccinated (a phenomenon called herd immunity). Vaccinating against HPV provides highly effective protection against the development of HPV-related cancers and disease. HPV vaccination influences cancer control, sexual health and is indicative of other vaccine compliance. The best time to be vaccinated is before a person becomes sexually active. A three dose schedule provides optimal protection. The HPV vaccine is provided free in schools to all males and females in year 8 under the School Based Immunisation Program. An above target result of this KPI would reflective positive performance, as WA Health works towards maximising the proportion of students who have completed the HPV series. This KPI is reported by the Department as it is a state wide service funded by the Department on behalf of all HSPs. This KPI is not reported by CAHS as the indicator is based on the registered school students on the SBIP database and not by the provider of program. CAHS by definition, services a prescribed cohort of the WA population (i.e. children and adolescents). Unlike the other Health Service Providers, the scope of CAHS activities is not prescribed on the basis of geographical regions.		This KPI aligns to the components of Outcome 2; particularly Western Australians have access to prevention services to live healthy and safe lives. It also aligns to the Strategic Intent priority of Prevention and Community Care Services. **State; National; International Alignment:** This same KPI is reported in: • The National HPV Vaccination Program Register produces annual coverage reports by state/territory. • The National Health Performance Authority also publicly reports these rates by statistical level area.
24. The percentage of (a) adults and (b) children who have a tooth retreated within six months of receiving initial restorative dental treatment		The target for adults is ≤ 8% and the target for children is ≤ 4%. This target is based on historical data.	This KPI does not provide definitive answers; rather it is designed to indicate potential problems within WA dental health service provision that might need addressing. This KPI is used to assess, compare and determine the potential to improve dental care for WA clients. This KPI represents the growing recognition that a capacity to evaluate and report on quality is a critical building block for system-wide improvement of healthcare delivery and patient outcomes. A low unplanned retreatment rate suggests that good clinical practice is in operation. Conversely, unplanned returns may reflect: • less than optimal initial management • development of unforeseen complications • treatment outcomes have a direct bearing on cost, utilisation of resources, future treatment options and patient satisfaction. By measuring and monitoring this KPI, the level of potentially avoidable unplanned returns can be assessed in order to identify key areas for improvement (i.e cost effectiveness and efficiency, initial treatment and patient satisfaction). This is a nationally reported KPI; the inclusion of this new KPI will provide opportunity for benchmarking across jurisdictions. This KPI will be reported in the NMHS Annual Report only, as they receive the budget to provide this State wide service. Performance against this KPI is not able to be disaggregated by HSP entity.	NMHS	**OBM Outcome and Strategic Intent Alignment:** Outcome 2 - Western Australians have access to prevention, health promotion and aged and continuing care services to live healthy and safe lives. It also aligns to the Strategic Intent priority of Prevention and Community Care Services and enabler of Accountability. **State; National; International Alignment:** The same indicator is reported as part of: • Australian Council on Healthcare Standards Oral Health Clinical Indicator set with 7 out of 8 State and Territory public oral health services providing data.
25. The percentage of patients who access emergency services at a small rural or		The target range for this KPI is between 89% and 91%. This target is based upon 5 years of trend analysis that shows that there is a gradually reducing	WACHS delivers a range of health services through its small hospitals spread across rural and remote Western Australia. The availability to access emergency services at these facilities is a clear community expectation. The outcome of returning home, where clinically-justified,	WACHS	**OBM Outcome and Strategic Intent Alignment:** Outcome 2 - Western Australians have access to prevention, health promotion and aged and continuing care services to live healthy and safe lives.

Indicator Title	Indicator Measure	Estimated Indicator Target	Indicator Rationale	Reporting Entities	Indicator Alignment
remote Western Australian hospital and are subsequently discharged home		trend, due to the increased effect of transferring patients to regional hubs across WACHS.	is the role of community primary health requiring urgent care. This KPI measures community primary health care services that are provided by Small Rural Hospitals. This allows the community to access primary care (prevention and promotion) services that are often limited in rural areas due the lack of General Practitioners (GPs). Providing these types of services, that would usually be provided by GPs, which allows people treated without admission to a hospital, is a significant community expectation of people living in country WA, and addresses the shortage of primary health care services		**State; National; International Alignment:** N/A
36. The percentage of Policy Frameworks and associated documents reviewed within the specified time period		The target for this KPI is currently under development. The specified time period for this KPI is Policy Frameworks will be reviewed within two years after first issue and at least every three years thereafter.	Under the HSA, the overall management of the WA health system is the responsibility of the Director General as the System Manager. The Director General has issued the following binding policy frameworks for HSPs to ensure service coordination and integration, and efficiency and effectiveness in the provision of health services across the WA health system. This KPI measures the effectiveness of the Department in ensuring the binding Policy Frameworks and associated documents they issue are current and reflective of the policy required to enable a safe, high quality and sustainable WA Health System.	DoH	**OBM Outcome and Strategic Intent Alignment:** This indicator aligns to the strategic leadership and planning services provided by the Department which enable a high quality and sustainable WA Health System represented in Outcome 3. It also aligns to the Strategic Intent enablers of Accountability and Partnerships as well as the values of Leadership, Excellence and Teamwork. **State; National; International Alignment:** N/A
37. The percentage of Health Service Performance Reports completed by the 17th working day of each month		The target for this KPI is currently under development.	This indicator measures the Department's ability to provide the service of "monitoring performance" to HSPs in a timely manner. This KPI aligns to the role of the Department as prescribed in the HSA in "Monitoring performance and taking remedial action when performance does not meet expected standards". This KPI is calculated by looking at the percentage of months when the HSPR is completed by the expected time for distribution to HSPs. This measurers how well the Department as System Manager is performing this function.	DoH	**OBM Outcome and Strategic Intent Alignment:** Outcome 3 - Strategic leadership, planning and support services that enable a safe, high quality and sustainable WA Health System. It also aligns to the Strategic Intent Priority of Health Services and Enablers of Accountability and Financial Management. **State; National; International Alignment:** N/A
38. Clinical Incidents (Proportion of all notified clinical incidents where the patient outcome was death)	The proportion of all notified clinical incidents where the patient outcome was death. A clinical incident is an event or circumstance resulting from healthcare which could have, or did lead to unintended harm to a person, loss or damage.	The target for this KPI is currently under development.	This KPI aligns to the role of the Department as prescribed in the HSA in "Overseeing, monitoring and promoting improvements in the safety and quality of health services." It also measures how safe WA Health hospitals services are, which is one of the six domains of measuring quality for WA Health (effective, efficient, timely/accessible, equitable, safe and patient centred).[20] A clinical incident is an event or circumstance resulting from healthcare which could have, or did lead to unintended harm to a person, loss or damage. This information is already captured by the Patient Surveillance Unit within the Department and is reported by the Department as it has the overall responsibility for overseeing, monitoring and promoting improvements in the safety and quality of health services. Change in the proportion may arise due to Patient Surveillance Unit activities undertaken to increase the overall level of reporting of notifiable incidents. It is a desirable outcome to have more incidents reported, investigated and actions taken to mitigate against future harm. This KPI provides the opportunity to measure the impact of the Department's policy at a system wide level upon clinical incidents.	DoH	**OBM Outcome and Strategic Intent Alignment:** This indicator aligns to the outcomes of safe and high quality listed in Outcome 3. It also aligns to the Strategic Intent Priority of Health Services and Enablers of Accountability and Financial Management. **State; National; International Alignment:** N/A
39. The percentage of system-wide, key budget forecasts produced by the Department of Health within agreed client	The key activities that the system manager has substantial control over and must be delivered in a timely fashion to ensure a robust budget setting	The target and specific numerator and denominator information for this KPI is currently under development.	This KPI aligns to the role of the Department as prescribed in the HSA in "Recommending to the Minister for Health the amounts that may be allocated from the health portfolio budget to HSPs; Entering into service agreements with HSPs outlining budget, activity and performance measures." It is important to have a KPI that measures the Departments performance on this service, as timely forecasts and	DoH	**OBM Outcome and Strategic Intent Alignment:** This indicator measures the planning and support services provided by the Department for the system that enable the outcomes of a high quality and sustainable WA Health System captured in Outcome 3. It also aligns to the Strategic Intent Enablers of Accountability and Financial Management.

[20] Presented by the DG to the Committee for Economic Development of Australia in April 2016.

Indicator Title	Indicator Measure	Estimated Indicator Target	Indicator Rationale	Reporting Entities	Indicator Alignment
timeframes	process are: 1. Financial year budget submission (one appropriation for all of WA Health) to the Department of Treasury 2. Delivery of the Final draft of the service agreements to each of the HSPs 3. Signing of Service Agreements between the DoH and HSPs to ensure budget information available for each HSP.		reports are necessary for the successful delivery of the WA Health Budget and ongoing financial monitoring. This KPI is essentially measuring the percentage performance (and non-performance) in relation to timeliness of key deliverables in the budget setting and agreement space. This KPI reflects how timely the Department's submission for a single financial apportionment from the Department of Treasury and subsequent collation of budget forecasts from HSPs and generation of system-wide budget forecasts and reports is provided.		**State; National; International Alignment:** N/A
40. Public Health Regulation (The percentage of regulations, policy and other supporting documents in the Annual Public Health Division Operational Plans which were completed)		The target for this KPI is 90%, and has been chosen as it represents the performance of the Department against the targets set in the Public Health Division annual plan. A percentage below the target would represent under performance. The denominator for this KPI will change each year to reflect the relevant Public Health Division annual plan.	This KPI aligns to the role of the Department as prescribed in the HSA as "Issuing binding policy frameworks and directions to health service providers" to ensure service coordination and integration, and efficiency and effectiveness in the provision of health services across the WA health system. Accordingly, this KPI measures the Department's ability to provide regulations, policy and other supporting documents (e.g. codes of practice) to support the role of HSPs in the delivery of approved services to approved State Standards. This KPI aligns with the *Public Health Division Strategic Plan 2016-2020*. Annual public health plans will be developed outlining the regulations, policy and other supporting documents which are to be developed, revised or issued over the upcoming 12 month period. This KPI will measure completion of these planned activities.	DoH	**OBM Outcome and Strategic Intent Alignment:** Outcome 3 - Strategic leadership, planning and support services that enable a safe, high quality and sustainable WA Health System. It also aligns to the Strategic Intent Priority of Prevention and Community Care Services. **State; National; International Alignment:** This KPI has an internal alignment to the *Public Health Division Strategic Plan 2016-2020* and the Public Health Division annual plan.
41. The percentage of responses from WA Health Service Providers and Department of Health who are satisfied or highly satisfied with the overall service provided by Health Support Services		As this is a new survey for HSS to conduct, targets for performance were not able to be finalised at the time of this submission.	This KPI aligns to the role of the statutory authority of HSS prescribed in the HSA in providing support services to both the Department and HSPs. It reports the satisfaction levels of services delivered to the Department and HSPs. Service recipients will be provided with a survey to complete and the responses will measure the extent to which the expectations of service delivery by HSS were met. Given the larger number of entities that will be responding to the survey (as a result of governance changes enacted by the HSA), we are confident that this diversity of response will provide an acceptable level of data.	HSS	**OBM Outcome and Strategic Intent Alignment:** Outcome 3 - Strategic leadership, planning and support services that enable a safe, high quality and sustainable WA Health System. It also aligns to the Strategic Intent Enabler of Partnerships. **State; National; International Alignment:** The wording for this indicator was drawn from two existing indicator reported by the WA Department of Premier and Cabinet in its 2014-15 Annual Report: "Service recipient's confirmation that services provided enable them to meet Executive Government's obligations" and "Service recipient's confirmation that high quality and timely policy advice is provided".
to be **removed:**					
Percentage of public patients discharged to home after admitted hospital treatment			This KPI has been removed as it is not considered to be a meaningful measure, as in almost all circumstances patients would be discharged to home after an acute illness that required hospitalisation. Additionally, in terms of statistical analysis this KPI does not provide data that is of value to HSPs or the Department.		
Survival rates for sentinel conditions			This KPI has not been selected to be continued has a new mortality related indicator has been included in the final suite: "Hospital standardised mortality ratio" (see KPI 5 above for further information and rationale).		
Loss of life from premature death due to identifiable causes of preventable disease (breast and cervical cancer)			This KPI has been removed as it is not able to be reported by individual HSP entities and both breast and cervical cancer preventative screening programs are now being reported by the above KPIs 22 and 23 respectively. These new KPIs were considered by WA Health to be better 'upstream' indicators, as they measured the performance of public health preventative measures at the beginning of the continuum of care, rather than this existing KPI which measured the result of people who had died from potential preventable diseases.		

Indicator Title	Indicator Measure	Estimated Indicator Target	Indicator Rationale	Reporting Entities	Indicator Alignment
Percentage of live-born infants with an Apgar score of three or less, five minutes post delivery			It has been determined, in consultation with the relevant stakeholders that the information measured by this KPI would be more appropriately provided as additional performance information within an Annual Report setting.		
Rate of hospitalisations for gastroenteritis in children (0-4 years)			This KPI has been removed as the outcome of this indicator cannot be directly affected by the Services provided by WA Health. This view was based upon advice from the relevant data custodians as this KPI is not key for demonstrating the extent of achievement of the Outcome as it focuses on hospitalisation episodes and not prevalence in the wider community.		
Rate of hospitalisation for selected respiratory conditions			This KPI has been removed from further reporting at it is unclear WA Health can influence these hospitalisation rates (for asthma, bronchitis, bronchiolitis and croup). Public health subject matter experts expressed the view that this indicator is not a major public health priority and rate of hospitalisations tend to reflect treatment patterns and access issues which if important should be measured more directly.		
Rate of hospitalisation for falls in older persons			This KPI has been removed based upon stakeholder and subject matter advice that the outcome this KPI is measuring is not directly affected by the Services provided by both HSPs and the Department.		
Proportion of people with cancer accessing admitted palliative care services			This KPI was replaced with the KPI “Proportion of people accessing community-based palliative care to assist them with their request to die at home”. The alternative KPI was selected as it was a contemporary measure supported by subject matter experts, better aligned to the community services that form the core of Outcome 2 activities and still allows examination of an issue of significant interest to WA’s ageing population.		
Dental health status of target clientele			All three of these Dental related KPIs have been removed due to their replacement with the more contemporary and meaningful new KPI 18 above: “Restorative treatment - teeth retreated within 6 months”. Additionally, these KPIs had no internal or national reporting alignment, a key principle for decision making in determining the final suite of OBM Framework effectiveness KPIs.		
Access to dental treatment services for eligible people					
Average waiting times for dental services					
Key Efficiency Indicators					
To be **continued:**					
12. Average cost per bed-day in specialised mental health inpatient units		The 2017/2018 targets for this KPI by entity are as follows: NMHS - $1,592 SMHS - $2,331 EMHS - $1,397 CAHS - $2,919 WACHS - $2,122.	Specialised admitted mental health inpatient units provide patient care in authorised hospitals and designated mental health units located within general hospitals. In order to ensure quality care and cost effectiveness, it is important to monitor the unit cost of admitted patient care in specialised mental health inpatient units. The efficient use of hospital resources can help minimise the overall costs of providing mental health care and enable the reallocation of funds to appropriate alternative non admitted care. This KPI is inclusive of specialised mental health units provided by a public facility or by a privately managed facility contracted by the Department of Health to provide services to public patients. These services are provided under service agreement with the MHC.	NMHS SMHS EMHS CAHS WACHS.	**OBM Service and Strategic Intent Alignment:** This KPI aligns to the services captured by Service 4: Mental Health Services. It also aligns to the Strategic Intent Priority of Health Services and Enablers of Financial management and Accountability. **State; National; International Alignment:** This KPI aligns with the bilateral Service Agreements between the Mental Health Commission and WA HSPs: “Average cost per purchased bed-day in acute specialised mental health units”. This KPI will be reported by the MHC from a purchaser perspective and by WA HSPs from a provider perspective.
26. Average cost of a transition care day provided by contracted non-government organisations/service providers		The target for this KPI is $315.	Additional detail has been added to the title of this KPI which has been previously reported as “Average cost per transition care day”, to make it easier to understand what service is being measured. The Transition Care Program is a joint Commonwealth and State and Territory initiative that aims to optimise the functioning and independence of older people and enable them to return home after a hospital stay rather than prematurely enter residential care. The Transition Care Program is tailored to meet the needs of the individual and aims to facilitate a continuum of care for older people in a non-hospital environment while giving them more time and support to make a decision on their longer term care arrangements.	DoH	**OBM Service Alignment:** This indicator aligns to the aged care services component of Service 5. It also aligns to the Strategic Intent Priority of Prevention and Community Care Services and Enablers of Partnerships, Financial Management and Accountability. **State; National; International Alignment:** N/A
27. Average cost per bed-day for specified residential care facilities, flexible care (hostels) and nursing		The target for this KPI is $422.	This KPI will only be reported in the WACHS Annual Report. WA’s public health system aims to provide safe, high-quality health care that ensures healthier, longer and better quality lives for all Western Australians. In order to improve, promote and protect the health of Western Australians it is critical that the health system is sustainable	WACHS	**OBM Service and Strategic Intent Alignment** This indicator aligns to the aged care services component of Service 5. It also aligns to the Strategic Intent Priority of Prevention and Community Care Services and Enablers of Financial Management and Accountability.

Indicator Title	Indicator Measure	Estimated Indicator Target	Indicator Rationale	Reporting Entities	Indicator Alignment
home type residents			by providing effective and efficient care that best uses allocated funds and resources. The WA Country Health Service provides long-term care facilities for rural patients requiring 24 hour nursing care. This health care service is delivered to high and low dependency residents in nursing homes, hospitals, hostels and flexible care facilities, and constitutes a significant proportion of the activity within the WA Country Health Service jurisdictions where access to non-government alternatives is limited. Only WACHS will report this KPI as given the limited numbers of residential aged care facilities in country Western Australia, residential aged care services are provided through the public hospital system in country areas. This is not the case for metropolitan services as people in the metropolitan area can access specialised residential aged care facilities, and these are not provided through the public hospital system.		**State; National; International Alignment:** N/A
28. Average cost per bed-day for WA Quadriplegic Centre inpatient services	The average cost per bed day for Quadriplegic Centre in-patient services. Cost per bed day is calculated on the Centre's total cost of service divided by occupied bed days.	The target for this KPI is $548.90. This target has been calculated by dividing the total budget Cost of service by the budget bed days per budgets approved by the Quadriplegic Centre Board and Submitted to the Department.	This KPI measures how efficiently the WA Quadriplegic Centre delivers its entire suite of services to its clients, whilst at the same time recognising best practice standards and in a manner that maintains quality care for all clients.	QUAD	**OBM Service and Strategic Intent Alignment** This indicator aligns to the continuing care services component of Service 5. It also aligns to the Strategic Intent Priorities of Prevention and Community Care Services and Health Services and Enabler of Partnerships. **State; National; International Alignment:** N/A
29. Average cost per WA Quadriplegic Centre community client for clinical and related services	Average cost per Quadriplegic Centre community client for clinical and related services. The KPI for cost per patient contact is calculated on the total Community Nursing Service budget allocation.	The target for this KPI is $73.26 per client visit. This target has been drawn from the Service Agreement between the Quadriplegic Centre and the Department, specifically the specification table for 2015/16 which specifies a unit price (indexed) of $73.26	The WA Quadriplegic Centre aims to assist in the prevention of inappropriate hospitalisation of community clients through the provision of primary care, where practicable. This KPI measures how efficiently the WA Quadriplegic Centre delivers its community nursing services to clients, which in turn lowers the instances of inappropriate hospitalisation of community clients.	QUAD	**OBM Service and Strategic Intent Alignment** This indicator aligns to the continuing care services component of Service 5. It also aligns to the Strategic Intent Priorities of Prevention and Community Care Services and Health Services and Enabler of Partnerships. **State; National; International Alignment:** N/A
31. Average cost per person of delivering population health programs by population health units		The 2017/2018 targets for this KPI by entity are as follows: NMHS - $79 SMHS - $30 EMHS - $39 CAHS - $250 WACHS - $358.	This KPI has been titled from the previous KPI title of “Average cost per capita of population health units”. Population health units support individuals, families and communities to increase control over and improve their health. With the aim of improving health, population health works to integrate all activities of the health sector and link them with broader social and economic services and resources by utilising the *WA Health Promotion Strategic Framework 2012–2016* (the latest version is due for public at the end of this year). This is based on the growing understanding of the social, cultural and economic factors that contribute to a person’s health status.	NMHS SMHS EMHS CAHS WACHS.	**OBM Service and Strategic Intent Alignment** This indicator aligns to the population health and promotion component of Service 6. It also aligns to the Strategic Intent Priorities of Prevention and Community Care Services and Chronic Disease Services and Enablers of Accountability and Financial Management. **State; National; International Alignment:** N/A
32. Cost per person of providing preventative interventions, health promotion and health protection activities that reduce the incidence of disease or injury		The target for this KPI is $52.02.	In order to improve, promote and protect the health of Western Australians it is critical that the health system is sustainable by providing effective and efficient care that best uses allocated funds and resources. The delivery of effective targeted preventative interventions, health promotion and health protection activities aims at reducing disease or injury within the community, fostering the ongoing health and wellbeing of Western Australians.	DoH	**OBM Service and Strategic Intent Alignment** This indicator aligns to the prevention, promotion and protection components of Service 6. It also aligns to the Strategic Intent Priorities of Prevention and Community Care Services and Chronic Disease Services and Enablers of Accountability and Financial Management. **State; National; International Alignment:** N/A

Indicator Title	Indicator Measure	Estimated Indicator Target	Indicator Rationale	Reporting Entities	Indicator Alignment
33. Cost per capita for patient transport provided by St John Ambulance Western Australia Ltd, based on the total accrued costs of these services for the estimated total population of Western Australia		The target for this KPI is $47.72.	To ensure Western Australians receive the care they need, when they need it, strong partnerships have been forged within the health care community through a collaborative agreement between St John Ambulance Australia – Western Australia Ambulance Service and the Western Australian Department of Health. This collaboration ensures that patients have access to an effective ambulance Service that aims to ensure the best possible health outcomes for patients requiring urgent medical treatment and transport services. Visibility of the previous patient transport Service (which has been amalgamated into Service 6: Public and Community health) is retained by the WA public through the inclusion of this KPI in the final OBM Framework KPI Suite. The expansion in regional WA has been very successful with teams now stationed in Bunbury, Busselton, Albany, Katanning, Northam and Geraldton, and plans are underway to establish new services and teams in other centres.	DoH	**OBM Service and Strategic Intent Alignment** This indicator aligns to the patient transport component of Service 6 Public and Community health services. It also aligns to the Strategic Intent Priorities of Prevention and Community Care Services and Chronic Disease Services and Enablers of Accountability and Financial Management. **State; National; International Alignment:** From a national perspective, this KPI aligns to the following ROGS indicator "9.31 Ambulance service organisations' expenditure per person".
34. Cost per capita for patient transport provided by the Royal Flying Doctor Service (Western Operations), based on the total accrued costs of these services for the estimated total population of Western Australia		The target for this KPI is $15.38.	To ensure Western Australians receive the care they need, when they need it, strong partnerships have been forged within the health care community through a collaborative agreement between the Royal Flying Doctor Service and the Western Australian Department of Health. This collaboration ensures that patients have access to an effective Royal Flying Doctor Service that aims to ensure the best possible health outcomes for patients requiring urgent medical treatment and transport services. Visibility of the previous patient transport Service (which has been amalgamated into Service 6: Public and Community health) is retained by the WA public through the inclusion of this KPI in the final OBM Framework KPI Suite. The RFDS in Western Australia services over 2.5 million square kilometres, operating out of five bases with 15 aircraft. Using the latest in aviation, medical and communications technology, the RFDS delivers emergency aeromedical response and treatment to sick and injured patients; inter-hospital transfers; telehealth consultations; allied health and medical specialist and nursing services to over 70,000 people each year in WA. The state of Western Australia is a vast area, and the RFDS provides the finest care to the furthest corner.	WACHS	**OBM Service and Strategic Intent Alignment** This indicator aligns to the patient transport component of Service 6 Public and Community health services. It also aligns to the Strategic Intent Priorities of Prevention and Community Care Services and Chronic Disease Services and Enablers of Accountability and Financial Management. **State; National; International Alignment:** N/A
To be **added:**					
9. Average admitted cost per weighted activity unit	The average admitted cost per weighted activity unit for all patients treated in public hospitals and public patients treated in public private partnership hospitals.	The target for this KPI is still under development. It will be drawn from the GBS process for 2017/2018 and aligned to the state price target relevant to each individual HSP.	This new KPI has been created to ensure a consistent methodology is applied to calculating and then measuring the performance of HSPs against the funding they receive through the GBS and subsequent Service Agreements and the activity delivered by each Hospital site (to be reported at an aggregated entity level). Admitted services received approximately 55.2% of the 2016/2017 budget allocation, it is imperative that efficiency of this Service delivery is accurately monitored and reported. The detail behind this KPI is still being finalised by WA Health, however the numerator will be total accrued admitted expenditure drawn from the general ledger and the denominator will be the total admitted weighted activity. This information will be in line with national reporting processes to IHPA, inclusive of the NHCDC process. WA Health has made a commitment with this new KPI to creating performance information that utilises a consistent calculation methodology across the business, and further work is being progressed to determine the detail behind what cost and activity information will be included and excluded from this KPI.	NMHS SMHS EMHS CAHS WACHS.	**OBM Service and Strategic Intent Alignment** This KPI aligns to Service 1: Public Hospital Admitted Services. It also aligns to the Strategic Intent Priority of Health Services and Enablers of Financial management and Accountability. **State; National; International Alignment:** This KPI aligns to the Service Agreements between the Department and each individual HSP and the nationally reported PAF Efficiency and financial performance Indicator: 6.2.4.4 Financial performance against activity funded budget (annual operating result). This KPI is similar to the current HSPR indicator "E3-7: YTD Unit cost to Price." It is envisaged that this new KPI will be replace the current HSPR indicator detailed above, allowing HSPs to have a monthly line of sight on their performance against this annual report KPI.

Indicator Title	Indicator Measure	Estimated Indicator Target	Indicator Rationale	Reporting Entities	Indicator Alignment
10. Average emergency department cost per weighted activity unit	The average emergency department cost per weighted activity unit for all patients treated in public hospitals and public patients treated in public private partnership hospitals.	The target for this KPI is still under development. It will be drawn from the GBS process for 2017/2018 and aligned to the state price target relevant to each individual HSP.	This new KPI has been created to ensure a consistent methodology is applied to calculating and then measuring the performance of HSPs against the funding they receive through the GBS and subsequent Service Agreements and the activity delivered by each Hospital site (to be reported at an aggregated entity level). Emergency department services received approximately 9.0% of the 2016/2017 budget allocation, and with the ever increasing demand on emergency departments and health services, it is imperative that emergency department service provision is continually monitored to ensure the efficient delivery of safe and high-quality care. The detail behind this KPI is still being finalised by WA Health, however the numerator will be total accrued non-admitted expenditure drawn from the general ledger and the denominator will be the total emergency department weighted activity. This information will be in line with national reporting processes to IHPA, inclusive of the NHCDC process. WA Health has made a commitment with this new KPI to creating performance information that utilises a consistent calculation methodology across the business, and further work is being progressed to determine the detail behind what cost and activity information will be included and excluded from this KPI.	NMHS SMHS EMHS CAHS WACHS.	**OBM Service and Strategic Intent Alignment** This KPI aligns to Service 2: Public Hospital Emergency Services. It also aligns to the Strategic Intent Priority of Health Services and Enablers of Financial management and Accountability. **State; National; International Alignment:** This KPI aligns to the Service Agreements between the Department and each individual HSP and the nationally reported PAF efficiency and financial performance Indicator: 6.2.4.4 Financial performance against activity funded budget (annual operating result). This KPI is similar to the current HSPR indicator "E3-7: YTD Unit cost to Price." It is envisaged that this new KPI will be replace the current HSPR indicator detailed above, allowing HSPs to have a monthly line of sight on their performance against this annual report KPI.
11. Average non-admitted cost per weighted activity unit	The average non-admitted cost per weighted activity unit for all patients treated in public hospitals and public patients treated in public private partnership hospitals.	The target for this KPI is still under development. It will be drawn from the GBS process for 2017/2018 and aligned to the state price target relevant to each individual HSP.	This new KPI has been created to ensure a consistent methodology is applied to calculating and then measuring the performance of HSPs against the funding they receive through the GBS and subsequent Service Agreements and the activity delivered by each Hospital site (to be reported at an aggregated entity level). Non-Admitted services received approximately 11.1% of the 2016/2017 budget allocation, it is imperative that efficiency of this Service delivery is accurately monitored and reported. The detail behind this KPI is still being finalised by WA Health, however the numerator will be total accrued non-admitted expenditure drawn from the general ledger and the denominator will be the total non-admitted weighted activity. This information will be in line with national reporting processes to IHPA, inclusive of the NHCDC process. WA Health has made a commitment with this new KPI to creating performance information that utilises a consistent calculation methodology across the business, and further work is being progressed to determine the detail behind what cost and activity information will be included and excluded from this KPI.	NMHS SMHS EMHS CAHS WACHS.	**OBM Service and Strategic Intent Alignment** This KPI aligns to Service 3: Public Hospital Non-Admitted Services. It also aligns to the Strategic Intent Priority of Health Services and Enablers of Financial management and Accountability. **State; National; International Alignment:** This KPI aligns to the Service Agreements between the Department and each individual HSP and the nationally reported PAF Efficiency and financial performance Indicator: 6.2.4.4 Financial performance against activity funded budget (annual operating result). This KPI is similar to the current HSPR indicator "E3-7: YTD Unit cost to Price." It is envisaged that this new KPI will be replace the current HSPR indicator detailed above, allowing HSPs to have a monthly line of sight on their performance against this annual report KPI.
13. Average cost per treatment day of non-admitted care provided by public clinical mental health services		The target for this KPI is still under development. It will be drawn from the GBS process for 2017/2018 and aligned to the state efficient price target.	Efficient functioning of public community mental health services is critical to ensure that finite funds are used effectively to deliver maximum community benefit. Services provided by public community-based mental health services include assessment, treatment and continuing care. The majority of services provided by public community-based mental health services are for people in acute phase of a mental illness who are receiving post-acute care. This KPI gives a measure of the cost effectiveness of treatment for public psychiatric patients under public community mental health care (non-admitted/ambulatory patients).	NMHS SMHS EMHS CAHS WACHS.	**OBM Service and Strategic Intent Alignment** This KPI aligns to Service 4: Mental Health Services. It also aligns to the Strategic Intent Priority of Health Services and Enabler of Partnerships. **State; National; International Alignment:** This KPI aligns with MHC Annual Report KPI of "Average cost per purchased treatment day of ambulatory care provided by public clinical mental health services", supporting interagency collaboration and whole-of-government transparency.
30. Average cost per client who receives support services from the Home and Community Care Program		The target for this KPI is $4,082.	The Western Australian Home and Community Care (**HACC**) Program is a joint funding initiative of the Commonwealth and WA State Governments which provides basic support services for eligible people of all ages with a disability and their carers to assist them to continue living independently at home. HACC support is designed to assist people with the greatest need and aims to maximise people's	DoH	**OBM Service and Strategic Intent Alignment** This indicator aligns to the aged care services component of Service 5. It also aligns to the Strategic Intent Enablers of Partnerships, Financial Management and Accountability.

Indicator Title	Indicator Measure	Estimated Indicator Target	Indicator Rationale	Reporting Entities	Indicator Alignment
			independence. The reach and effectiveness of the Home and Community Care Program can be determined through monitoring the number of people in the target population who have received home and community care services. This in turn can support the development of targeted strategies that aim to ensure that the people with the greatest need have access to the services they require and are provided with the care they need in the most appropriate setting – ensuring the well-being and quality of life for Western Australians in need. This KPI provides an indication of the average cost per person with an ongoing functional disability living in the community who receives support services from the HACC program. This KPI is very similar to the previous reported KPI of "average cost per person of HACC services delivered to people with long term disability". Reference to the limitation of clients "with long term disability" has been removed in order to ensure this KPI is reflective of the broader range of members of the public who access HACC services.		**State; National; International Alignment:** N/A
35. The average cost of WA Health provided dental health programs for (a) enrolled school children and (b) socio-economically disadvantaged adult patients		The target for part (a) of the KPI is $134 and the target for part (b) is $394. These targets are for 16/17 as taken from the 2015-16 Government Budget Statements. They will be amended in the 16/17 GBS process when the targets for 17/18 will be forecast.	This KPI combines the existing KPIs of "Average cost of service for school dental service" and "Average cost of completed courses of adult dental care" into one KPI for ease of readability and contextual understanding of the results reported against the KPI. When combined, part (a) and part (b) of this KPI reflect the entire ambit of WA Health dental services. Early detection and prevention of dental health problems in children can ensure better health outcomes and improved quality of life throughout the crucial childhood development years and into adult life. The school dental service program ensures early identification of dental problems and where appropriate, provides treatment. Dental disease places a considerable burden on individuals and communities. While dental disease is common, they are largely preventable through population-based interventions, and individual practices such as personal oral hygiene and regular preventive dental care. Costly treatment and high demand on public dental health services emphasises the need for a focus on prevention and health promotion.	NMHS	**OBM Service and Strategic Intent Alignment** This indicator captures the cost of dental services provided as part of the overall Public and Community Health Services captured in Service 6. It also aligns to the Strategic Intent Priorities of Prevention and Community Care Services and Chronic Disease Services and Enablers of Accountability and Financial Management. **State; National; International Alignment:** N/A
42. Average cost of Public Health Regulatory Services per head of population	The denominator for this KPI is the total persons in Western Australia (Estimated Resident Population) for the reference period as at 30 June.	The target for this KPI $4 (based on 2015-16 cost centre expenditure and appropriate escalator).	As system manager, the Public Health Division performs system-wide regulatory functions including the regulation of food safety, vector control, waste-water management, tobacco licensing, radiation safety and medicines and poisons in order to promote health in the community; prevent disease before it occurs; and manage risks to human health, whether natural or man-made. This indicator measures the Department's ability to provide these functions in an efficient manner and aligns with a key provision of the Public Health Bill 2016 to consolidate and streamline regulatory tools to regulate any given risk to public health.	DoH	**OBM Service and Strategic Intent Alignment** This KPI aligns to Service 7: Health System Management - Policy and Corporate Services. It also aligns to the Strategic Intent Enablers of Accountability, Financial Management and Partnerships. N/A
43. Average percentage on time production of key system-wide financial reports released by the WA Department of Health to internal, State and Commonwealth stakeholders		The target for this KPI is currently under development. Delivery of the system-wide financial reports only has two states: • Performing: delivery on time or in less time than the expected deadline; and • Not-performing: actual delivery to clients (Treasury or DoH or	This KPI aligns to the role of the Department as prescribed in the HSA in "Recommending to the Minister for Health the amounts that may be allocated from the health portfolio budget to HSPs; Entering into service agreements with HSPs outlining budget, activity and performance measures." This KPI has been modelled on the following Australian Department of Finance have "Key financial reports delivered to the Australian Government within agreed timeframes".	DoH	**OBM Service and Strategic Intent Alignment** This KPI aligns to Service 7: Health System Management - Policy and Corporate Services. It also aligns to the Strategic Intent Enabler of Accountability and Financial Management. **State; National; International Alignment:** N/A

Indicator Title	Indicator Measure	Estimated Indicator Target	Indicator Rationale	Reporting Entities	Indicator Alignment
		Commonwealth) beyond what was the agreed deadline. Note that any changes to the original deadline must be mutually agreed between the client and the System Manger to be considered a change in the expected deadline for the purpose of this calculation.			
44. The total cost per full time equivalent worker to undertake the System Manager role of providing strategic leadership, planning and support services to Health Service Providers	The calculation will be total expenditure divided by the relevant FTE.	The target for this KPI is currently under development. Work is being progressed by the relevant Department work streams to finalise this information.	The delivery of system wide health and corporate policy and programs enables the Department to perform its role as a change agent leading development and implementation of policy to meet the State's health needs. This KPI aligns to the strategic policy and planning services provided by the Department to the whole of WA Health. It measurers how efficient the Department is in its provision of System Manager services of strategic leadership, planning and support to HSPs.	DoH	**OBM Service and Strategic Intent Alignment** This KPI aligns to Service 7: Health System Management - Policy and Corporate Services. It also aligns to the Strategic Intent Enabler of Accountability and Financial Management. **State; National; International Alignment:** N/A
45. Average cost of Accounts Payable services per transaction	The total cost of accounts payable services divided by the number of Accounts Payable Invoice Lines Processed	The target for this KPI is $4.69. This represents a 0.75% reduction in the estimated 2016/17 average cost of $4.73.	This KPI aligns to the role of HSS as a HSP prescribed in the Health HSA in ensuring "the operations of the health service provider are carried out efficiently, effectively and economically". This KPI captures the role of HSS in delivering transactional finance services to HSPs in an efficient manner.	HSS	**OBM Service and Strategic Intent Alignment:** This KPI aligns to Service 8: Health Support Services. It also aligns to the Strategic Intent Enabler of Financial Management. **State; National; International Alignment:** N/A
46. Average cost of Accounts Receivable services per transaction	The total cost of accounts receivable services divided by the number of Accounts Receivable Invoice Lines Processed	The target for this KPI is $43.22. This represents a 0.75% reduction in the estimated 2016/17 average cost of $43.55.	This KPI aligns to the role of HSS as a HSP prescribed in the HSA in ensuring "the operations of the health service provider are carried out efficiently, effectively and economically". This KPI captures the role of HSS in delivering transactional finance services to HSPs in an efficient manner.	HSS	**OBM Service and Strategic Intent Alignment:** This KPI aligns to Service 8: Health Support Services. It also aligns to the Strategic Intent Enabler of Financial Management. **State; National; International Alignment:** N/A
47. Average cost of payroll and support services per WA Health employee	The total cost of payroll and HR support services divided by the Average Headcount (WA Health)	The target for this KPI is $889.68. This represents a 0.75% reduction in the estimated 2016/17 average cost of $896.40.	As a WA Health 'shared services' organisation, HSS performs a range of employment and payroll services on behalf of HSPs and the Department. This indicator measures the efficiency of HSS to provide the continuum of 'hire to retire' workforce services to HSPs.	HSS	**OBM Service and Strategic Intent Alignment:** This KPI aligns to Service 8: Health Support Services. It also aligns to the Strategic Intent Enabler of Financial Management. **State; National; International Alignment:** N/A
48. Average cost of Supply Services by purchasing transaction	The total cost of supply services divided by the number of Purchase Order Lines Processed (Metropolitan only)	The target for this KPI is $55.56. This represents a 0.75% reduction in the estimated 2016/17 average cost of $55.98.	This KPI aligns to the HSS 2016/17 Performance Objectives as detailed in the SA between the Department CEO and HSS, which prescribes that HSS will seek "to improve efficiencies in supply, procurement and contract management in order to support improved value for money for WA Health". This indicator measures the efficiency of HSS to provide supply chain services to HSPs.	HSS	**OBM Service and Strategic Intent Alignment:** This KPI aligns to Service 8: Health Support Services. It also aligns to the Strategic Intent Enabler of Financial Management. **State; National; International Alignment:** N/A
49. Average cost of supporting a WA Health personal computer (PC)	The total cost of ICT services divided by the Average Device Count (WA Health)	The target for this KPI is $4,655.21. This represents a 0.75% reduction in the estimated 2016/17 average cost of $4,690.39.	This KPI aligns to the 'Key Outcomes and Priorities' section listed in the SA between the Department CEO and HSS, which prescribes that HSS will seek to "implement an updated computer operating environment, removing difficulties encountered by staff in using	HSS	**OBM Service and Strategic Intent Alignment:** This KPI aligns to Service 8: Health Support Services. It also aligns to the Strategic Intent Enabler of Financial Management.

Indicator Title	Indicator Measure	Estimated Indicator Target	Indicator Rationale	Reporting Entities	Indicator Alignment
			outdated operating and other systems". This indicator measures the ability of HSS to deliver ICT services to its customers in an efficient manner.		**State; National; International Alignment:** N/A
to be **removed:**					
Average cost per casemix adjusted separation for tertiary hospitals			This KPI has been selected to be removed as it has been replaced with a more contemporary and transparent suite of cost indicators listed above as KPIs "9, 10 and 11".		
Average cost per casemix adjusted separation for non-tertiary hospitals			This KPI has been selected to be removed as it has been replaced with a more contemporary and transparent suite of cost indicators listed above as KPIs 9, 10 and 11".		
Average cost of admitted public patient treatment episodes in private hospitals			This KPI has been selected to be removed as it has been replaced with a more contemporary and transparent suite of cost indicators listed above as KPIs "9, 10 and 11".		
Average cost per home based hospital patient day			This KPI has been removed as stakeholder engagement determined that this KPI did not produce a meaningful result that could be used to assist with performance measurement and management. The methodology used for this KPI made it difficult to compare and measure costs across HSPs. Additionally this KPI did not have any HSPR or national reporting alignment, a key evaluation principle applied to determining which KPIs would be continued.		
Average cost per home based hospital care day			This KPI has been selected to be removed as this Service has been incorporated into Service One "Public Hospital Admitted Services".		
Average cost per emergency department attendance			This KPI has been selected to be removed as it has been replaced with a more contemporary and transparent suite of cost indicators listed above as KPIs "9, 10 and 11".		
Average cost per three month period of care for specialised community mental health			This KPI has been removed and replaced with the new efficiency KPI above 13. The modified KPI was classified as a new KPI because it no longer reliant on 3 month clinical assessments as per the national *Key Performance Indicators for Public Mental Health Services, 3rd edition*.		
Average cost per trip of Patient Assisted Travel Scheme (PATS)			This KPI has been removed as it does not measure efficiency of access to patient transport services adequately; the average cost of this service delivery is not a robust measure of access to high quality care.		
Average cost per breast screening			This KPI has been removed as it was not determined to provide meaningful information. This breast screening service that is provided to the WA public is a critical component of both State and Federal preventative health services, and the critical measurement component of percentage of breast screening is measured above by the above new effectiveness KPI "22. Participation rate of women aged 50 – 69 years who participate in breast screening ((a) Indigenous women; (b) Non-Indigenous women)".		
Average cost per client receiving contracted palliative care services			This KPI has been removed as it is no longer appropriate under the revised OBM Framework. This KPI measured admitted palliative care Services which are now measured as part of new KPIs 9, 10 and 11 above.		

8. Scope of the WA Health OBM Framework

The OBM Framework establishes a process for monitoring the financial and service delivery performance of the WA health system. It encompasses and expands on existing performance reporting contained WA Health Annual Reports, and will be implemented during the 2017/2018 budget submission, Budget Papers, revenue and resource allocation, financial and performance reporting and the Annual Reports.

Pursuant to the HSA the Director General can issue binding policy frameworks for HSPs to ensure a consistent approach to matters across WA Health. HSPs will be responsible for the establishment of local policy for their services, consistent with the relevant policy frameworks. The WA Health OBM Framework has a related policy, which will be issued under the *Budget and Resource Allocation Policy Framework* detailed below.

8.1. OBM Framework Policy

The OBM Framework Policy (which is currently under development) will create binding compliance obligation upon both the Department and HSPs, ensuring that the work detailed in this submission and improvements to business-as-usual processes detailed below remain on target. It will be issued under the *Budget and Resource Allocation Policy Framework* pursuant to the HSA and will ensure that there is consistent application and adherence to the revised OBM Framework across the WA health system.

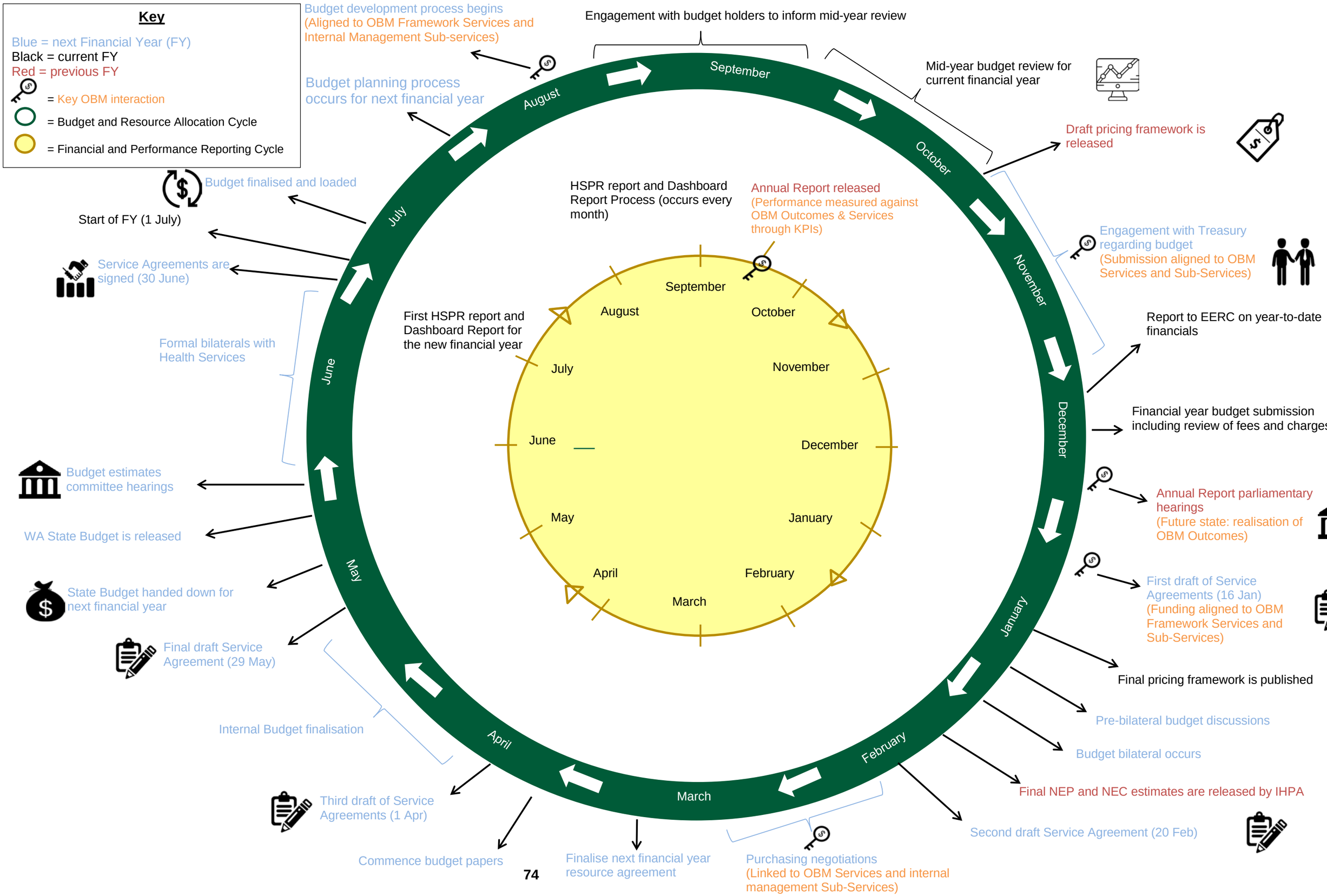
This consistency of application in a documented form of the OBM Framework is new for WA Health, and will assist with internal budget, purchasing and performance management processes. This will then have a flow on effect into external agency reporting.

8.2. Improvement to the WA Health Budget and Performance Reporting Cycle

The submitted OBM Framework will improve the connection between the budget submission process and the annual reporting performance function of the WA health system. The OBM Framework Outcomes, Services and internal management view of Sub-Services will be used as a basis for budgeting, measuring performance and reporting.

Outlined below in Figure 6 is the WA Health Budget, Resource Allocation and Performance Management Cycle which highlights the key impact points of the OBM Framework within business-as-usual processes, creating greater awareness of how the performance information measured against the OBM Framework is gathered and its application across the Department from budget submission to GBS, ending in the annual reporting process. The OBM Framework KPIs are built into the budget process and provided for external review in both the GBS and Annual Reports.

Figure 6: WA Health Budget, Resource Allocation and Performance Management Cycle



8.3. Next Steps

To implement the revised OBM Framework will take significant effort particularly the maintenance and management of the cost centre mapping, and the adoption of the OBM Framework through the Department of Health's budget, purchasing, resource allocation and performance monitoring cycle.

The change has been signalled and business units in both the Department of Health and HSPs have commenced re-orientation and redesign. This is further facilitated by the Functional Review and Readiness Assessment and the Transition Plans for both the Department of Health to System Manager, and HSPs to Statutory Entities.

As the WA Health system transitions to the new governance model, which is to be completed by 1 July 2018, there will be a requirement to review and consider whether the functional changes change the WA Health OBM Framework. The intention is that the OBM Framework is assessed for "best-fit" within the first year of transition and amended for the final year of transition.

Some modifications to WA Health's OBM Framework will be required and will be captured in future annual submissions as required.

9. Request for Change

This submission has provided the detailed rationale and evidence base behind the revised WA Health OBM Framework. Summarised in Table 18 below is WA Health's request to the Under Treasurer to amend its current OBM Framework.

Table 18: Summary of WA Health Submission to amend its current OBM Framework

OBM Framework Component	Existing	Proposed	Section of Submission and Rationale for Change
Government Goal	**Goal 1: Better services** Greater focus on achieving results in key service delivery areas for the benefit of all Western Australians.	No change	-
WA Health Agency Goal	-	Delivery of safe, quality, financial sustainable and accountable healthcare for all Western Australians.	Section 4
Agency Level government desired outcomes	**Outcome 1** Restoration of patient's health, provision of maternity care to women and newborns and support for patients and families during terminal illness.	**Outcome 1** Western Australians have access to public hospital based services that enable treatment and restorative health care.	Section 4
	Outcome 2 Enhance health and wellbeing of Western Australians through health promotion, illness and injury prevention and appropriate continuing care.	**Outcome 2** Western Australians have access to prevention, health promotion and aged and continuing care services to live healthy and safe lives.	
	-	**Outcome 3** Strategic Leadership, planning and support services that enable a safe, high quality and sustainable WA Health System.	
Services	**Service 1:** Public hospitals admitted patients	**Service 1:** Public Hospital Admitted Services	Section 5
	Service 2: Home based hospital programs	**Service 2:** Public Hospital Emergency Services	
	Service 3: Palliative care	**Service 3:** Public Hospital Non-Admitted Services	
	Service 4: Emergency department	**Service 4:** Mental Health Services	
	Service 5: Public hospital non-admitted patients	**Service 5:** Aged and Continuing Care Services	
	Service 6: Patient transport	**Service 6:** Public and Community Health Services	
	Service 7: Prevention, promotion and protection	**Service 7:** Health System Management – Policy and Corporate Services	
	Service 8: Dental health	**Service 8:** Health Support Services	
	Service 9: Continuing care	-	
	Service 10: Contracted mental health	-	
Key Performance Indicators - Effectiveness	Refer to Table 17.	Refer to Table 17.	Section 7
Key Performance Indicators – Efficiency	Refer to Table 17.	Refer to Table 17.	Section 7

OBM Framework Component	Existing	Proposed	Section of Submission and Rationale for Change
Stakeholder Consultation	**Health Service Providers**	North Metropolitan Health Service South Metropolitan Health Service East Metropolitan Health Service Child and Adolescent Health Service WA Country Health Service The Quadriplegic Centre Health Support Services	
	Department of Health	Purchasing and System Performance Division Office of the Deputy Director General and Reform Public Health Division Clinical Services and Research Division System Policy and Planning Division	
	Department of Treasury	Executive and Project Officer staff	
	Office of the Auditor General	Executive and Project Officer staff	
	Mental Health Commission	Executive and Project Officer staff	

10. References

WA Health Strategies, Frameworks, Policies and Reports

- WA Health Annual Report 2014-15 (Department of Health, Metropolitan Health Service and WA Country Health Service) http://ww2.health.wa.gov.au/Our-performance/Annual-Report
- WA Department of Health Reform Program (information page) http://ww2.health.wa.gov.au/Improving-WA-Health/Health-reform
- WA Department of Health *Better Care Better Health Better Value WA Health Reform Program 2015-2020* http://ww2.health.wa.gov.au/~/media/Files/Corporate/general%20documents/Health%20Service%20Boards/Better-Health-Better-Care-Better-Value-WA-Health-Reform-Program.ashx
- WA Health Immunisation Strategy 2016-2020: http://ww2.health.wa.gov.au/Articles/F_I/Immunisation-strategy-2016
- Department of Health Western Australia, 2015, *Outcome Based Service Structure Project: Current and Future State Assessment*, Perth Western Australia. (Internal documentation produced for the project. Copies are available upon request to Office of the Assistant Director General Purchasing and System Performance)
- Department of Health Western Australia, 2014, *Admissions, Readmissions, Discharge and Transfer Policy for WA Health Services,* Perth, Western Australia. Available online from: http://www.health.wa.gov.au/circularsnew/circular.cfm?Circ_ID=13125
- Department of Health Western Australia, 2015, *WA Health Strategic Intent 2015-2020*, Perth Western Australia. Available online from: http://ww2.health.wa.gov.au/About-us/Strategic-Intent
- Clinical Services Framework 2014-2024 http://ww2.health.wa.gov.au/Reports-and-publications/WA-Health-Clinical-Services-Framework-2014-2024
- End of Life Framework http://ww2.health.wa.gov.au/Articles/A_E/End-of-life-framework
- WA Health System Performance Report 2015-16
- WA Health System Performance Report Definitions Manual
- WA Aboriginal Health and Wellbeing Framework 2015-2030 http://ww2.health.wa.gov.au/ZZ-Improving-Health-in-WA/Aboriginal-Health/WA-Aboriginal-Health-and-Wellbeing-Framework-2015-2030

Western Australian State Government Documents

- Department of Treasury, Western Australia, 2004, *Outcome Based Management Guidelines*, Perth, Western Australia. Available online from: https://www.treasury.wa.gov.au/uploadedFiles/_Treasury/Publications/Outcome_Based_Management.pdf

National Strategies, Frameworks, Policies and Reports

- National health Data Dictionary http://www.aihw.gov.au/publication-detail/?id=10737422826 (version 16) http://meteor.aihw.gov.au/content/index.phtml/itemId/268110

- Report on Government Services 2015 http://www.pc.gov.au/research/ongoing/report-on-government-services/2016
- Department of Health Australia, 2014, Aboriginal and Torres Strait Islander Health Performance Framework, Available from: http://www.health.gov.au/indigenous-hpf
- National Partnership Agreement on Essential Vaccines http://www.pc.gov.au/research/supporting/national-partnership/essential-vaccines-data
- Clinical Indicator User Manual –Oral Health Version 3
- BreastScreen Australia National Accreditation Standards http://www.cancerscreening.gov.au/internet/screening/publishing.nsf/Content/accreditation
- National Health Reform Performance and Accountability Framework http://nhpa.gov.au/internet/nhpa/publishing.nsf/Content/PAF
- Our Hospitals and Health Services [Performance Indicators website] http://www.health.wa.gov.au/OurHospitalsandHealthServices/home/
- My Hospitals website http://www.myhospitals.gov.au/
- AIHW Elective surgery procedures list
- National Survey of Mental Health and Wellbeing, 2007 http://www.health.gov.au/internet/main/Publishing.nsf/Content/mental-pubs-m-mhaust2
- National Mental Health Report 2013 http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-n-report13
- National Health Agreement http://www.federalfinancialrelations.gov.au/content/national_agreements.aspx
- Australian public mental health Services 2005 https://mhsa.aihw.gov.au/indicators/nkpi/
- Fourth National Mental Health Plan http://www.health.gov.au/internet/main/publishing.nsf/content/mental-pubs-f-plan09
- Australian Childhood Immunisation Register https://www.humanservices.gov.au/health-professionals/services/medicare/australian-childhood-immunisation-register-health
- National Centre for Immunisation, Research and Surveillance Coverage Reports http://www.ncirs.edu.au/provider-resources/immunisation-handbook-tables/
- National Health Priority Areas http://www.aihw.gov.au/national-health-priority-areas/
- Australian Commission on Safety and Quality in Health Care http://www.safetyandquality.gov.au/
- Australian Council on Healthcare Standards Oral Health Indicator set

Other Jurisdictions

- States Immunisation registers

International

- Institute of Healthcare Improvement, Move your dot: Measuring, evaluating and reducing hospital mortality rates (Part 1). Boston: IHI, 2003; Canadian Patient Safety Institute. Targeted Interventions. Safer Healthcare Now! Edmonton: CPSI, 2006. http://www.saferhealthcarenow.ca/EN/Pages/default.aspx

11. Appendices

1. WA Health Reform Program
2. Treasury and Office of Auditor General Feedback – actions and outcomes
3. Project Objectives, Scope and Benefits
4. OBSS Executive Committee Governance and Structure
5. OBSS Executive Committee Terms of Reference
6. Evaluation Principles for Design of the revised OBM Framework
7. Agency and Jurisdictional Research on Outcome Statements
8. Additional Research on Outcome Statements – Central Agency Considerations
9. Proposed Service and Program Descriptors – Evidence matrix as at 3 March 2016
10. Proposed Sub-service Descriptors – Evidence Matrix of Strategic Alignment
11. Alignment of WA Health KPIs to other reporting obligations as at 22 February 2016
12. Stakeholder Communications Log

Appendix 1 WA Health Reform Program

The WA Health Reform Program 2015-2020 (Reform Program) is an integrated program of work aligned to the critical enablers identified in WA Health's Strategic Intent. This work is focused on the building blocks that underpin the essential services WA Health delivers to the community. These building blocks are listed below in Figure 9:

Figure 7: WA Health Reform Program 2015-2020 Reform Building Blocks

- **Supporting our workforce** – through development and implementation of the WA Health Strategic Workforce Plan 2015-2025; and research, planning and projects to ensure an optimal workforce mix.
- **Greater accountability** – through new legislation to replace the *Hospitals and Health Services Act 1927* including establishment of Boards of Governance for each Health Service as separate statutory authorities; and establishment of the Department of Health as the 'System Manager'. This will be supported by a Functional Review and Readiness Assessment to transition the health system to new governance arrangements; a holistic performance management system that aligns with the revised governance and accountability structures; and improving clinical outcomes through continued implementation of Activity Based Management (ABM).
- **Improved financial management** – through how we budget and allocate resources, how we procure goods and services, how we raise revenue and record financial transactions.
- **Stronger partnerships** – across our system with other government agencies, non-government organisations, consumers, community groups, private providers and others; and continued protection of public health and safety through a mix of legislation, community education and targeted programs.
- **On-going commissioning of infrastructure** – through delivery of key metropolitan projects and transformation of health services in regional Western Australia, with sound governance for transition activities.
- **More effective delivery of Information and Communications Technology (ICT) and Support Services** – through implementation of the WA Health ICT Strategy 2015-2018 and the establishment of the Health Support Services (HSS) division.
- **Supporting research and innovation** – by embedding a vibrant, relevant and effective research culture into the core activities of WA Health, and stimulating innovation.

The Reform Program consists of a series of projects that will be rolled out in two phases:

- Phase 1 is underway and involves projects related to system governance, system performance, support services, procurement and contract management.
- Planning is beginning for Phase 2 projects that will support patient safety and quality, workforce planning, develop leadership, and promote partnerships. The Reform Program involves a system-wide effort to sustain and improve quality health care and staff will be critical to its success.

New Health Service Boards will bring a broader skills set to the governance of Health Services and build stronger links with clinicians and their local communities. A greater focus on all aspects of performance will provide the public with more relevant information to hold WA Health to account for the services it delivers. This means better information for front line staff on their clinical performance, including costs to deliver their services, the impact of their decisions on patient outcomes, and comparisons across sites to minimise unwarranted clinical variation. It is expected that as a result of the Reform Program, WA Health will:

1. Better meet the needs of the community through increased local engagement in decision making
2. Improve system leadership including strategy, policy and system planning
3. Improve ability for clinicians and front-line staff to improve patient outcomes and deliver evidence- based, best practice treatment
4. Have improved clinical and financial performance
5. Be a more engaged, responsive, accountable and sustainable health system.

The OBM Framework consolidates and embodies the WA Health Reform Program, particularly the building blocks of Greater Accountability and improved financial management.

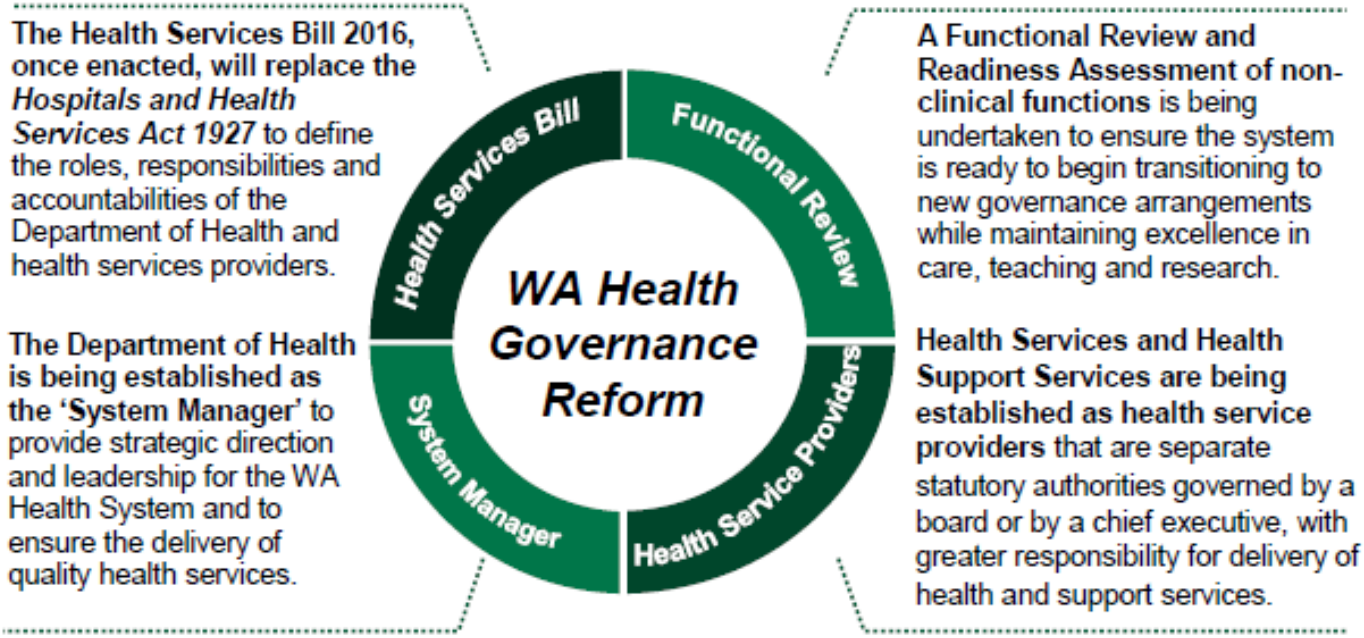
WA Health Structure

Changes to the governance of WA Health

Currently the governance of WA Health is concentrated centrally, with all authority and accountability resting with the Director General of the Department of Health. With an annual budget of more than $8 billion, approximately 44,000 staff and more than 90 hospitals, WA Health is now too large and complex to operate under this model of governance. There is an opportunity for WA Health to be more responsive and innovative in meeting the health needs of local communities and of a growing and ageing population. Changes to the governance of WA Health are required to deliver a safe, high quality, sustainable health system for all Western Australians.

As part of the changes to the governance of WA Health, the following four areas of reform are being undertaken to modernise the governance of WA Health and enable greater accountability and decision-making closer to service delivery and patient care:

Figure 8: WA Health Governance Reform



Role of the System Manager

The Department of Health, led by the Director General, will become the System Manager responsible for the overall management, performance and strategic direction of WA Health. The Director General will issue binding policy frameworks, enter into service agreements with health service providers and ensure the ongoing performance of all aspects of the WA Health system. The System Manger carries out the following for the WA Health System:

- Strategic leadership, planning and direction of the WA Health System.
- Recommending to the Minister for Health the amounts that may be allocated from the health portfolio budget to health service providers.
- Overseeing, monitoring and promoting improvements in the safety and quality of health services.
- Entering into service agreements with health service providers outlining budget, activity and performance measures
- Arranging for the provision of health services by contracted health entities.
- Monitoring performance and taking remedial action when performance does not meet expected standards.

- Managing system wide industrial relations and setting conditions of employment for health service provider employees.
- The Director General has several mechanisms of remediation:
    - Issuing binding policy frameworks and directions to health service providers
    - Agreeing performance objectives with chief executives of health service providers
    - Evaluation and performance management of a health service provider under the service agreement
    - Assessing compliance, performance, safety, quality, and patient services via powers of investigation, inspection and audit
    - Power to conduct an inquiry into the functions, management or operations of health service providers.

Role of Health Service Providers and Health Support Services

Health Services will become Health Service Providers that are separate, board-governed statutory authorities, legally responsible and accountable for the delivery of health services for their local areas and communities. Health Support Services (**HSS**) will be established as a chief executive-governed health service provider that is a statutory authority accountable for the delivery of support services.

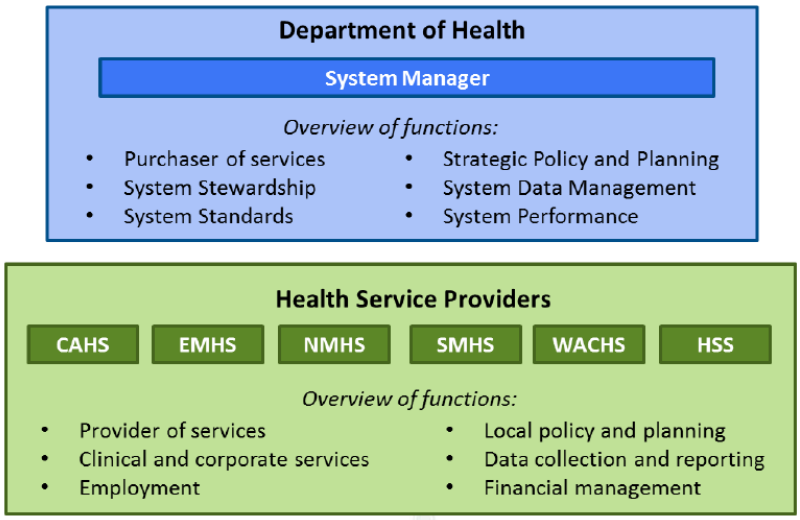
Health Service Providers and Health Support Services will become separate employing authorities, and will be governed by Boards. Health Service Boards will oversee Health Service Providers rather than individual public hospitals, as existed in the past. Chief Executives will manage the day-to-day operations of Health Service Providers.

The role of Health Service Providers and Boards include:

- Providing safe, high quality, efficient and economical health services to their local communities.
- Monitoring and improving the quality of health services.
- Accountable for delivering health services in accordance with Service Agreements with the Director General including funding, performance measures (for example clinical, financial, safety and quality, audit), and operational targets.
- Employing health service staff.
- Contributing to and implementing system wide plans issued by the Department of Health.
- Complying with policy frameworks and directions issued by the Director General.
- Developing policies to suit the local context, within the guidelines of the policy frameworks set by the System Manager.
- Maintaining land, buildings and assets controlled and managed by the health service.
- Consulting with health professionals working in the health service and consultation with health consumers and community members about the provision of health services.
- Cooperating with other providers of health services, including providers of primary health care, in planning for, and providing, health services.
- The Minister can also issue directions to Health Services with respect to the performance of their functions.

Provided in below in Figure 11 is a summary of the split between the Department of Health and Health Service Providers under the new WA Health governance structure.

Figure 9: Overview of non-clinical functions across WA Health


Department of Health
System Manager
Overview of functions:
Purchaser of services
System Stewardship
System Standards
Strategic Policy and Planning
System Data Management
System Performance
Health Service Providers
CAHS
EMHS
NMHS
SMHS
WACHS
HSS
Overview of functions:
Provider of services
Clinical and corporate services
Employment
Local policy and planning
Data collection and reporting
Financial management

Appendix 2 Treasury and Office of Auditor General feedback – actions and outcomes

WA HEALTH OBM FRAMEWORK SUBMISSION – FEEDBACK FROM TREASURY AND OAG

Note:

- KPIs in **black text** are existing annual report KPIs and KPIs in red text are indicators that are either completely new or are currently reported through other mechanisms but not in WA Health Annual Reports.
- Action and investigation information has been generated through discussion with PSP Executive members and relevant work stream staff.
- The numbering of these KPIs was produced at a point in time, and will not match the numbering provided for in the final version of this submission.

Section of the Submission	Treasury Feedback	OAG Feedback	Action and Investigation	Outcome of Action
General Comments	• The submission contains a large volume of information that, while clearly very useful for internal purposes (including briefing the Minister for Health), is not required for submission to the Under Treasurer.		• It is recommended that the level of detail in the submission be retained as is. • No action is required.	• N/A
Section 5 - Services	• Generally, the discussion of proposed services is clear – we have no major issues with the submission content in relation to Services 1 to 5. • We remain concerned with the aggregation of different activities/areas into Service 6. Service Line 6 totals $1.4 billion, including services currently separately identified in the OBM structure, and are not convinced with the rationale provided for their aggregation: o Patient Transport Services ($209 million); ▪ The activities comprising Patient Services are regarded as appropriate for recognition as a separate service from the rest of the Public and Community Health Services. The rationale provided for their aggregation is noted as their delivery in a community setting – however this appears inconsistent with the approach adopted for Service 1 – where home care services delivered outside a hospital setting are explicitly considered for inclusion in the Public Hospital Admitted Service, which indicates the setting of a service is not definitive. The view that Patient Transport Services are "not a core business" of WA Health appears based on the fact that the RFDS and St Johns Ambulance services are provided under contract – but this contractual arrangement is not considered to reduce the interest of the Public and Parliament in relation to this material service that is of vital importance to the health sector. o Small Rural Hospitals ($252 million): ▪ We note that small hospitals are often block funded because fluctuating activity would make an		• WA Health believes it has a strong rationale for each of the Services within the Framework – and there will be no amendment at this stage to the Service structure. • Amendment may occur upon a review of the Structure two years post implementation in 2017/2018. • No action is required.	• N/A

Section of the Submission	Treasury Feedback	OAG Feedback	Action and Investigation	Outcome of Action
	activity based funding model inappropriate. Listing this service separately recognises the fixed costs and absence of economies of scales associated with running small hospitals – providing a clearer view of the performance of different elements of the Health system than incorporating this service into a broader service group. We note that final draft 1.7 of WA Health OBM changes (from August 2014) proposed an additional service for Small Rural Hospitals, including KPIs. The submission does not provide any compelling argument why this should not be progressed. • For Services 7 and 8, the link of these new Services to the new Outcome is well made, and we have no issues with these Services at this time.			
Section 6 – Sub-Services	• We do appreciate the additional discussion on sub services in section 6, but suggest this section also be condensed, and perhaps moved to an appendix accompanying the submission.		• It is recommended that the level of detail in the submission be retained as is. • No action is required.	• N/A
Section 7 - KPIs	• Information in Table 17: o Great to see additional information provided regarding inter-jurisdictional, benchmarking, etc. o No need to provide much (if any) additional information for KPIs that are to be retained, and are unchanged; o Focus to be on what has being added, changed or removed; o Much of the information in the 'Indicator Rationale' column does not add to the rationale e.g. the following from the proposed KPI 'average cost per patient transported by RFDS' does not explain why this is the most appropriate way to measure the efficiency of this service. Again, it might be useful internally, but not for the UT to decide on individual KPIs.		• The feedback regarding the indicator measure column should be amended in the submission. • All other information should remain in this table.	• The feedback regarding the indicator measure column has been adopted and amended accordingly in the submission.
Effectiveness KPIs				
KPI 1 "Unplanned hospital readmission rates (Unplanned hospital readmissions of public hospital patients within 28 days for selected surgical procedures: (a) knee replacement; (b) hip replacement; (c) tonsillectomy & adenoidectomy; (d) hysterectomy;		• I would suggest all area health services should have the same target for each procedure. Also, consider having one overall target which takes into account the various procedures. • CAHS should consider other procedures that are relevant only for CAHS unplanned hospital readmissions.	• System Performance will undertake the following actions: o Review the target information and consider whether variance in the procedure targets for each HSP is an appropriate approach. o Provide the rationale as to why CAHS does not report against all procedures and the plan for implementing procedures specific to CAHS. o Detail the above information in the	• This action has been completed and the following information confirmed: o Targets for procedures will not be varied for each HSP, as recommended by the OAG there will be the same target for all HSPs.

Section of the Submission	Treasury Feedback	OAG Feedback	Action and Investigation	Outcome of Action
(e) prostatectomy; (f) cataract surgery; g) appendicectomy)"			2016/2017 submission.	
KPI 3 "Elective surgery waiting times – the proportion of all elective patients on the wait list who's waiting time is over the clinically recommended time for their urgency category at census date, reported by urgency category and reportable status".	• The note included in the rationale column will be pending the outcome of any 2016-17 submission request.		• No action required.	• N/A
KPI 5 "Hospital infection rates: Healthcare-associated Staphylococcus aureus bloodstream infections (HA-SABSI) per 10,000 occupied bed-days in public hospitals".	• We understand that an estimated 20% of the human population are long term carriers of SAB, and one of the five most common causes of hospital acquired infections. How do we determine if SAB is healthcare associated, particularly for non-admitted patients?		• OBSS Project team will: o Contact Rebecca McCain and Simone from CDC to obtain the answer to TSY's comments. o Reflect outcome of above request in the 2017/2018 submission.	• This action has been completed and the following information confirmed: o The assumptions made by Treasury are not quite correct. o You cannot be a long term carrier of SAB (Staphylococcus aureus bacteraemia). o Staphylococcus aureus is a highly pathogenic organism and once in your bloodstream is associated with a marked increase in morbidity and mortality – mortality estimated at 20-25%. o Approximately 30% of the human population are asymptomatic carriers of S.aureus, that is they are colonised with the organism and it is not causing any infection. o S.aureus is a common cause of many different types of hospital acquired infections e.g. wound infections, bloodstream infection o SAB is the most common cause of healthcare associated bloodstream infections. o There are National definitions used to determine if a SAB event is healthcare or community acquired and they include criteria for patients who may be receiving care as an outpatient or Hospital in the home or as a day case. o Once a patient acquires a SAB it would be extremely rare for them not to be admitted to hospital for care.
KPI 6 "Hospital standardised mortality ratio (percentage of WA public hospitals who are rated as performing or highly performing in comparison to their national peers for the ratio of observed and expected numbers of hospital separations that result in the patient's death)".	• Is there not another equivalent comparator assessing quality and safety across children's hospitals?		• System Performance will undertake the following actions: o Provide the rationale to the OBSS project team for inclusion in the 2017/2018 submission with respect to why CAHS cannot report against this KPI; and o System Performance's plan to create more CAHS specific indicators in the future.	• This action is complete. • There is currently no established method (national or international) to calculate paediatric specific HSMR. This is an area of ongoing development by several Australian groups such as AIHW and the University of Melbourne.
KPI 8 "The percentage of admitted Aboriginal and Non-Aboriginal patients who left against medical advice" **Note:** This was previously titled "Percentage of admitted Aboriginal patients who discharged themselves against medical advice	• Why only focus on Aboriginal patients? Don't we need the non-Aboriginal patients number to at least compare?		• OBSS Project team will: o Contact Vikki to obtain additional information on the progress of this indictor into the HSPR and update the indicator and measurement information in the 2017/2018 submission.	• The action has been completed – this indicator will be split into the two cohorts as suggested by TSY. • Further information on this KPI has been provided by Performance and will be incorporated into the 2017/2018 submission.

Section of the Submission	Treasury Feedback	OAG Feedback	Action and Investigation	Outcome of Action
(DAMA)"				
KPI 15 "Childhood immunisation ((a) percentage of children fully immunised at 12-15 months: Aboriginal and (b) of children fully immunised at 12-154 months: Total)"	• Why does CAHS not report under this KPI? From CAHS website, immunisations is shown as CAHS core business.		• System Performance will undertake the following actions: o Liaise with the relevant HSPR data custodian to confirm this same indicator is currently reported by HSPs. o If HSPs do report this indicator in the HSPR, checking whether CAHS's performance against this indicator is material. o Determine whether HSPs, CAHS or the Department should be reporting this existing indicator. o Include this information in the 2016/2017 submission. • OBSS project team to pick up the above outcome in the 2017/2018.	• This action is complete. • This indicator is based on the child's residential postcode rather than the provider. CAHS by definition, services a prescribed cohort of the WA population (i.e. children and adolescents). Unlike the other Health Service Providers, the scope of CAHS activities is not prescribed on the basis of geographical regions.
KPI 19 "Response times for patient transport services delivered by St John Ambulance (Percentage of priority 1 calls attended to within 15 minutes in the metropolitan area by St John Ambulance Western Australia Ltd)".		• This is an existing KPI for DoH. Therefore it is unclear why it is listed as an addition.	• OBSS Project team will: o Update the submission to change this back to existing – and comment that the existing combined KPI is been spilt into KPI 20 and 21.	• This action has been completed in the 2017/2018 submission.
KPI 20 "Response times for patient transport services delivered by the Royal Flying Doctor Service (Percentage of Royal Flying Doctor Service (Western Operations) inter-hospital transfers meeting the state-wide contract target response time for priority 1 calls)".		• What is the basis for moving this to WACHS as they do not control the contract? • Royal Flying Doctors is only a portion of what is spent at WACHS. Patient assisted travel costs also includes airfares, car hire, taxis, etc. Where will this be reported / measured?	• OBSS Project team to: o Note that WACHS does control the contract for this Service, so it is appropriate for only WACHS to report this indicator. o Add additional rationale to the 2017/2018 regarding what type of services this KPI will capture – and what others listed by OAG are inter-hospital costs. • System Performance will undertake the following actions: o Ensure 2016/2017 KPI manuals are reflective of clear inclusions and exclusions for this existing KPI.	• This OBSS Project action has been completed. WACHS have confirmed the following information: o WACHS is the budget holder for and manages the RFDS Contract. It is appropriate for only WACHS to report this KPI in its Annual Report. o The RFDS KPI is related to contract costs only. The patient assisted travel costs of airfares, car hire, taxis, etc are captured as part of intra-hospital transfers and have nothing to do with the RFDS KPI.
KPI 21 "The percentage of palliative care Silver Chain patients that die at home" Note: This was previously titled "Percentage of people accessing community-based palliative care to assist them with their request to die at home".		• There needs to be a robust system for measuring people who are dying at home as opposed to those dying in hospital.	• OBSS Project team will: o Liaise with Rob Willday from System Policy and Planning to obtain the information to satisfy OAG comments. o Provide the response from Rob to System Performance to check rationale. o Update 2017/2018 submission accordingly.	• This action is complete. • The data custodian has confirmed that numerator and denominator information for this KPI can be calculated through a robust measurement process.

Section of the Submission	Treasury Feedback	OAG Feedback	Action and Investigation	Outcome of Action
KPI 22 "Participation rate of women aged 50 – 74 years who participate in breast screening: (a) Indigenous women aged 50 – 74 years; (b) Non-Indigenous women aged 50 – 74 years"	• Why is NMHS the only entity reporting?		• OBSS Project team: o Based on Feedback from the Data Custodian Ruth Bostock, this KPI is being amended back to the existing KPI of 50-69 years. o Add additional rationale from data custodian as to why this cannot be split out by entity and must be reported by NMHS.	• This action has been completed in the 2017/2018 submission.
KPI 23 "The percentage of year 8 students that complete their HPV vaccination series"	• Why does CAHS not report under this KPI?		• System Performance will undertake the following actions: o Provide the rationale to the OBSS project team for inclusion in the 2017/2018 submission as to why this KPI cannot be disaggregated. • OBSS Project team to: o Update the 2017/2018 submission to provide additional information as to why this has to be reported by the Department as a State based indicator.	• This action is complete. • This indicator is based on the registered school students on the SBIP database and not by the provider of program. CAHS by definition, services a prescribed cohort of the WA population (i.e. children and adolescents). Unlike the other Health Service Providers, the scope of CAHS activities is not prescribed on the basis of geographical regions.
KPI 24 "The percentage of (a) adults and (b) children who have a tooth retreated within six months of receiving initial restorative dental treatment"	• Why is NMHS the only entity reporting?		• OBSS Project team to: o Add additional rationale from data custodian as to why this cannot be split out by entity and must be reported by NMHS into the 2017/2018 submission.	• This action is complete and rationale has been provided in the submission, with respect to the delivery of a State wide Service by NMHS on behalf of the State and the inability for this data to be disaggregated by HSP.
KPI 25 "The percentage of patients who access emergency services at a small rural or remote Western Australian hospital and are subsequently discharged home" Note: This was previously titled the "Small rural hospital indicator" placeholder.	• There are no KPIs for Small Rural Hospitals – a KPI should be included.	• It is unclear as to how this will be measured and what would be reported.	• No action required – this was already being progressed by WACHS and the OBSS project team.	• A KPI has been finalised in consultation with WACHS and has been included in the submission: "The percentage of patients who access emergency services at a small rural or remote Western Australian hospital and are subsequently discharged home". • This KPI measures community primary health care services that are provided by Small Rural Hospitals. This allows the community to access primary care (prevention and promotion) services that are often limited in rural areas due the lack of General Practitioners (GPs). Providing these types of services, that would usually be provided by GPs, which allows people treated without admission to a hospital, is a significant community expectation of people living in country WA, and addresses the shortage of primary health care services.
KPI 36 "The Department of Health leads policy development on key priority issues".		• In its current wording, this KPI is unauditable. It is unclear as to how this will be measured and what reported (a percentage?). The rationale talks about a survey, but it is unclear as to how this relates to the indicator wording. If the Department intends on using a survey, then it would be better to word the indicator as "% of people satisfied that the Department leads development on key priority issues." "Key priority issues" should be clearly defined at the outset.	• OBSS Project team to: o Liaise with Brooke Fowles and Nancy Appleby with respect to an alternative KPI for Policy Services provided by the Department. o If no alternative can be determined, this KPI will be removed from the suite.	• A meeting occurred on Monday 1 August 2016. • This work is being progressed for inclusion in the submission of a policy service KPI.
KPI 37 The percentage of		• This could be viewed as more of a workload	• OBSS Project team to:	• The OBSS Project team have changed the title of this KPI in

Section of the Submission	Treasury Feedback	OAG Feedback	Action and Investigation	Outcome of Action
Health Service Performance Reports completed by the 17th working day of each month Note: This KPI was previously titled “The average percentage of on time production of the monthly Health Service Performance Report by the Department of Health”.		indicator as opposed to a true effectiveness indicator. I am not sure whether remedial action is monitored, but measuring whether the number of instances of remedial action over time may give a better indication on how effective DoH is in monitoring the performance of HSPs. If the Department was to use this indicator, then the timeframe should be included in the wording of the indicator. For example, "percentage of Health Service Performance Reports produced within XX days of month end".	o Revise the wording of this KPI in 2017/2018 submission. • System Performance will undertake the following actions: o Provide support to OBSS project team with respect to timeframe information.	the 2017/2018 submission, and are waiting on information from Performance to add the timeframe to the KPI title and the target information for this KPI.
KPI 38 “Clinical Incidents: The proportion of all notified clinical incidents where the patient outcome was death”	• Why is this KPI not reported by individual Health Service Providers?	• We would need to be satisfied that there is a robust system to measure this KPI. In particular, at what point of time would the patient outcome be measured? For example, would it only include instances where the patient died in hospital, or would it cover instances where the patient died at a later point of time due to complications associated with the incident?	• OBSS Project team to: o Provide this feedback to Safety and Quality and capture response to OAG feedback in the 2017/2018 submission.	• This action is complete. Safety and Quality have confirmed the following in response to the comments made by the OAG: • There is no hard and fast time period for the point in time at which the patient outcome would be measured. It really comes down to whether the incident was related to the outcome (in this instance death). Obviously as more time goes by, the likelihood of a link existing and then of it being recognised, reduces. • In response to second question, if the patient's death, where it occurs outside of hospital, were known to their treating team AND where the death was attributable to a clinical incident; then it would be reportable. • It is important to note that there are issues beyond Health's control, the most basic of which is that a patient can die outside of hospital without the hospital being informed. Furthermore, where the hospital is informed, this does not necessarily happen in a timely fashion. Finally, you need to differentiate between a hospital being informed, in which case, a note would be entered into the medical records and PAS; and the patient's treating team being informed. • Further, most of the healthcare provided to patients is delivered outside of the hospital setting by other providers in the community setting. Hence, there isn't necessarily always a straight relationship between an event and a subsequent outcome.
KPI 39 “The percentage of system-wide, key budget forecasts produced by the Department of Health within agreed client timeframes”		• We would need to have clear definitions as to what are 'key budget forecasts'. In addition, the timeframes need to be included in the wording of the KPIs unless they are different for each HSP.	• OBSS Project team to: o Confirm with Resource Allocation the response to the comments made by OAG. o Update the 2017/2018 submission accordingly.	• This action is complete.
KPI 40 “Public Health Regulation (the percentage of regulations, policy and other supporting documents in the Annual Public Health Division Operational Plans which were completed)” Note: This KPI was previously titled “Public Health Regulation: Percent of completed regulations, policy and other supporting documents which support the	• We have some concern with the consistency of measurement year on year. For example, the number and complexities of policy workloads each year may be expected to change.	• I think it would be better to revise the wording to state "the percentage of regulations, policy and other supporting documents in the Annual Public Health Plans which were completed". That way it is clear that you are measuring annual targets rather than a cumulative number.	• OBSS Project team to: o Provide the feedback from OAG and TSY on this KPI to Public Health and seek a decision as to the revision of the wording. o Update the 2017/2018 submission accordingly.	• This action is complete. • The KPI has been reworded in consultation with the Public Health division as follows: “Public Health Regulation (the percentage of regulations, policy and other supporting documents in the Annual Public Health Division Operational Plans which were completed)”. • In terms of Treasury’s concerns, Public Health provided the following response “the workload and mix will change from year to year, as outlined in our yearly operational plans. The KPI, however, measures our effectiveness in getting that work done. We could look at the trends over the respective years”.

Section of the Submission	Treasury Feedback	OAG Feedback	Action and Investigation	Outcome of Action
role of Health Services Providers in the delivery of approved services to approved State standards".				
KPI 41 "The percentage of responses from WA Health Service Providers and Department of Health who are satisfied or highly satisfied with the overall service provided by Health"		• The OAG will need to take into consideration the number of surveys conducted throughout the year and whether the survey will represent an unbiased view.	• System Performance will undertake the following actions: o Confirm the target with HSS for this KPI and include in the 2016/2017 submission. • OBSS Project team to: o Pick up the target information from the 2016/2017 submission and include in the 2017/2018 submission.	• The target information will not be available within the timeframes of the submission. • A comment has been made in the submission with respect to the development of a target for this KPI, which will occur in the next two to three months. • This information will be available for the 2017/2018 reporting period.
Effectiveness KPIs to be removed				
Percentage of live-born infants with an Apgar score of three or less	• Can we please have some more information on the rationale for the decision? I.e. what has changed from the original position that this KPI was appropriately provided in the Budget?		• The original rationale for these KPIs has not been retained in a documented form. • KPIs were removed on the basis of subject matter feedback, HSP voting and PSP Executive voting. • The rationale for the removal of these KPIs has been captured in the submission based on the above process, no additional information is available. • The OBSS project team: o Will make a general comment in the 2017/2018 submission that there has not been a robust or documented decision making processes for the inclusion of KPIs 15 years ago, and we have no further information as to why they were previously measured/reported. o The development process and documentation detailed in this submission will set the standard for all future submissions. This will ensure that moving forward to rationale for why a KPI was included or removed will be captured and documented.	• This action is complete.
Rate of hospitalisation for selected respiratory conditions	• Why were these KPI previously measured/reported - i.e. what was the previous rationale for inclusion and why is that no longer valid? What are the replacement KPIs which will address the previously identified measurement need?.			
Rate of hospitalisation for falls in older persons				
Proportion of people with cancer accessing admitted palliative care	• Previous inclusion of this KPI implies that there may have been access issues requiring measurement - which the identified replacement KPI does not address? Why was this previously measured, and what has changed so that it is no longer necessary?			
Access to dental treatment services for eligible people	• Why was this previously measured, and what has changed so that it is no longer necessary?			
Average waiting times for dental services	• Why was this previously measured, and what has changed so that it is no longer necessary?			
Efficiency KPIs				
KPI 27 "Average cost per bed-day for specified residential care facilities, flexible care (hostels) and nursing home type residents"	• Why is this KPI only measured in WACHS? Do these types of facilities/services not exist in the metro area?		• The OBSS project team to: o Seek advice from WACHS to confirm that only WACHS receives WA public funding for these services hence why they are the only entity to report against this KPI.	• This action is complete. • Given the limited numbers of residential aged care facilities in country Western Australia, residential aged care services are provided through the public hospital system in country areas. This is not the case for metropolitan services as people in the metropolitan area can access specialised residential aged care facilities, and these are not provided through the public hospital system.

Section of the Submission	Treasury Feedback	OAG Feedback	Action and Investigation	Outcome of Action
KPI 33 "The average cost of WA Health provided dental health programs for enrolled school children and socio-economically disadvantaged adult patients"	• Why is the target the same for the same for adults and children? Why is NMHS the only entity reporting this KPI?		• The OBSS project team to: o Review target source provided by data custodian. o Update the 2017/2018 submission accordingly.	• This action is complete. o The target for part (a) is $134 ; and o The target for part (b) is $394.
KPI 34. Average cost per patient transported by St John Ambulance Patient Transfer Service		• The Department needs to ensure that patient transport data is robust. We have reported significant issues in previous years because there are no processes to verify data provided by external service providers.	• The OBSS project team to: o Provide this feedback to the KPI Data Custodian Rob Willday. • System Performance will undertake the following actions: o Undertake a review of the KPI data collection process for this KPI as part of 2016/2017 annual report processes.	• This action is complete. • The data custodian for this KPI has confirmed that Deliotte undertake an independent audit of St John's financial and activity data.
KPI 35. Average cost per patient transported by the Royal Flying Doctor Service (Western Operations)		• Similarly, we would need to ensure that data provided by RFDS is robust and verified by the Department.	• The OBSS project team to: o Provide this feedback to the KPI Data Custodian at WACHS. • System Performance will undertake the following actions: o Undertake a review of the KPI data collection process for this KPI as part of 2016/2017 annual report processes.	• This action is complete.
KPI 42 "Average cost of Public Health Regulatory Services per head of population"	• Is this KPI measured per person as in per capita?	• Is this per person in the state?	• The OBSS project team to: o Review the KPI Definition to respond to feedback. o Update the 2017/2018 submission appropriately.	• This action is complete. • The denominator for this KPI is the total persons in Western Australia (Estimated Resident Population) for the reference period as at 30 June. • This KPI has been reworded as follows "Average cost of Public Health Regulatory services per head of population" in order to make it clearer to reader what is being measured by this KPI.
KPI 43 "Average percentage on time reporting of system wide safety and quality indicators and performance data by the Department of Health to stakeholders."		• I assume this does not capture the same performance data captured by effectiveness indicator 37. It would be better to include what 'on-time reporting' is within the KPI. ie within xx days of month-end etc.	• The OBSS project team to: o Liaise with S&Q regarding this feedback and some other KPI options to replace KPI 43 that may provide more meaningful information.	• This action is complete.
KPI 44 "Average percentage on time production of key system-wide financial reports released by the WA Department of Health to internal, State and Commonwealth stakeholders."		• I believe this KPI is too high level. Another option is to have specific KPIs for each of the core reporting requirements. • For example, percentage of service level agreements finalised within XX months of year-end, percentage of Commonwealth financial reports which met agreed timeframes etc.	• The OBSS project team to: o Liaise with relevant PSP Division data custodians to consider alternative wording for this KPI.	• This action is complete.
Patient Assisted Travel Scheme	• There are no KPIs for the PATS		**No action required.**	N/A
Small Rural Hospitals	• There are no KPIs for Small Rural Hospitals		**No action required.**	N/A

Section of the Submission	Treasury Feedback	OAG Feedback	Action and Investigation	Outcome of Action
Efficiency KPIs to be removed				
Average cost per trip of PATS	• Why were these KPI previously measured/reported and why has this rationale/need changed?		**No action required.**	N/A
Average cost per breast screening				

Appendix 3 OBSS Reform Project Objectives, Scope and Benefits

Project Objectives

The overarching objective of the Project is to develop an improved OBM Framework that is connected and utilised across the budget, resource allocation, performance management and reporting cycle to provide adequate information to the public, parliament and WA Health on the delivery of WA Health services. The case for change that lead to the initiation of the Project, and the Project Objectives are outlined below.

Figure 10: Project Objectives

Case for change	Objectives
The current OBSS does not: • Adequately provide information to the public on the services delivered by WA Health. • Reflect the defined Activity Based Funding (ABF) service categories, or clearly define and categorise the non-ABF service categories. • Align with the structures used for the purposes of the budgeting; resource allocation; revenue alignment and the financial and performance reporting and management. An improved OBSS means that WA Health can: • Develop and communicate budget proposals in a timely and non-contradictory manner. • Use an outcome based management structure to effectively and consistently report and account for the effectiveness and efficiency of the health system publicly. • Improve the efficiency and timeliness of the resource allocation process.	• To develop an OBSS that reflects the services that WA Health actually delivers. • To ensure the OBSS is aligned with the ABF service categories and non-ABF services. • To implement a single OBSS for use in: a) The publically available Annual Reports and Budget Papers; and b) The WA Health processes of: budget development, revenue alignment, resource allocation and the financial and performance reporting/management. • To support the streamlining, accuracy and effectiveness of WA Health budget, allocation, performance, management and reporting processes. • To achieve improved public accountability for WA Health.

Development of an improved OBM Framework that is connected and utilised across the budget, resource allocation, performance management and reporting cycle will enable:

- More relevant information to be provided to the community, Parliament and WA Health employees about the services WA Health is publically funded to deliver.
- Improved reporting of our performance to enable the community and Parliament to monitor and track key changes over time.
- A more streamlined and consistent approach to our budget, resource allocation, performance management and reporting processes.
- Alignment with national structures such as ABF and national performance indicators to improve comparisons with other States.

The Project will result in a revised OBM structure for WA Health. The revised OBM Framework is scheduled to be implemented for the 2017-18 budget cycle, in first instance in the 2016 budget submission then flowing through to the WA Health budget papers and Annual Reports.

Project Scope

The scope of the reform that has occurred as an outcome of the Project, and its resultant revised OBM Framework is outlined below:

Figure 11: Project Scope

In scope	Out of scope
• Determination/agreement on the purpose, definitions and outputs of the OBSS for collective use. • Review and determination of WA Health service and program outputs. • Review of OBSS used within other jurisdictions and agencies. • Develop outcome statements, Services and KPIs • Alignment/testing of the OBSS to ensure the structure will achieve the requirements of the WA Health Budget Submission and Budget papers, Annual Reports, Allocation, Financial and Performance Monitoring and Reporting & FTE/Workforce Reporting. • Mapping of OBSS with the organisational structure to provide a transparent and connected understanding of financial and service performance. • Business rules that incorporate data capture and reporting for KPIs. • Consultation with Health Services, DoH Divisions and Directorates as well as Treasury, Office of the Auditor-General, HIN and HCN & other Government agencies.	• The project will not become a single Business Intelligence (BI) Tool; rather it will align with current BI tools and inform development of others. • Driving the current reform of Budget and Resource Allocation processes (though it is a key interdependency). • The reform or improvement to cost centres is being driven/led by the WA Health Reform Cost Centre Project.

The scope of the Project covers WA Health's performance management framework as reported in the annual report. The performance management framework is referred to as OBM Framework, which contains the "Outcomes", "Services" and "Key Performance Indicators".

The purpose of the assessment undertaken by the Project was to:

1) Review the current WA Health OBM framework and identify all opportunities to amend or completely revise the structure to better reflect the business of WA Health and assist with performance reporting and the story provided to the WA public;
2) Confirm or make recommendations to amend WA Health's annual reporting KPIs and ascertain the scope and impact of any changes proposed on each reporting entity; and
3) Demonstrate, where appropriate, the relationship between proposed Outcome Statements and KPIs and other reporting initiatives of WA Health such as the NHA performance reporting, PAF, ABF performance reporting and other internal performance reporting.

Project Benefits

#	Benefit	Quantification	Expected delivery date
1	Provide adequate information to the public and parliament about the services WA Health delivers to achieve outcomes.	▪ An updated OBSS and indicators aligned to OBSS provide adequate information on WA Health performance. ▪ OBSS in Annual Reports and Budget Papers match those in the budget modelling and resource allocation. ▪ Ease, effectiveness, efficiency of Budget estimates process.	▪ Will monitor benefit at: - March, June and July-September 2017 - January and June 2018
2	The OBSS aligns with defined ABF service categories – thereby enhancing implementation of ABF/M.	▪ ABF categories match in OBSS to those used in budget modelling and budget allocation.	▪ Will monitor benefit at: - September 2016 - March and June 2017 - January 2018
3	Clearly defined and categorised non-ABF service categories of WA Health.	▪ Non-ABF categories in OBSS match those used in budget modelling and budget allocation.	▪ Will monitor benefit at: - September 2016 - March and June 2017 - January 2018
4	Able to develop and communicate budget proposals in a timely and non-contradictory manner.	▪ Treasury and WA Health agree on OBSS structure used for budget submission and negotiation.	▪ Will monitor benefit at: - April-June 2017 - January-March 2017
5	Improved efficiency and timeliness of the resource allocation process through better alignment of the structures used for the purposes of the budgeting; resource allocation; revenue alignment and the financial and performance reporting and management.	▪ OBSS is used in a consistent manner across the budget development, budget allocation, resource allocation and performance management process.	▪ Will monitor benefit at: - January-March 2017 - April-June 2017
6	Consistently report and account for the effectiveness and efficiency of the health system publicly.	▪ Annual Report process provides advice on the same OBSS as used throughout WA Health for other business purposes.	▪ January-July 2018
7	Implement Outcome Based Management throughout WA Health's budgeting, allocation, performance and reporting cycle.	▪ Clear alignment of Budget Submission, Budget Papers, Revenue Alignment, Allocation and Service Agreements.	▪ September 2016 – June 2018

Appendix 4 OBSS Executive Committee Governance and Structure

The OBSS Executive Committee was formed as part of the project management methodology used by the Department, to ensure that the revised OBM Framework was designed, developed, tested and implemented in a manner that better reflects the business of WA Health and is an outcome of a collaborative process between the Department and Health Service Providers. The membership of the OBSS Executive Committee was comprised of the following representatives as outlined in below, and the Terms of Reference of the OBSS Executive Committee can viewed at Appendix 5 of the Submission.

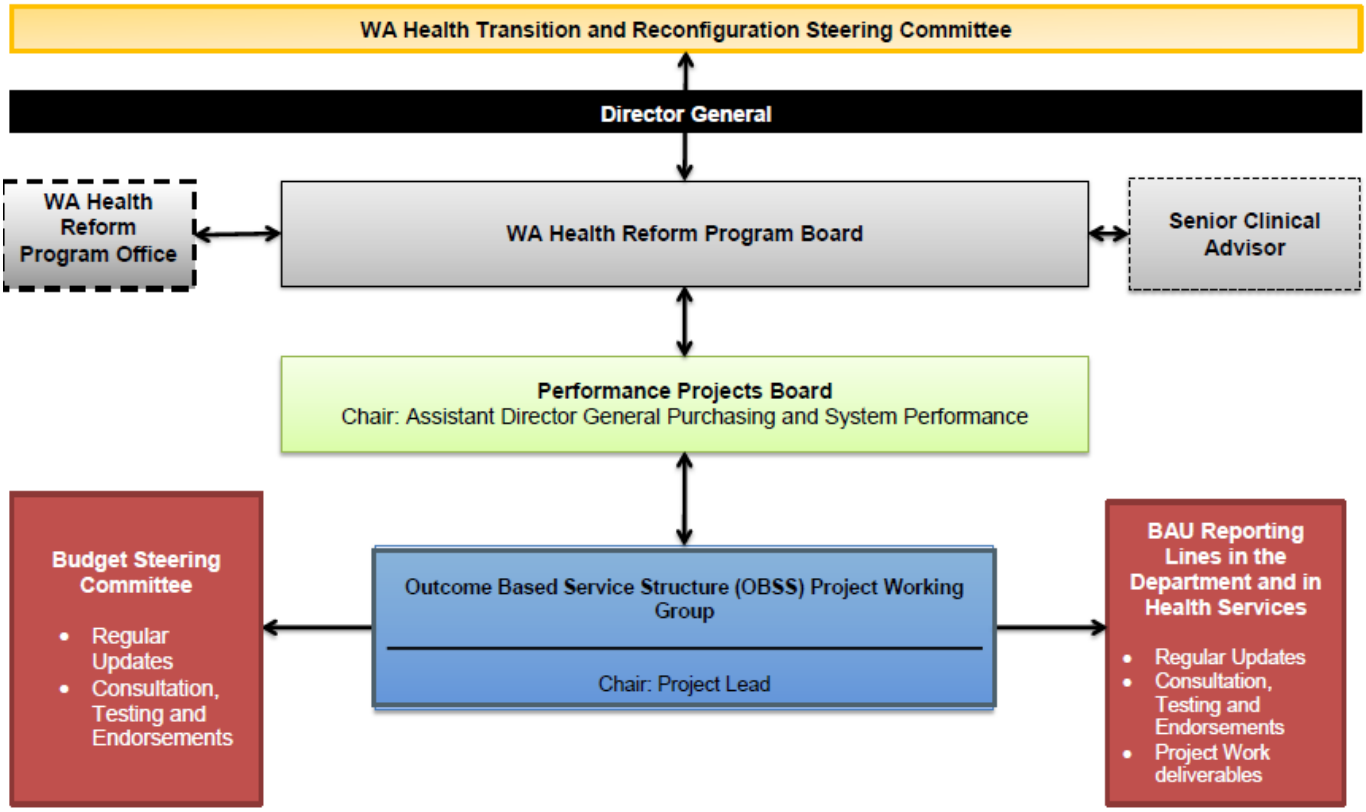
Table 19: Membership of the OBSS Executive Committee

Chair	A/Chief Executive, North Metropolitan Health Services
Members	• A/Group Director Resources, Purchasing and System Performance, DoH • A/Group Director Performance, Purchasing and System Performance, DoH • North Metropolitan Health Service representative • South Metropolitan Health Service representative • WA Country Health Service representative • Child and Adolescent Health Service representative • A/Director Budget Strategy, Purchasing and System Performance, DoH • A/Director Financial Operations, Purchasing and System Performance, DoH • A/Director Performance, Purchasing and System Performance, DoH • A/Director Health Services Purchasing, Purchasing and System Performance, DoH • Project Manager, OBSS Project • Manager, OBSS Project.
Secretariat	Reform Office, Purchasing and System Performance, DoH

The overarching objective of the OBSS Executive Committee was the "Development of a single OBSS that better reflects WA Health's business that will consistently align the budget process, resource allocation, the performance and financial reporting as well as the Annual Reports. Involvement in the development of the OBSS will require members to provide input into the design, review and provide feedback, and participate in the mapping, testing and implementation"[21]. Outlined on the following page is a diagrammatic view of the OBSS Executive Committee governance structure.

[21] WA Health OBSS Executive Committee Terms of Reference.

Figure 12: OBSS Executive Committee Governance Structure



Performance Projects Board (PPB)

The purpose of the PPB is to ensure the delivery of the six performance grouped projects within the WA Health Reform Project. Decisions that cannot be made by consensus or by the Chair of the OBSS Executive Committee are escalated to the PPB for decision. The key objectives of the PPB are:

a) To improve the WA Health budget and allocation process, inclusive of a framework that shifts towards a mature purchaser-provider model, ensures earlier advice and negotiation, better management of cost pressures, as well as prioritisation and delivery of better value for money.
b) Development of a single outcome based service structure that will consistently align the budget process, resource allocation, the performance and financial reporting as well as the annual report.
c) Revision and development of a holistic performance management system, with a single source of truth, common toolset and business rules for WA Health that aligns to purchasing agreements, performance agreements, operational plans, strategic intent and the governance reforms.
d) To enhance the understanding and application of ABM across WA Health through improvements to the capacity and capability required to operate effectively within an ABM environment.
e) To introduce streams of reform that will improve WA Health's ability to increase own source revenue so that WA Health can set and meet increased increase own source revenue targets.
f) To introduce streams of reform that will improve WA Health's ability to increase own source revenue so that WA Health can set and meet increased increase own source revenue targets.

Appendix 5 Outcome Based Service Structure Project Executive Committee – Terms of Reference

Purpose	The Outcome Based Service Structure Project Working Group (OBSS Working Group) will meet to design, develop, test and implement an improved OBSS that better reflects WA Health Business.
Objective	Development of a single OBSS that better reflects WA Health's business that will consistently align the budget process, resource allocation, the performance and financial reporting as well as the Annual Reports. Involvement in the development of the OBSS will require members to provide input into the design, review and provide feedback, and participate in the mapping, testing and implementation.
Responsibilities	• Delivery of the single OBSS that consistently aligns with budget process, resource allocation, the performance and financial reporting as well as the Annual Reports. • Health Service participation and collaboration to ensure that the single OBSS is flexible enough and adequately represents the needs of the Health Service. • Ensure that Executives in the Department and the Health Services are kept abreast of OBSS Project development. • Develop Project Plans and Project Management products as required for the timeframe of the Project. • Research, design, develop, map, test and implement the OBSS. • Identify, manage and escalate risks and issues impacting the project delivery. • Report on progress to the Performance Projects Board. • Delegate work related to the OBSS structure to operational staff in the Department and Health Services as required to meet the project deliverables.
Membership	*Chair:* 1. A/Chief Executive, North Metropolitan Health Services *Members:* 2. A/Group Director Resources, Purchasing and System Performance, DoH 3. A/Group Director Performance, Purchasing and System Performance, DoH 4. North Metropolitan Health Service representative 5. South Metropolitan Health Service representative 6. WA Country Health Service representative 7. Child and Adolescent Health Service representative 8. A/Director Budget Strategy, Purchasing and System Performance, DoH 9. A/Director Financial Operations, Purchasing and System Performance, DoH 10. A/Director Performance, Purchasing and System Performance, DoH 11. A/Director Health Services Purchasing, Purchasing and System Performance, DoH 12. Project Manager, OBSS Project 13. Manager, OBSS Project 14. Manager, OBSS Project *Secretariat:* 15. Reform Office, Purchasing and System Performance, DoH.
Decision making protocol	• Decisions will be made by general consensus in the first instance. • In circumstances where a consensus cannot be reached, then the decision of the Chair is final.
Absence protocol	• Members of the Working Group may nominate an appropriate proxy if they are unable to attend meetings. • Working Group members must inform the Chair as soon as possible if they intend to send a proxy to a meeting. • Proxies are entitled to participate in meeting discussion and are allowed a role in decision making.
Frequency	• Meetings will meet monthly and will be held 90 minutes, at the Department of Health.
Constitution Period	• The Working Group will continue for the period of the OBSS Project. • The term of the Working Group will be reviewed annually.
Papers	• An agenda will be circulated at least two (2) working days prior to meetings. • An action list will be generated and circulated within one (1) working day of the meeting being held. • Minutes of meetings will be circulated within five (5) working days of the meeting being held.

Appendix 6 Evaluation Principles for Design and Decision-Making on Outcome Statements and the Service Structure

Overarching Principle 1: Transparency of Public Reporting

To improve the accuracy of public reporting (through budget papers and annual reports)

- Information provided in the budget papers/annual reports against the OBM structure is accurate with clear business rules for developers and clear understanding for users.

To provide information of interest to the public/community on WA Health service delivery

- Public interest in services that WA Health delivers should be considered
- Service lines should represent categories of delivery that are of public interest
- Service lines, and/or programs aligned to service lines, should allow for performance measures against categories of public interest.

A structure that can accommodate reporting/acquittal by budget holder or entity

- Each entity within WA Health will be required to produce an annual report – the new governance structure will set the entities
- Each annual report requires reporting against funding held and expensed by that entity
- To accommodate this, the structure must be able to provide entity details against the service lines, programs, outputs etc. for financial reporting KPIs as well as efficiency KPIs.

Overarching Principle 2: Ensuring Business Integrity

To improve alignment with the WA Health resource acquisition, allocation, performance management cycle and to improve alignment with ABF/ABM

- The significant WA Health management processes related to acquiring resources through government, allocating resources to services and programs, managing performance and reporting should all align with the OBM structure.
- This will be achieved through improved alignment with key deliverables such as: budget submission, budget papers, service agreements, performance management framework, health service performance report and financial reporting.
- The requirement for WA Health to manage its business by activity has been mandated and introduced since the last update of the current service structure.
- The new/revised service structure should allow for better alignment with the way WA health acquires funding, allocates, performance manages and reports its business based on activity.

To provide information that is material financially

- WA Health manages over 8 billion dollars' worth of government funding for service and program delivery.
- The materiality of service lines and programs is significant and the breakup into categories that require ongoing management, explanation to the public and financial reporting should be considered.
- Materiality has been approximated at $400 million (around 5%).

A structure that aligns with WA Health's Strategic and Operational Intent

- WA Health Strategic Intent outlines priorities and enablers for WA Health – these will be considered in the service structure representation
- Operations policy documents such as Operational Plans and the Clinical Services Framework will be referenced for appropriate service and program lines.

Enablers to the above Principles:

To accommodate implementation and reporting of Outcome Based Management (OBM) across WA Health

- Services:
  - The supply of an activity or good to a user external to the agency providing the service.
  - Services comprise programs and outputs.
- Service relationship to Outcomes:
  - Clearly understood, documented and reported government desired outcomes that contribute to the government goal for WA Health.
  - The ability to understand, document and report on the effect, impact, result on or consequence (the outcome) for the community, environment or target clients of government services (as per the service structure).
- Service relationship to KPIs:
  - Provides an overview of the critical or material aspects of outcome achievement or service provision.

A structure that has considered other jurisdictions and agencies structures

- A review of other health jurisdictions service structures has been completed – rationale with regard to other jurisdictions service structure categories will be considered.
- A review of other WA Government agencies has been completed – rationale with regard to other agencies service structure categories will be considered.

Outcome Statements and Service Lines	Sub Services	ABF	Programs	Rationales that support the Outcome	Review of WA and Other Jurisdictions Central and Service Agencies
WA Government Goal: Greater focus on achieving results in key service delivery areas for the benefit of Western Australians					
WA Health Agency Goal: Delivery of quality, transparent, financially sustainable and evidence based Healthcare for all Western Australians					
Alignment with WA Health strategic vision "to deliver a safe, high quality, sustainable health system for all Western Australians"					
Outcome 1: "Western Australians have access to public hospital based services that enable treatment and restorative health care".					
1. Public Hospital Admitted Services (approx. $3.54B) Descriptor: The provision of healthcare services to patients in metropolitan and major rural hospitals that meet the criteria for admission and receive treatment and/or care for a period of time, including public patients treated in private facilities under contract to WA Health. Admission to hospital and the treatment provided may include access to acute and/or subacute inpatient services, hospital in the home services and the quadriplegic centre. Teaching and training activities as well as research activities provided by the public health service to facilitate development of skills and acquisition or advancement of knowledge related to admitted services is also included in this service group.	1. Acute inpatient	Y	01. Acute Inpatient	• Compliance with the requirements of Outcome Based Management and the associated November 2004 Guidelines; Treasurer's Instructions 808 Resource Agreement, 903 Agency Annual Reports and 904 Key Performance Indicators, which deal with Outcome Statements and their utilisation. • Outcome 1 describes the end result, impact or consequence of service lines 1 to 4 for the Western Australian public; receipt of public hospital based services [end result] + treatment and restorative health care [end result]. • Outcome 1 is consistent with the WA Government Goal of "greater focus on achieving results in key service delivery areas for the benefit of Western Australians", maintaining reporting alignment with the WA Health Budget Papers and Annual Reports. • Review of other jurisdictions, other WA Government agencies and initial consultations with DoH stakeholders suggest measurable KPIs are possible for this proposed outcome. • Aligns with a continuum of care approach; a system that guides and tracks patients over time through a comprehensive array of health services spanning all levels and intensity of care. The Continuum of Care covers the delivery of healthcare over a period of time, and may refer to care provided from birth to end of life.	• Consideration was given to the WA agencies (Education, Transport, Police and Corrective Services) examined in the OBM Current and Future State Assessment. All utilise outcomes that reflect the provider focus of the services delivered, similar to that proposed for Outcome 1. • WA MHC has the following outcome "Accessible and high quality mental health services and supports that are recovery-focussed and promote mental health and wellbeing". This outcome is measured through the following key effectiveness indicators: readmissions to hospital within 28 days of discharge; Percent of contacts with community-based public mental health non-admitted services within 7 days post discharge from public mental health inpatient units; Proportion of services funding directed to publicly funded community mental health services and Proportion of service funding directed to community organisations. • WA Department of Education has the following outcome "A public school system which provides access to a quality education throughout WA". This is measured through 4 effectiveness indicators; Participation rate, Apparent retention rate, Secondary graduation rate and Students achieving at or above national minimum standards in the National Assessment Program. Review of WA and other Jurisdictional Central Agencies determined: • NSW DPC has the following performance goal "Improve government transparency by increasing access to government information". This is measured through two performance measure: is improving government transparency by making it easier to access information about government services (1-10 disagree/agree scale) – consumers, and is improving government transparency by making it easier to access information about government services (1-10 disagree/agree scale) – businesses.
	2. Sub-acute inpatient	Y	02. Sub-acute Inpatient		
	3. Public, Private Partnership - Inpatient	Y	03. Public, Private Partnership - Inpatient		
	4. Teaching, Training and Research - Admitted	Y	04. TTR - admitted		
2. Public Hospital Emergency Services (approx. $699M) Descriptor: The provision of services for the treatment of patients in emergency departments of metropolitan and major rural hospitals, including public patients treated in private facilities under contract to WA Health. The services provided to patients are specifically designed to provide emergency care, and include a range of pre-admission, post-acute and other specialist medical, allied health, nursing and ancillary services. Teaching and training activities as well as research activities provided by the public health service to facilitate development of skills and acquisition or advancement of knowledge related to emergency services is also included in this service group.	5. Emergency Department Activity	Y	06. ED Activity		
	6. Public, Private Partnership - ED	Y	07. Public, Private Partnership - ED		
	7. Teaching, Training and Research - ED	Y	08. TTR - ED		
3. Public Hospital Non-Admitted Services (approx. $695M) Descriptor: The provision of metropolitan and major rural hospital services to patients who do not undergo a formal admission process, this includes public patients treated by private facilities under contract to WA Health and includes services provided in outpatient clinics, community based clinics or in the home. The services provided to patients include procedures, medical consultation, allied health or clinical nurse specialists. Teaching and training activities as well as research activities provided by the public health service to facilitate development of skills and acquisition or advancement of knowledge related to non-admitted services is also included in this service group.	8. Non-Admitted Activity	Y	09. Non-admitted Activity		
	9. Public, Private Partnership - non-admitted	Y	10. Public, Private Partnership - Non-admitted		
	10. Teaching, Training and Research - non-admitted	Y	11. TTR - non-admitted		
4. Mental Health Services (approx. $647M) Descriptor: The provision of acute and/or subacute mental health inpatient and non-admitted patient services, including specialised mental health services that provide overnight care in a psychiatric hospital or a specialised mental health unit in an acute hospital. This includes public patients treated in private facilities under contract to WA Health. This service group includes community care provided by public mental health programs and teaching, training and research activities provided by the public health service to facilitate development of skills and acquisition or advancement of knowledge related to mental health services. A person's need for mental health services can be short, medium, long term or intermittent, and often spans various levels of care and service areas across the health continuum.	11. Acute inpatient mental health	Y	12. Acute Inpatient Mental Health		
	12. Sub-acute inpatient - Mental Health	Y	13. Sub-acute Inpatient - Mental Health		
	13. Non-Admitted Patients - Mental Health	Y	14. Non-Admitted Patients - Mental Health (Block)		
	14. Public, Private Partnership - Inpatient Mental Health	Y	15. Public, Private Partnership - Inpatient Mental Health		
	15. Teaching, Training and Research - Mental Health	Y	16. TTR -mental health		
	16. Mental Health Programs	N	17. Non-Admitted Patients - Mental Health (Programs)		

Outcome Statements and Service Lines	Sub Services	ABF	Programs	Rationales that support the Outcome	Review of WA and Other Jurisdictions Central and Service Agencies
Outcome 2: "Provision of prevention, health promotion, aged and continuing care services for all Western Australians to live healthy, safe and supported lives".					
5. <u>Aged and Continuing Care Services (approx. $498M)</u> Descriptor: The provision of aged and home care services and community based palliative care services. Aged and home care services includes programs that assess the care needs of older people, provide functional interim care or support for older, frail, aged and younger people with disabilities to continue living independently in the community and maintain independence. Community based palliative care services are delivered by private facilities under contract to WA Health, focused on the prevention and relief of suffering, quality of life and the choice of care close to home.	17. Aged and Home Care Services	**N**	18. Aged Care Assessment Program (ACAP) 19. Aged Care Assessment Teams (ACAT) 20. Home and Community Care (HACC) 21. Transitional and Home Care Programs 22. Residential and respite care 23. Other	• Compliance with the requirements of Outcome Based Management and the associated November 2004 Guidelines; Treasurer's Instructions 808 Resource Agreement, 903 Agency Annual Reports and 904 Key Performance Indicators, which deal with Outcome Statements and their utilisation. • Aligns with a continuum of care approach; a system that guides and tracks patients over time through a comprehensive array of health services spanning all levels and intensity of care. The Continuum of Care covers the delivery of healthcare over a period of time, and may refer to care provided from birth to end of life. • Describes the end result, impact or consequence of service lines 5 to 6 for the Western Australian public: provided with health care and support [end result] + healthy, safe and supported lives [consequence]. • Consistent with the WA Government Goal of "greater focus on achieving results in key service delivery areas for the benefit of Western Australians", maintaining reporting alignment with the WA Health Budget Papers and Annual Reports. • Review of other jurisdictions, other WA Government agencies and initial consultations with DoH stakeholders suggest measurable KPIs are possible for all proposed Outcomes. Outcome 2 can be measured by a combination of leading and lagging effectiveness indicators.	• Consideration was given to the WA agencies (Education, Transport, Police and Corrective Services) examined in the OBM Current and Future State Assessment. All utilise outcomes that reflect the provider focus of the services delivered, similar to that proposed for Outcome 2. • WA Department of Transport has the following outcome: "An accessible and safe transport system". This is measured through 11 effectiveness indicators, such as Percentage by which the waiting time standard for metropolitan area taxis is met and Rate of reported incidents (accidents) on the water per 100 commercial vessels surveyed. • WA MHC has the following outcome "Accessible and high quality mental health services and supports that are recovery-focussed and promote mental health and wellbeing". This outcome is measured through key effectiveness indicators such as: readmissions to hospital within 28 days of discharge; Percent of contacts with community-based public mental health non-admitted services within 7 days post discharge from public mental health inpatient units; Proportion of services funding directed to publicly funded community mental health services. Review of WA and other Jurisdictional Central Agencies determined: • The term "support" is used by the WA Department of Premier and Cabinet. Support is measured through two effectiveness indicators: "Targets for support services are met or exceeded" and "Service recipient's confirmation that services provided enable them to meet Executive Government's obligations". • The term "supporting" is used by the Victorian Department of Premier and Cabinet in two of its Outcome Statements. Supporting is measured through effectiveness indicators such as "DPC leads policy development on key priority issues" and "DPC responds effectively to significant state issues". • NSW Department of Health has the following direction (similar to outcomes) "Keeping people healthy" and measures this through indicators such as: Current (daily or occasional) smoking in adults aged 16 years and over; Overweight or obesity in adults aged 16 and over; Alcohol consumption at levels posing a lifetime risk to health, adults aged 16 and over; Potentially preventable hospitalisations by sex and Children fully immunised at one year, NSW and National 2008-9 to 2012-13.
6. <u>Public and Community Health Services (approx. $1.15B)</u> Descriptor: Healthcare services and programs delivered to increase optimal health and wellbeing, encourage healthy lifestyles, reduce the onset of disease and disability, reduce the risk of long-term illness as well as detect, protect and monitor the incidence of disease in the population. This includes public health programs, Aboriginal health programs, environmental health, community based dental services, the provision of grants to non-government organisations for public and community health purposes, emergency road and air ambulance services, services to assist rural based patients travel to receive care and the services provided by small rural hospitals.	19. Public Health Services	**N**	25. Health Promotion, Primary Care, Education and Research Services 26. Health Protection and Screening Services 27. Workforce Development and Support Programs		
	20. Admitted programs (non-ABF)	**N**	28. Renal Programs 29. Blood Contract Programs 30. Complex and Long Stay Programs		
	21. ED Programs (non-ABF)	**N**	31. FINE –ED 32. St John Ambulance 33. Royal Flying Doctor Service 34. Other ED Programs 35. Other Emergency transport services		
	22. Non-admitted programs (non-ABF)	**N**	36. Other non-admitted programs		
	23. Aboriginal Health Programs	**N**	37. Aboriginal Health		
	24. Community Dental Health	**N**	38. Oral Health Centre WA 39. Community Dental Health 40. Perth Dental Hospital 41. Aged Care - Dental		
	25. Small Rural Hospitals	**N**	42. SIHI,RFR and Non ABF hospitals		
	26. Patient Assisted Travel Services	**N**	43. Patient Assisted Transport (PATS)		
Outcome 3:"Leadership in system wide policy and management strategies to support efficient and secure healthcare services for all Western Australians".					
7. <u>Health System Clinical Corporate Support Services (approx. $511M)</u> Descriptor: The provision of strategic policy and planning services, system performance monitoring and purchasing linked to the state-wide planning, budgeting and regulation process; corporate recruitment, payroll, finance and business systems services; information and communication technology services; diagnostic services across the full range of pathology disciplines throughout metropolitan and regional WA; and the management of the supply chain and whole of health contracts.	27. Health Service Support Services	**N**	44. HCN 45. HIN	• Compliance with the requirements of Outcome Based Management and the associated November 2004 Guidelines; Treasurer's Instructions 808 Resource Agreement, 903 Agency Annual Reports and 904 Key Performance Indicators, which deal with Outcome Statements and their utilisation. • Outcome 3 describes the end result, impact or consequence of service line 7 for the Western Australian public. • Alignment with the strategic enablers identified in the WA Health Strategic Intent 2015 – 2020: Accountability, Financial Management, Partnerships, Infrastructure, Information and Communication Technology, as well as Research and Innovation.	• Consideration was given to the WA agencies (Education, Transport, Police and Corrective Services) examined in the OBM Current and Future State Assessment. WA Departments of Transport and Education also specify outcomes that incorporate consideration of their system manager role, respectively "Integrated transport services that facilitate economic development" and "Education and training providers, and teachers, comply with the appropriate regulatory and policy requirements". Review of WA and other Jurisdictional Central Agencies determined: • The WA DoF has the following outcome "A sustainable, efficient, secure and affordable energy sector". Secure is measured through the effectiveness indicator of "The extent to which policy and program development objectives for the year are achieved". • WA TSY has the following outcome "Value for money from the management of the Government's non-residential buildings and public works". This is measured through an effective indicator:

Outcome Statements and Service Lines	Sub Services	ABF	Programs	Rationales that support the Outcome	Review of WA and Other Jurisdictions Central and Service Agencies
				• Outcome 3 reflects the role of the Department as System Manager and is reflective of the new Governance Board Structure. • Outcome 3 will drive a more meaningful, transparent and accountable set of KPIs, where the metrics/products from the Department and non-area health services such as HSS's are not included in the performance of Health Services. • Similar to WA Department of Transport whose System Manager role involves the integrated planning, development, regulation and policy functions whilst providing direct state-wide services to the community through motor vehicle and driver licensing services and operation of transport modes not delivered by Main Roads WA or PTA. In 2013-14, DoT spent $380 million and employed 1,441 FTE to deliver these functions.	"Percentage of significant projects in the New Buildings program delivered within approved". • WA DPC has the following outcome "The Premier and Ministers receive high quality, rigorous and timely policy advice". This is measured through "Service recipient's confirmation that high quality and timely policy advice is provided". • Vic DoF/TSY has a mission to "provide leadership in economic, financial and resource management. Our role is to ensure that the Government and the State of Victoria benefit from the highest standard of economic, financial and resource management". • NSW TSY Mission: "Promote the long term interests of New South Wales through leadership in economic policy and financial management strategies to deliver a strong, competitive economy and better services". • The term "support" is used by the WA Department of Premier and Cabinet. Support is measured through two effectiveness indicators: "Targets for support services are met or exceeded" and "Service recipient's confirmation that services provided enable them to meet Executive Government's obligations". • The term "supporting" is used by the Victorian DPC in two of its Outcome Statements. Supporting is measured through effectiveness indicators such as "DPC leads policy development on key priority issues" and "DPC responds effectively to significant state issues". • NSW TSY has a target under its mission to "Improve Efficiency and Effectiveness of Expenditure". This is measured through how effectively TSY "Maintain expense growth below long-term revenue growth".

Appendix 7 Agency and Jurisdictional Research on Outcome Statements

2.1.3 (e) Service Focused Agency and Jurisdiction Outcomes	
WA Agency Outcomes	**Jurisdiction Outcomes**
Department of Transport Outcome 1: An accessible and safe transport system. Outcome 2: Vehicles and Road users that meet established vehicle standards and driver competencies to deliver safe vehicles and safe drivers. Outcome 3: Integrated transport systems that facilitate economic development.	**NSW** Direction 1: Keep people healthy Direction 2: Provide world class clinical care Direction 3: Deliver truly integrated care Strategy 1: Supporting and developing our workforce Strategy 2: Supporting and harnessing research and innovation Strategy 3: Enabling eHealth Strategy 4: Designing and building future-focused infrastructure
Main Roads WA Outcome 1: A safe road environment. Outcome 2: Reliable and efficient movement of people and goods. Outcome 3: Improve co-ordination and community awareness of road safety in WA. Outcome 4: Improved community access and roadside amenity. Outcome 5: A well maintained road network. Outcome 6: Facilitate economic and regional development.	
Public Transport Authority Outcome 1: Accessible, reliable and safe public transport system. Outcome 2: Protection of the long-term functionality of the rail corridor and railway infrastructure.	**VIC** Objective 1: Reduce preventable disease and protect the community from public health hazards. Objective 2: Improve the quality, effectiveness and efficiency of health care services for Victorians. Objective 3: Increase the financial sustainability of the health system.
WA Police 2013-14 Budget paper: Outcome 1: Lawful behaviour and community safety. Outcome 2: Offenders apprehended and dealt with in accordance with the law. Outcome 3: Lawful road-user behaviour. 2014-15 Budget paper: Outcome 1: Contribute to community safety and security	**SA** Our Community: We advocate for everyone to reach their full potential Our Health: 1) We make healthy choices in how we live; 2) We educate young people about healthy living; 3) We assist people to deal with all forms of illness and to live a satisfying life where they can contribute to their community
Department of Corrective Services Outcome 1: A safe, secure and decent corrective services which contributes to community safety and reduces offenders' involvement in the justice system.	**QLD** Dependent on each Hospital and Health Service's Strategic Health Plan. FY2015-16 Budget papers include the following objectives: <u>Queensland Ambulance Service</u> Objective: To provide timely and quality ambulance services which meet the needs of the Queensland community <u>Hospital and Health Services</u> Objective: Hospital and Health Services are independent statutory bodies established on 1 July 2012 to provide public hospital and health services in accordance with the *Hospital and Health Boards Act 2011*, the principles and objectives of the national health system and the Queensland Government's priorities for the public health system. <u>The Council of Queensland Institute of Medical Research (QIMR)</u> Objective: To enhance health by developing improved diagnostics, treatments and prevention strategies in the areas of cancer, infectious diseases, mental health and complex disorders. <u>Queensland Mental Health Commission</u> Objective: To drive ongoing reform towards a more integrated, evidence-based, recovery-orientated mental health, drug and alcohol system. <u>Office of the Health Ombudsman</u> Objective: To protect the health and safety of the public, promote professional, safe and competent practice by health practitioners, promote high standards of service delivery by health service organisations, and maintain confidence in Queensland's health system by managing health complaints in a timely, fair, impartial and independent manner, while operating transparently and reporting publicly on its performance.
Mental Health Commission Outcome 1: Accessible and high quality mental health services and supports that are recovery focused and promote mental health and wellbeing. Outcome 2: Prevent and delay the uptake, incidence of use and harm associated with alcohol and drug use.	
Department of Education Outcome 1: A public school system which provides access to a quality education throughout Western Australia	
Department of Education Services Outcome 1: Registered and/or accredited education and training providers comply with the appropriate legislative and/or other regulatory requirement.	
School Curriculum and Standards Authority Outcome 1: Quality curriculum outline (Kindergarten to year 12) and assessment (years 11 – 12) in Western Australia.	

Appendix 8 Additional Research on Outcome Statements – WA, NSW, VIC Central Agency Considerations

[Evidence Matrix and Rationale in support of Outcome 3: Consideration of WA, NSW and VIC Central Government Agencies]

Note: Due to the requirement that WA Agencies comply with the Public Sector OBM Guidelines (2004), there is alignment with the use of outcomes, services and KPIs (split into "effective" and "efficient"). Although there are strong similarities and considerations from the jurisdictional review, a 1:1 alignment with the proposed WA OBM Structure and Outcomes is not possible, particularly with respect to the use of KPIs. The document should be reviewed with this caveat in mind.

Central Agency	Agency Level Outcomes	Goals and Services	Key Performance Indicators (KPIs)	Key Considerations for WA Outcome Statements
WESTERN AUSTRALIA				
Department of Premier and Cabinet (**DPC**) Source: 2014/2015 Annual Report	1. **Executive Government receives appropriate support.** 2. **The Premier and Ministers receive high quality, rigorous and timely policy advice.**	**WA Government Goals:** • DPC report against 1 of the 5 WA Government Goals: o Results based service delivery • In addition to the WA Government Goals, DPC have their own Departmental goals: o Providing leadership in all facets of policy development, from the progression of key sector reforms to developing innovative solutions to complex policy issues o Leading and supporting our people through providing development opportunities and an engaging work environment to produce the best services, and leaders for today and the future o Providing implementation support through coordinating, monitoring and partnering o Providing quality and timely policy advice to support the Premier and Cabinet o Delivering quality and timely services to support the administration of Government. **Services:** • Outcome 1: o Service 1: Administration of Executive Government Services • Outcome 2: o Service 2: Government Policy Management.	• Key performance indicators (KPIs) allow the Department to assess and monitor performance in areas identified as critical to our business. • The key effectiveness indicators reported were chosen for their ability to enable assessment to be made of the extent to which the Department's activities are achieving, or have made substantial progress towards achieving Outcome 1 and Outcome 2. • Further explanation is provided where there are significant variances between Actual and Target indicators. **Variances greater than 10% are considered significant**. **KPIs related to Outcomes (Effectiveness):** • Key **Effectiveness** Indicators for Outcome 1: 1. Targets for support services are met or exceeded. 2. Service recipient's confirmation that services provided enable them to meet Executive Government's obligations. • Key **Effectiveness** Indicator for Outcome 2: 1. Service recipient's confirmation that high quality and timely policy advice is provided.	• DPC report against the same service based government goal as WA Health. • DPC's Outcome 2 is closely related to the policy service provided by the Department of Health as System Manager. • The term "quality" used in Outcome 2 is measured through the department's ability to provide high quality and timely policy advice, similar to the current function of DoH. • The agency-level outcomes directly relate to the purpose and goals set out in the Department's *Strategic Plan 2013–17*, and the service structure to deliver these outcomes has been designed around the administrative and policy functions of the Department. • KPIs are used to measure the Department's performance both on a **quarterly and annual basis**, ensuring the delivery and achievement of the relevant services, outcomes, and Government Goal.
Department of Treasury (**TSY**) Source: 2014/2015 Annual Report	1. **Sustainable and transparent public sector finances.** 2. **A strong and competitive State economy.** 3. **Value for money outcomes in service delivery and infrastructure provision.** 4. **Value for money from the management of the Government's non-residential buildings and public works.**	**WA Government Goals:** • TSY report against 3 of the 5 WA Government Goals o Financial and economic responsibility. o Results based service delivery. o State building – major projects. **Services:** • Outcome 1 - Sustainable and transparent public sector finances: o Service 1: Financial management and reporting. o Service 2: Manage the Government's asset sales program (excluding land sales). • Outcome 2 - A strong and competitive State economy: o Service 3: Economic and revenue forecasts and policy development. • Outcome 3 - Value for money outcomes in service delivery and infrastructure provision: o Service 4: Evaluation and planning of Government service delivery and infrastructure provision. • Outcome 4 - Value for money from the management of the Government's non-residential buildings and public works: o Service 5: Leads the planning and delivery of new Government buildings.	**KPIs related to Outcomes (Effectiveness):** • Key **Effectiveness** Indicators for Outcome 1: 1. Status of the State's credit rating. 2. Unqualified audit opinion on the Annual Report on State Finances. 3. Percentage of approved asset sales program completed within agreed timeframes. • Key **Effectiveness** Indicators for Outcome 2: 1. Accuracy of key general government revenue forecasts: ▪ tax revenue ▪ mining revenue 2. Accuracy of key economic forecasts (percentage point difference): ▪ employment growth ▪ real State Final Demand growth • Key **Effectiveness** Indicators for Outcome 3: 1. Percentage of the Department's material resource allocation recommendations complying with the Service Provision Analysis Framework. 2. Percentage of highest value agencies complying with the Strategic Asset Management Framework or equivalent accredited mechanism • Key **Effectiveness** Indicators for Outcome 4: 1. Percentage of significant projects in the New Buildings program delivered within approved: ▪ Budget ▪ timeframe	• TSY use the term "sustainable" and measure this though various finance based effectiveness indicators. • Of note is the use of a KPI that reflects an "Unqualified audit opinion on the Annual Report on State Finances". • The use of the term "value for money" is used in 2 of the 4 Outcomes, a term that has not been considered as an option for WA Health Outcomes.
Department of Finance (**DoF**) Source: 2013/2014 Annual Report	1. **Due and payable revenue is collected and eligible grants, subsidies and rebates paid.** 2. **Value-for-money from public sector procurement.** 3. **Decommissioning of Shared Services.** 4. **Provision of corporate services.** 5. **Value-for-money from the**	**WA Government Goals:** • DoF report against 4 of the 5 WA Government Goals: o Financial and economic responsibility o Results based service delivery o State building – major projects o Social and environmental responsibility • DoF outcomes related to government goals: o Goal: Financial and economic responsibility: 1. Due and payable revenue is collected and eligible grants, subsidies and rebates paid.	**KPIs related to Outcomes (Effectiveness):** • Key **Effectiveness** indicators for Outcome 1: o Extent to which due revenue is collected. o Extent to which correct grants, subsidies and rebates are paid. • Key **Effectiveness** indicators for Outcome 2: o Profitability of the State's ($000) light vehicle fleet. o Extent to which client agencies agree that their agency contracts and CUAs achieved value-for-money. • Key **Effectiveness** indicators for Outcome 3: o Progress with the decommissioning reform of the Western Australian public	• The rationale for not using an effectiveness indicator for outcome 4 is that the service provided "relate to the corporate services provided directly by the Department to support the outcomes and activities of the Department of Treasury". • The terms used in Outcome 2 of "sustainable", "secure" and "efficient" are similar to the proposed Outcome 3 for WA Health.

Central Agency	Agency Level Outcomes	Goals and Services	Key Performance Indicators (KPIs)	Key Considerations for WA Outcome Statements
	management of the Government's non-residential buildings and public works. 6. **A sustainable, efficient, secure and affordable energy sector.**	o Goal: Results based service delivery: 2. Value-for-money from public sector procurement. 3. Decommissioning of Shared Services. 4. Provision of corporate services o Goal: State building – major projects: 5. Value-for-money from the management of the Government's no residential buildings and public works. o Goal: Social and environmental responsibility: 6. A sustainable, efficient, secure and affordable energy sector. **Services:** • Outcome 1 - Due and payable revenue is collected and eligible grants, subsidies and rebates paid: o Service 1: Revenue assessment and collection, and grants and subsidies administration. • Outcome 2 - Value-for-money from public sector procurement: o Service 2: Development and management of CUAs, state fleet leasing and disposal, and providing facilitation service for agency specific contracts. • Outcome 3 **-** Decommissioning of Shared Services: o Service 3: Project management, decommissioning of the whole-of-government shared corporate services reform. • Outcome 4 - Provision of corporate services: o Service 4: Services to government. • Outcome 5 - Value-for-money from the management of the Government's non-residential buildings and public works: o Service 5: Leads the planning, delivery, management and maintenance of government buildings, projects and office accommodation. • Outcome 6 - A sustainable, efficient, secure and affordable energy sector: o Service 6: Development and implementation of energy policy and programs.	sector for shared services by achievement of the following milestones: 1. number of agencies rolling-out by year 2. change in Shared Services FTEs as a result of decommissioning • Key **Effectiveness** indicators for Outcome 4: o An effectiveness indicator is not reported for this outcome as it relates to the corporate services provided directly by the Department to support the outcomes and activities of the Department of Treasury. • Key **Effectiveness** indicators for Outcome 5: o Percentage of significant projects in the New Buildings program delivered within 10% of approved budget. • Key **Effectiveness** indicators for Outcome 6: o The extent to which policy and program development objectives for the year are achieved.	
OTHER JURISDICTIONS: NEW SOUTH WALES				
Department of Treasury (**TSY**) Source: 2013-14 Annual Report	NSW 2021 Government Goal is to "**Rebuild State Finances**", achieved through the following targets: **1. Effective Balance Sheet Management.** **2. Improve Financial Management and Controls.** **3. Improve Efficiency and Effectiveness of Expenditure.** **4. Reform Revenue** **5. Improve Public Trading Enterprise (PTE) performance.**	**NSW TSY Mission: "Promote the long term interests of New South Wales through leadership in economic policy and financial management strategies to deliver a strong, competitive economy and better services".** **Services:** • Provide fiscal and economic advice to contribute to sound policy development and informed decision-making. • Advise on the effective use of the State's resources to deliver better services, including through capital investment. • Support public sector agencies in the application of the Government's Wages Policy. • Provide leadership in microeconomic reform to support a strong, competitive economy. • Drive public sector financial accountability by promoting a contemporary legislative and policy framework. • Facilitate private sector involvement in major capital projects and manage major asset transactions. • Manage the Government's shareholding in State Owned Corporations and monitor performance to improve the commercial effectiveness of the sector. • Collaborate with agencies and other stakeholders to find sound solutions that add value to policy and service delivery outcomes. • Assess financial and economic risk and provide advice on risk management. • Disseminate frameworks for economic assessment and advise on the economic impact of policies. • Provide strategic public and private sector industrial relations advice to the NSW Government. • Create and maintain a working environment that allows our people to excel.	**Key Performance Measures related to Targets:** • Key indicator for **Target 1**: o Maintaining a Triple-A credit rating for NSW. o State superannuation liabilities on track to be fully funded by 30 June 2030. • Key indicator for **Target 2**: o Deviation of underlying actual expenses from Budget. o Keeping the State Budget in surplus. • Key indicator for **Target 3**: o Maintain expense growth below long-term revenue growth • Key indicator for **Target 4**: o NSW's share of GST revenue relative to an equal per capita share. o NSW total State General Government revenue per capita to be less than the average for the other states. • Key indicator for **Target 5**: o Commercial government business agencies achieving an appropriate rate of return on equity.	• NSW TSY do not use outcomes, rather there is one overarching mission, supported by a government goal, split into 5 Targets. These Targets can be considered within the context of the proposed outcomes. • Unlike WA Agencies, KPIs are not split into "effective" and "efficient". • Leadership as encapsulated in Targets 4 and 5 is respectively dealing with reform and improving the performance of other public enterprises. This is related to the system manager function that the proposed WA Health Outcome 3 encompasses. • Target 3 "improving efficiency and effectiveness of expenditure" relates to the oversight and system reform functions that the WA Health system manager will achieve. • Target 3 also alludes to the role the NSW Department of Treasury has in driving (financial) accountability. This is comparable to the role the WA Health system manager will perform for ensuring financial and clinical accountability from the Health Services.

Central Agency	Agency Level Outcomes	Goals and Services	Key Performance Indicators (KPIs)	Key Considerations for WA Outcome Statements
Department of Premier and Cabinet (**DPC**) Source: 2013-14 Annual Report	**DPC has 6 Key Initiatives (Rather than Outcomes):** **1. Lead the government's agenda for change.** **2. Take a lead in national policy.** **3. Drive the delivery of the NSW 2021 Plan.** **4. Contribute to an efficient customer focused public sector.** **5. Facilitate private sector partnerships and investment.** **6. Empower our people.**	**DPC are responsible for leading (or co lead) the following NSW 2021 Goals:** 1. Invest in critical infrastructure (Goal 19) 2. Restore trust in State and Local Government as a service provider (Goal 30) 3. Improve government transparency by increasing access to government information (Goal 31) 4. Involve the community in decision making on government policy, services and projects (Goal 32). **Performance on Goals is measured though Targets:** • Goal - Invest in critical infrastructure: o Target 1: Increase expenditure on critical NSW infrastructure. o Target 2: Improve the quality of urban and rural State Roads. o Target 3: Enhance rail freight movement • Goal - Restore trust in State and Local Government as a service provider: o Target 4: Promote integrity and accountability in the public sector. o Target 5: Increase customer satisfaction with government services. o Target 6: Improve innovation within the public sector. • Goal - Improve government transparency by increasing access to government information: o Target 7: Increase the public availability of government information. o Target 8: Up to date information about government services. • Goal - Involve the community in decision making on government policy, services and projects: o Target 9: Increased proportion of people who feel able to have a say on issues that are important to them. o Target 10: Increase opportunities for people to participate in local government decision making	• Performance Measures for **Target 1**: o Total State investment in infrastructure (excluding the public finance enterprise sector, but including general government and government trading enterprises). o Total funds allocated annually to regional infrastructure (4 year rolling average). o Australian Government funding for NSW infrastructure (% relative to other States). o Australian Government funding for NSW infrastructure (dollar). • Performance Measures for **Target 2**: o Percentage of urban State Roads with a 'good' road smoothness where surface 'roughness' is less than 4.2 IRI (International Roughness Index). o Percentage of rural State Roads with a 'good' road smoothness where surface 'roughness' is less than 4.2 IRI (International Roughness Index). o Percentage of State Roads with a 'good' road smoothness where surface 'roughness' is less than 4.2 IRI (International Roughness Index). • Performance Measures for **Target 3**: o Total proportion of containers transported by rail through Port Botany, including import, export and empty containers. o Proportion of import, export and empty containers transported by rail through Port of Newcastle and Port Kembla. • Performance Measures for **Target 4**: o NSW public sector employee perceptions of integrity as applied in their workplace. o NSW public sector employee perceptions of accountability as applied in their workplace. • Performance Measures for **Target 5**: o Overall satisfaction with the NSW Public Sector Services (1-10 dissatisfied/satisfied scale) – consumers. o Overall satisfaction with the NSW Public Sector Services (1-10 dissatisfied/satisfied scale). • Performance Measures for **Target 6**: o NSW public sector employee perceptions of innovation within the sector. • Performance Measures for **Target 7**: o Compliance with the mandatory proactive release requirements under GIPA. • Performance Measures for **Target 8**: o Is improving government transparency by making it easier to access information about government services (1-10 disagree/agree scale) – consumers. o Is improving government transparency by making it easier to access information about government services (1-10 disagree/agree scale) – businesses. • Performance Measures for **Target 9**: o Encourages public to participate and have a real say in decision-making on government policy, services and projects (1-10 disagree/agree scale). • Performance Measures for **Target 10**: o Percentage of councils in NSW with a published community engagement strategy to support the development of Community Strategic Plans.	• DPC does not measure its performance based on the 6 Initiatives they must deliver, and are detailed in its annual report. • Rather, the performance of DPC is measured against the 4 NSW 2021 goals it is lead/co-lead for, through 10 Targets. • Unlike WA Agencies, KPIs are not split into "effective" and "efficient". • Target 4 mentions directly "promoting accountability" i.e. a core intended function of the WA Health system manager. • Target 4 also includes "promotion of integrity" within the sector, another leadership role, as well as essential for public and Government confidence. This is a key idea that aligns with the role of system manager. • Target 6 describes "improving innovation within the …sector". The intention for WA Health's system manager is that it will drive system-wide innovation. • DPC's description of themselves as "contributing a unifying intelligence to the system of government" could as easily be applied to the Department of Health and its forthcoming role as the system manager for WA Health.
OTHER JURISDICTIONS: VICTORIA				
Department of Treasury and Finance (**DTF**) Source: 2013-14 Annual Report	**Departmental Objectives:** **1. Sound financial management of Victoria's fiscal resources.** **2. Guide government actions to increase Victoria's productivity and competitiveness.** **3. Drive improvement in public sector asset management and the delivery of infrastructure.** 4. **Deliver efficient whole of government common services to the Victorian public sector.**	**DTF Vision:** "prosperous future for all Victorians. To fulfil this vision we provide economic and financial policy advice to the Government with the aim of increasing the living standards of all Victorians". **DTF Mission**: "provide leadership in economic, financial and resource management. Our role is to ensure that the Government and the State of Victoria benefit from the highest standard of economic, financial and resource management". **Services (DTF** uses the term "output groups"): 1. Strategic Policy Advice 2. Financial Management Services 3. Risk Management Services 4. Resource Management Services 5. Regulatory Services 6. Revenue Management Services	KPIs related to **Objectives**. • Performance Indicators for **Objective 1**: o Demonstrate strong fiscal discipline by maintaining an annual budget surplus of at least $100 million. o General government net debt reduced as a percentage of GSP over the decade to 2022. o Effective financial risk management and prudential supervision of public financial corporations and public non-financial corporations. • Performance Indicators for **Objective 2**: o Reduce regulatory burden by 25 percent by 2014 through streamlining regulatory requirements. o Ensure approved public sector enterprise bargaining agreements comply with wages policy and support improvements to productivity and workplace reform. o Reduce the costs and barriers to doing business in Victoria. • Performance Indicators for **Objective 3**: o Ensure high-value high-risk Government projects are completed within agreed time frames and scope through ensuring adherence to standards. o Enable efficient and accountable asset management by implementing a new	• Rather than "Outcomes" DTF use "Objectives" against which performance is measured. • Unlike WA Agencies, KPIs are not split into "effective" and "efficient". • Objective 2 makes reference to "guiding actions", which from a holistic perspective, will be the role of the WA System Manager with reference to the Health Services. Also mentioned in this objective is a focus on increasing "productivity and competitiveness" which the WA System Manager will lead to ensure achievement of the National Efficient Price and other relevant cost, quality and effectiveness indicators. • Objective 3 uses the words "drive improvement" which aligns with the strategic leadership role that the WA System Manager will assume in ensuring continuous

Central Agency	Agency Level Outcomes	Goals and Services	Key Performance Indicators (KPIs)	Key Considerations for WA Outcome Statements
			Asset Management Accountability Framework in 2013-14. o Increased engagement with industry to enable improved compliance and productivity in the Victorian construction industry. • Performance Indicators for **Objective 4**: o Drive productivity and efficiency by increasing the benefits delivered from government procurement contracts. o Drive efficiency by maintaining low vacancy rates for government office accommodation.	improvement at a system wide level. • Of interest to the system manager role for WA Health, VIC DTF describes itself as "reform oriented", providing "strategic leadership" and "delivering innovative and timely policy advice".
Department of Premier and Cabinet (**DPC**) Source: 2013-14 Annual Report	**Departmental objectives:** **1. Supporting high-quality government decision-making and implementation.** **2. Developing and promoting an thriving Victorian arts and cultural sector.** **3. Supporting and promoting full participation in strong and vibrant communities.** 4. **Promoting an effective, accountable and professional public administration.**	**DPC Mission:** "display exemplary leadership and innovation to support the Victorian Government in achieving strong public policy and service delivery outcomes for all Victorians". **Services:** 1. Strategic Advice and Support: o Output 1: Strategic Advice and Government Support o Output 2: Government-wide Leadership and Implementation 2. Arts and Cultural Development o Output 3: Access, Industry Development and Innovation o Output 4: Cultural Infrastructure and Facilities o Output 5: Arts Portfolio Agencies 3. Supporting and Strengthening Communities o Output 6: Multicultural Affairs and Citizenship o Output 7: Aboriginal Affairs o Output 9: Veterans' Affairs 4. Public Sector Management, Governance and Support: o Output 10: Advice and Support to the Governor o Output 11: State Services Authority o Output 12: Ombudsman Services o Output 13: Chief Parliamentary Counsel Services	Key Performance Indicators related to **Objectives**: • Performance Indicators for **Objective 1**: o DPC leads policy development on key priority issues o DPC responds effectively to significant state issues • Performance Indicators for **Objective 2**: o Victoria's reputation as an international centre for arts and culture is enhanced o Access to arts and cultural programs is improved, particularly for schoolchildren, youth, families and regional communities Victoria's cultural venues and state owned facilities are maintained to provide continuously improving services to Victorians • Performance Indicators for **Objective 3**: o Culturally, linguistically and religiously diverse communities are better able to participate in and contribute to the social, cultural, economic and democratic life of Victoria o Capacity-building activities undertaken with Aboriginal community groups: cultural heritage management o Level of participation in Anzac celebration and visits to Shrine of Remembrance • Performance Indicators for **Objective 4**: o The Governor is supported effectively in the exercising of his functions and powers o A centre for excellence that fosters an efficient, ethical and responsible public sector o Fairness, integrity and respect for human rights and administrative excellence in the Victorian public sector are effectively promoted o Services provided to the state relating to the development, drafting, publication and implementation of legislation are comprehensive, integrated and of a high quality	• Unlike WA Agencies, KPIs are not split into "effective" and "efficient". • DPC's performance is measured in two ways: Objectives are measured through KPIs and services are measured through outputs. • Objective 1 speaks indirectly about the "influencing" or "guidance" role that a central agency or system manager has. • 3 out of 4 of the objectives speak of a core role of this central agency being "promotion". • More specifically, Objective 4 deals with promoting "effectiveness" and "accountability". • This ties-in with the central agency driving continuous improvement and leading reform, which are objectives of the "System Manager".

Appendix 9 Proposed Service and Program Descriptors – Evidence Matrix as at 3 March 2016

Item	Proposed Service Line Definition	Program Lines	Alignment with CSF Definitions	Alignment with ABF Definitions	National Health Data Dictionary
1.	**Public Hospital Admitted Services** An admitted patient is defined as a person who meets the criteria for admission and additional criteria specific to the applicable admission category and care type, and undergoes a hospital's admission process (documented) to receive treatment and/or care for a period of time. **Excluded:** Non-admitted (emergency or outpatient) services provided to a patient who is subsequently classified as an admitted patient shall not be regarded as part of the admitted episode. Public Hospital: A hospital controlled by a state or territory health authority. Public hospitals offer free diagnostic services, treatment, care and accommodation to all eligible patients.[22]	**Acute inpatient** Acute care is (admitted patient) care in which the clinical intent or treatment goal is to: • manage labour (obstetric) • cure illness or provide definitive treatment of injury • perform surgery • relieve symptoms of illness or injury (excluding palliative care) • reduce severity of an illness or injury • protect against exacerbation and/or complication of an illness and/or injury; which could threaten life or normal function, including involuntary psychiatric patients • perform diagnostic or therapeutic procedures.		**Admitted acute care** All public and private hospitals in Australia group admitted acute episodes of care to the Australian Refined Diagnosis Related Group (AR-DRG) classification system. The AR-DRG Classification System is a patient classification system that provides a clinically meaningful way of relating the types of patients treated in a hospital to the resources it requires. AR-DRGs consists of approximately 700 patient classes with each patient being classified based on their diagnoses, surgical procedures and other routinely collected data. Users of the classification system include clinical coders, clinicians, researchers, epidemiologists, public health officials, state and territory health agencies, health funds, public and private hospitals, health economists and statisticians. How the classification works Admitted acute episodes of care in Australian public and private hospitals are coded. The coding system is based on a set of three standards: • International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM) is used to code diseases and problems • Australian Classification of Health Interventions (ACHI) is used to code procedures and interventions • Australian Coding Standards (ACS) is used as a supplement to ICD-10-AM and ACHI to assist Clinical Coders in the use of the classifications. These standards form the basis of the AR-DRG classification with procedure and diagnosis codes grouped to DRGs. The disease and procedure classifications and coding standards and the AR-DRG are currently updated approximately every two years to reflect changes in clinical practice, and to ensure the classifications remain clinically relevant and robust. Wide clinical consultation is undertaken through committees and working groups which include the ICD-10-AM Technical Group (ITG) and the DRG Technical Group (DTG) specifically established to inform the development and refinements of the AR-DRG classification system. The codes from ICD-10-AM and ACHI form the foundation of AR-DRG and hence good quality clinical documentation and clinical coding using these two classifications is vital for accurate and representative DRG assignment. AR-DRG version 7.0 is the specified classification for admitted acute care for ABF in 2014-15 and 2015-16. AR-DRG version 8.0 is due for release in July 2015, will be used for pricing July 2016. The current Eighth Edition of ICD-10-AM/ACHI/ACS will be used in Australia until 30 June 2015. The ICD-10-AM/ACHI/ACS Ninth Edition will be implemented on 1 July 2015.	**Admitted patient** A person who undergoes a hospital's formal admission process to receive treatment and/or care. Such treatment or care is provided over a period of time and can occur in hospital and/or in the person's home (as a 'hospital-in-the-home' patient) (METeOR identifier 268957). **Public admitted hospital patient** Public admitted hospital patient' includes persons enrolled in Medicare who, on admission to a recognised hospital or soon after, receive or elect to receive a public hospital service free of charge. This includes patients for whom treatment is contracted to a private hospital. It does not include Department of Veterans' Affairs patients and compensable patients. Code 1 also includes patients who were admitted to a private hospital as public patients.

[22] IPHA definition.

Item	Proposed Service Line Definition	Program Lines	Alignment with CSF Definitions	Alignment with ABF Definitions	National Health Data Dictionary
		Sub-acute inpatient Subacute Care: Specialised multidisciplinary care in which the primary need for care is optimisation of the patient's functioning and quality of life. A person's functioning may relate to their whole body or a body part, the whole person, or the whole person in a social context, and to impairment of a body function or structure, activity limitation and/or participation restriction. Subacute care comprises the defined care types of rehabilitation, palliative care, geriatric evaluation and management and psychogeriatric care. Non-acute Admitted Patient: Maintenance care provided to nursing home type patients, respite care, care awaiting placement, and any other care where the primary goal is maintenance of current health status in a patient with a chronic condition or disability.		Subacute care is defined as specialised multidisciplinary care in which the primary need for care is optimisation of the patient's functioning and quality of life. A person's functioning may relate to their whole body or a body part, the whole person, or the whole person in a social context, and to impairment of a body function or structure, activity limitation and/or participation restriction. Subacute care comprises the following care types: • Rehabilitation care • Palliative care • Geriatric evaluation and management (GEM) care • Psychogeriatric care Non-acute care comprises the following care type: • Maintenance care	
		Acute inpatient mental health			**Admitted patient mental health care service** A specialised mental health service that provides overnight care in a psychiatric hospital or a specialised mental health unit in an acute hospital. Psychiatric hospitals and specialised mental health units in acute hospitals are establishments devoted primarily to the treatment and care of admitted patients with psychiatric, mental or behavioural disorders. These services are staffed by health professionals with specialist mental health qualifications or training and have as their principal function the treatment and care of patients affected by mental disorder/illness.
		Sub-acute inpatient mental health			
		Teaching, Training and Research	In the context of public health services, teaching and training can be defined as activities that facilitate the acquisition of knowledge, or practice of skill, that are prerequisites for an individual to gain the necessary qualifications to practice in the medicine, nursing and midwifery or allied health professions (Independent Hospital Pricing Authority 2013). Research can similarly be defined as activities where the primary aim is the advancement of knowledge, which ultimately improves patient health outcomes. Whilst the tertiary hospitals undertake extensive teaching and training, the responsibility for this also extends to all hospitals and public health services in the community. At a minimum, smaller hospitals provide access to clinical e-learning, some medical nursing and allied health teaching programs and some rotational student placements. Tertiary hospitals provide intern, registrar	Teaching and training describes: the activities provided by or on behalf of a public health service to facilitate the acquisition of knowledge, or development of skills. These activities must be required for an individual to: • attain the necessary qualifications or recognised professional body registration to practice; • acquire sufficient clinical competence upon entering the workforce; or • undertake specialist/advanced practice in medicine, dentistry, nursing, midwifery or allied health. **Hospital teaching, training and research activities DSS 2015** The purpose of the Hospital teaching, training and research activities DSS is to collect information about teaching, training and research activities, funded by the states and territories that are associated with Australian public hospitals. For the purposes of this DSS, the term 'teaching and training' refers to the activities provided by or on behalf of a public health service to facilitate the acquisition of knowledge, or the development of skills. These activities must be required for an individual to: • attain the necessary qualifications or recognised professional body registration to practice;	

Item	Proposed Service Line Definition	Program Lines	Alignment with CSF Definitions	Alignment with ABF Definitions	National Health Data Dictionary
			and resident teaching as well as specialist nursing and allied health teaching. Also, the tertiary hospitals are responsible for teaching and training in specialty areas where opportunities for learning are limited at smaller hospitals, given the more general nature of their service delivery. The research activities that are embedded in the tertiary hospitals are integrally linked with the universities and other organisations, such as medical research institutes and the hospital research foundations.	• acquire sufficient clinical competence upon entering the workforce; or • undertake specialist or advanced practice in the fields of medicine, dentistry, nursing, midwifery or allied health. For the purposes of this DSS, the term 'research' refers to the activities undertaken in a public health service where the primary objective is the advancement of knowledge that ultimately aims to improve consumer and patient health outcomes and/or health system performance. The activity must be undertaken in a structured and ethical way, be formally approved by a research governance or ethics body, and have potential for application outside of the health service in which the activity is undertaken. For activity based funding purposes, the definition of research relates to the public health service's contribution to maintain research capability, excluding the costs of research activities that are funded from a source other than the state or territory or provided in kind. It is intended that the DSS will capture those activities that are unique to hospital delivery and thus activities that set hospitals apart in terms of cost. The scope of the DSS is establishment level data on teaching, training and research activities which occur in public hospitals.	
		Teaching, Training and Research Mental Health	In the context of public health services, teaching and training can be defined as activities that facilitate the acquisition of knowledge, or practice of skill, that are prerequisites for an individual to gain the necessary qualifications to practice in the medicine, nursing and midwifery or allied health professions (Independent Hospital Pricing Authority 2013). Research can similarly be defined as activities where the primary aim is the advancement of knowledge, which ultimately improves patient health outcomes. Whilst the tertiary hospitals undertake extensive teaching and training, the responsibility for this also extends to all hospitals and public health services in the community. At a minimum, smaller hospitals provide access to clinical e-learning, some medical nursing and allied health teaching programs and some rotational student placements. Tertiary hospitals provide intern, registrar and resident teaching as well as specialist nursing and allied health teaching. Also, the tertiary hospitals are responsible for teaching and training in specialty areas where opportunities for learning are limited at smaller hospitals, given the more general nature of their service delivery. The research activities that are embedded in the tertiary hospitals are integrally linked with the universities and other organisations, such as medical research institutes and the hospital research foundations.	Teaching and training describes: the activities provided by or on behalf of a public health service to facilitate the acquisition of knowledge, or development of skills. These activities must be required for an individual to: • attain the necessary qualifications or recognised professional body registration to practice; • acquire sufficient clinical competence upon entering the workforce; or • undertake specialist/advanced practice in medicine, dentistry, nursing, midwifery or allied health. There is no standard national definition for TT&R. Various descriptions of TT&R have been adopted for the purposes of guiding TT&R policy across Australia. Some of these definitions do not offer a distinction between ‘teaching’ and ‘training’. This raises a question of the materiality of distinguishing teaching and training from one another, and the basis upon which any distinction should be made.	

Item	Proposed Service Line Definition	Program Lines	Alignment with CSF Definitions	Alignment with ABF Definitions	National Health Data Dictionary
		Public, Private Partnership - Inpatient	Privately managed public hospital partnerships such as those with the Joondalup, Peel and Midland hospitals demonstrate the collaboration between the State and the non-government hospital sector in providing primarily admitted patient services to the community.		
		Community Service Subsidy - Inpatient			
		Quad Centre			
		Admitted Service Programs • Blood contract programs • Cancer care programs • Complex and long stay programs • Renal programs • Surgery programs • Workforce development and support programs - inpatients			**Rehabilitation care (Admitted care)** Rehabilitation care is care in which the clinical intent or treatment goal is to improve the functional status of a patient with an impairment, disability or handicap. It is usually evidenced by a multi-disciplinary rehabilitation plan comprising negotiated goals and indicative time frames which are evaluated by a periodic assessment using a recognised functional assessment measure. It includes care provided: • in a designated rehabilitation unit (code 2.1), or • in a designated rehabilitation program, or in a psychiatric rehabilitation program as designated by the state health authority for public patients in a recognised hospital, for private patients in a public or private hospital as approved by a registered health benefits organisation (code 2.2), or • under the principal clinical management of a rehabilitation physician or, in the opinion of the treating doctor, when the principal clinical intent of care is rehabilitation (code 2.3).
2.	**Public Hospital Emergency Services (appox $950M):** Emergency Department means an area within a hospital matching all of the descriptors applicable to one of the levels described in below table Emergency Department Service means the provision of care to a person by an Emergency Department.	**ED Activity**		**Emergency care** EDs are dedicated hospital-based facilities specifically designed and staffed to provide 24 hour emergency care. The role of the ED is to diagnose and treat acute and urgent illnesses and injuries. Patients are seen in order of medical urgency with non-urgent patients being seen after more acute patients. On arrival in the ED, patients are assessed by a clinician and given a triage score. A triage score is a ranking from one to five (one being the most urgent and five being non-urgent) used to prioritise or classify patients on the basis of illness or injury severity and need for medical and nursing care. During the treatment phase of their time in ED patients are assessed by a clinician, a diagnosis is made and treatment is given, if required. How the classification works Several factors influence the classification of emergency care activity in Australia. Patient presentations are grouped into	

Item	Proposed Service Line Definition	Program Lines	Alignment with CSF Definitions	Alignment with ABF Definitions	National Health Data Dictionary
				categories which reflect: • the type of visit of the patient presentation (i.e. whether it is an emergency presentation; whether it is a planned return visit or pre-arranged admission) • what happens to the patient once the ED presentation is finished (e.g. the patient may be admitted to hospital; be discharged or transferred to another hospital; or may choose to leave before treatment is completed) • how urgently the patient needs to receive treatment (based on the triage score given to the patient upon initial assessment) • the diagnosis given for the patients' presentation. Patient presentations to emergency services are classified using Urgency Disposition Groups (UDGs), whereas patient presentations to emergency departments are classified using Urgency Related Groups (URGs). UDGs group patient presentations on the basis of the type of visit, episode end status and triage; whereas URGs group patient presentations on the basis of type of visit, episode end status, triage and major diagnostic block (MDB). The main difference between these two classification systems is that URGs use an additional category to further identify similar patient presentations when compared to UDGs (i.e. major diagnostic blocks). Because of this, the URG classification has more groups to classify patient presentations into. For example, the current URG classification (version 1.4) has 114 groups; while the UDG classification (version 1.3) has 17 groups. **Emergency service care DSS 2015-16** The scope of this DSS is emergency services provided in activity based funded hospitals which do not meet any of the following criteria: • Purposely designated and equipped area with designated assessment; treatment and resuscitation areas. • Ability to provide resuscitation, stabilisation and initial management of all emergencies. • Availability of medical staff available in the hospital 24 hours a day. • Designated emergency department nursing staff 24 hours a day, 7 days a week, and a designated emergency department nursing unit manager. The care provided to patients in emergency services/urgent care centres is, in most instances, recognised as being provided to non-admitted patients. Patients being treated in emergency services/urgent care centres may subsequently become admitted. All patients remain in-scope for this collection until they are recorded as having physically departed the emergency service/urgent care centre, regardless of whether they have been admitted. For this reason there is an overlap in the scope of this DSS and the Admitted patient care national minimum data set (APC NMDS). The scope also includes services where patient did not wait or died on arrival. Patients with Department of Veterans' Affairs or compensable funding source are also included in the scope of the collection. Excluded from the scope are: Care provided to patients in General Practitioner co-located units.	

Item	Proposed Service Line Definition	Program Lines	Alignment with CSF Definitions	Alignment with ABF Definitions	National Health Data Dictionary
		Public, Private Partnership - ED			
		Workforce development and support – ED Workforce development and support services that are not directly funded through TT&R methodology. These services and programs provide support and development services to nurses and doctors.			
		Community Service Subsidy - ED			
		Emergency Transport Services Provides the emergency road ambulance services to the public. Currently includes contracts between the Department of Health and St John Ambulance <u>Royal Flying Doctor Service</u> Provides funding for emergency flight services for critical patients. Currently contracts between the Department of Health and RFDS.			**Health related care – Patient transport** This item comprises transportation in a specially-equipped surface vehicle or in a designated air ambulance to and from facilities for the purposes of receiving medical and surgical care. Includes all government ambulance services and transport provided by the Royal Flying Doctors Service, care flight and similar services, emergency transport services of public fire rescue departments or defence that operate on a regular basis for civilian emergency services (not only for catastrophe medicine). Includes transport between hospitals or other medical facilities and transport to or from a hospital or other medical facility and a private residence or other non-hospital/medical services location. The provider of this service could be a public or private.
		Emergency Department Programs (where majority classified/supports ED patients and is non-ABF)			
3.	**Public Hospital Non-Admitted Services** In general, non-admitted patients receive 'simpler', less prolonged treatment, monitoring and evaluations than same day or overnight patients. Non-admitted patients do not meet the admission criteria, and do not undergo a hospital's formal admission process. Non-admitted patient categories include (but are not limited to): • patients attending for a procedure on the non-admitted procedures (Type C) list, without other justification for admission documented by the treating medical practitioner in the medical record • patients who receive their entire	**Non-admitted Activity**	**Non-admitted (outpatient) Services** With advancements in medical technology and clinical practice, non-admitted services from WA Health and other health care providers have become an important part of the suite of care available to the patient community. The recognition that these services can be used instead of admitted care and that they do not have to be provided in hospital, have made this mode of treatment important to achieving both quality outcomes and managing demand. The handling of non-admitted services has been expanded significantly in CSF 2014. The services are defined as one of three types: • Non-admitted outpatient services (described by hospital site and clinical	There are two broad categories of in-scope, **public hospital non-admitted services**:[23] • Category A: Specialist Outpatient Clinic Services; and • Category B: Other Non-admitted Patient Services and Non-Medical Specialist Outpatient Clinics. Category A is defined as: This comprises all clinics in the Tier 2 Non-Admitted Services classification, classes 10, 20 and 30 that were reported as a public hospital service in the 2010 Public Hospital Establishments Collection in terms of their activity, expenditure or staffing, with the exception of the General Practice and Primary Care (20.06) clinic, which is considered by the Pricing Authority to be ineligible for Commonwealth funding as a public hospital service. Category B is defined as: This comprises Other Non-admitted Patient Services and Non-Medical Specialist Outpatient Clinics and class 40 of the Tier 2 Non-Admitted Services (except Commonwealth funded Aged Care Assessment (40.02), Family Planning (40.27), General	**<u>A non-admitted patient service event</u>** "An interaction between one or more healthcare provider(s) with one non-admitted patient, which must contain therapeutic/clinical content and result in a dated entry in the patient's medical record". Non-Admitted activity is recorded and funded on Service Event counts. Service Event (SE): • one or more healthcare provider(s), • one non-admitted patient, • must contain therapeutic/clinical content, and • must result in a dated entry in the patient's medical record. 'Healthcare Provider' is any person involved in or associated with the delivery of health care to a client, or caring for client's wellbeing: • Aboriginal and Torres Strait Islander health worker • Allied health professional

[23] Non-admitted services must be public hospital services that are provided in a community setting that are designed to prevent or shorten hospital admission.

Item	Proposed Service Line Definition	Program Lines	Alignment with CSF Definitions	Alignment with ABF Definitions	National Health Data Dictionary
	care within the Emergency Department (excluding admissions to short stay units). • dead on arrival (no active resuscitation) • babies who are stillborn, or show no sign of life at birth • patients attending an outpatient clinic (refer to exclusions below) • other non-admitted patients: • boarders • posthumous organ donor Exclusions: Outpatient (non- admitted) care provided to an inpatient is included as part of the admitted care episode and is not to be reported as separate activity, for example: • Inpatients receiving non-admitted care during an admission, when attending an outpatient clinic or allied health service. • Patients receiving non-admitted outpatient care on the same day as admission, for example where the patient has a procedure/treatment in an outpatient clinic requiring, or followed by, subsequent same day or overnight admission.		specialty): services related to a hospital admission (e.g. before and/or after an admitted patient episode of care); or services that require highly specialised expertise and/or expensive equipment. • Community coordinated multidisciplinary services (described by geographical area and service type): services for the complex non-admitted patient irrespective of age with complex and/or rehabilitative conditions which require the coordinated care of two or more specialist disciplines (medical, nursing and allied health). This is goal orientated and generally time limited. • Community single specialty services (described by geographical area and service type): services which require care by a single specialist based in the community with little or no need for care coordination between disciplines. These services are not related to an inpatient episode and can receive referrals from a variety of sources e.g. GPs. **Non-admitted Outpatient Service Definitions (p 89)** The generic service definition for non-admitted hospital outpatient services below outlines service levels from Level II to Level VI. This describes services that are related to a hospital admission (e.g. before and after care) OR services that require highly specialised expertise and/or expensive equipment (for details of how other non-admitted outpatient services are described in the CSF please refer to section 6a Non-admitted (outpatient) services). Categories of outpatient services include: • Procedures • Medical consultation • Standalone diagnostic • Allied health and/or clinical nurse specialist intervention	Counselling (40.33) and Primary Health Care (40.08)). To be eligible for Commonwealth funding as an Other Non-admitted Patient Service and Non Medical Specialist Outpatient Clinics or a class 40 Tier 2 Non-Admitted Service, a service must be: • directly related to an inpatient admission or an emergency department attendance; or • intended to substitute directly for an inpatient admission or emergency department attendance; or • expected to improve the health or better manage the symptoms of persons with physical or mental health conditions who have a history of frequent hospital attendance or admission.	• Nursing professional, including a nurse practitioner • Medical professional • Therapy aide. An **outpatient clinic** is defined by the National Health Data Dictionary in the following terms: “Hospitals use the term ‘clinic’ to describe various arrangements under which they deliver specialist outpatient services to non-admitted non-emergency department patients. Services provided through specific organisational units staffed to administer and provide a certain range of outpatient care in defined locations, at regular or irregular times and where one or more specialist providers deliver care to booked patients. Generally, in such clinics, a booking system is administered and patient care records are maintained to document patient attendances and care provided”. 1. Procedural 2. Medical Consultation 3. Diagnostic 4. Allied Health or Clinical Nurse Specialist ‘Clinic’ Deliver services to non-admitted non-emergency department patients • Through specific organisational units • in defined locations • at regular or irregular times • with one or more providers • a booking system is administered • patient care records are maintained for attendances and care provided What is included: • The cost unit for the non-admitted care is a Non-Admitted Patient Service Event • Scope: service events occurring in outpatient clinics in ABF hospitals and in the community • Classification: NHCDC Tier 2 Clinics V2.0 • NHCDC Round 15 non-admitted data for 99 establishments and 103 Tier 2 Clinics • Calculates the mean cost for the trimmed data in each Tier 2 clinic • Cost parameters converted to cost weights by dividing each by the mean modelled cost for all in-scope acute admitted episodes. • Cost weights are then converted to price weights used to assign nWAU **Non-admitted Outpatient data**: All Public Hospitals, Private Hospitals and Non Government Organisations that provide public outpatient services

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		Non-Admitted Patients - Mental Health	**Mental Health Services – Child and Adolescent, Adult and Older Adult** Mental health clinical services are concerned with the assessment, diagnosis, monitoring and treatment for people who have a mental illness or disorder characterised by a clinically significant disturbance of thought, mood, perception, memory and/or behaviour. Mental health clinical services address the needs of individuals across the age spectrum (children, adolescents, adults and older aduts). A person's need for mental health services can be short, medium, long term or intermittent, and often spans various levels of care and service areas across the health continuum.		**Residential mental health care service** A residential mental health service is a service that is considered by the state, territory or commonwealth funding authorities as a service that: • has the workforce capacity to provide specialised mental health services; and • employs suitably trained mental health staff to provide rehabilitation, treatment or extended care on-site: to consumers residing on an overnight basis; in a domestic-like environment; and • encourages the consumer to take responsibility for their daily living activities. These services include those that employ mental health trained staff on-site 24 hours per day and other services with less intensive staffing (but the trained staff must be on site for a minimum of 6 hours a day and at least 50 hours per week). Suitably trained residential mental health care staff may include: • individuals with Vocational Education and Training (VET) qualifications in community services, mental health or disability sectors; • individuals with tertiary qualifications in medicine, social work, psychology, occupational therapy, counselling, nursing or social sciences; and • individuals with experience in mental health or disability relevant to providing mental health consumers with appropriate services.
		Teaching, Training and Research			
		Rehab in the Home (RITH)		**Rehabilitation care** Rehabilitation is care in which the primary clinical purpose or treatment goal is improvement in the functioning of a patient with an impairment, activity limitation or participation restriction due to a health condition. The patient will be capable of actively participating. Rehabilitation care is always: • delivered under the management of or informed by a clinician with specialised expertise in rehabilitation, and • evidenced by an individualised multidisciplinary management plan which is documented in the patient's medical record. The plan must include negotiated goals within specified time frames and formal assessment of functional ability. Activity Inclusions: • Consultations on the following services:	**Rehabilitation and Disability** Nursing care to patients recovering from injury and illness, and assistance and facilitation for patients with disabilities to live more independently.

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				• amputee rehabilitation • brain injury rehabilitation • care and rehabilitation of stroke patients • counselling, prosthetics, orthotics or podiatry provided as part of a rehabilitation program • general rehabilitation (including falls, reconditioning and pain) • orthopaedic rehabilitation • rehabilitation for genetic conditions such as spina bifida • rehabilitation for injuries to the spinal cord and column • rehabilitation for neurological disorders • rehabilitation services provided in a day hospital • vestibular rehabilitation • spinal injury rehabilitation Activity Exclusions: • rehabilitation activity occurring in a spinal clinic (20.31) • rehabilitation services provided by allied health/clinical nurse specialist (40.12) • cardiac rehabilitation provided by allied health/clinical nurse specialist (40.21) • management in pulmonary rehabilitation clinic (40.60)	
		Non-Admitted Programs **(where majority classified/supports non admitted patients and is non-ABF)** • Chemotherapy and Radiotherapy Outpatient Programs • FINE - CoNeCT			
4.	**Aged and Continuing Care Services**	**Aged and Home Care Services** <u>Aged Care Assessment Program</u> The Aged Care Assessment Program is a cooperative working arrangement between the Commonwealth and state and territory governments to operate Aged Care Assessment Teams (ACATs) across Australia. The core objective of the ACAP is to comprehensively assess the care needs of frail older people and to assist them to gain access to the most appropriate types of care, including approval for Commonwealth Government subsidised care services. <u>Home and Community Care Program</u> This includes funding allocated from the Commonwealth and the State Government for providing nursing care and other support services to enable people to stay at home when their capacity for independent living is at risk of premature admission to long-term residential care.	**Ageing and Aged Care – Services that support National Aged Care Programs** These are services that support eligible persons to access Australian Government funded aged care services. They are currently jointly funded by the Australian and WA Governments and are administered by WA Department of Health. **Ageing and Aged Care – Continuing Care for the Older Person** These services assist the transition for the older person from an inpatient hospital setting to receiving care as a non-admitted patient. These services can either be provided through an outpatient clinic or provided in a person's residence in the community.		**Aged Care** Nursing care to the elderly in community settings, residential aged care facilities, retirement villages and health care facilities.

Item	Proposed Service Line Definition	Program Lines	Alignment with CSF Definitions	Alignment with ABF Definitions	National Health Data Dictionary
		Palliative Care Services – community (approx $30M) Programs and services that are directly related to supporting cancer and palliative care services.	**Palliative Care Services** Palliative Care specialist services are for patients who have progressive, life limiting or life threatening malignant and/or non malignant disease. The focus of care is on the prevention and relief of suffering, quality of life and the choice of care close to home. Patients who are having life prolonging treatment are not excluded from referral to palliative care. Palliative care services can be delivered in any setting, such as hospital, home, residential care or in hospice/palliative care units. Specialist services provide consultancy, advice and support to the primary care providers; assessment/management of symptoms which are beyond the capacity of the primary care team to manage optimally; specialist assessment/ management of the patient and their families' psychological, social or spiritual needs; and direct patient care in an inpatient hospice/palliative care.	**Palliative care** Palliative care is care in which the primary clinical purpose or treatment goal is optimisation of the quality of life of a patient with an active and advanced life-limiting illness. The patient will have complex physical, psychosocial and/or spiritual needs. Palliative care is always: • delivered under the management of or informed by a clinician with specialised expertise in palliative care; and • evidenced by an individualised multidisciplinary assessment and management plan which is documented in the patient's medical record. The plan must cover the physical, psychological, emotional, social and spiritual needs of the patient, as well as include negotiated goals.	**Palliative Care** Palliative care is care in which the clinical intent or treatment goal is primarily quality of life for a patient with an active, progressive disease with little or no prospect of cure. It is usually evidenced by an interdisciplinary assessment and/or management of the physical, psychological, emotional and spiritual needs of the patient; and the provision of grief and bereavement support for the patient and their carers/family.
5.	**Community Health Services (approx $850M)** <u>Public health care services that are</u>: • Provided outside the hospital. • First level care provided by health services and systems with a suitably trained workforce comprised of multi-disciplinary teams supported by integrated referral systems. • A general practitioner is a primary health care provider, as are nurses, pharmacists and allied health providers – dentists, podiatrists and so on. • Focused on continuous health needs of a person and whole Community through partnership relationship between clients/service. Examples include: • Child Health Services and Development. • Community based diabetes and chronic disease services/programs where the primary focus is the ongoing management of stable diabetes patients • Primary Health Care Services and Programs <u>Community Health Services are:</u> • NOT PHC, not IHPA funded non-admitted, not aged care • For mental health where the	**Public Health Services** • Health promotion, primary care, education and research • Health protection and screening services	**Primary Health Care Services** Primary health care is provided by an array of people including general practitioners, dentists, public health professionals, community health nurses, midwives, nurse practitioners, Community Mental Health Practitioners, pharmacists, Aboriginal health workers, paramedics, audiologists, optometrists, allied health professionals, and carers across the local, state and Commonwealth government sectors, non-government organisations, Medicare Locals and the private sector (e.g. GP Super Clinics and other privately run practices). Primary health care may also include access to helpline services such as Health Direct. **Health promotion programs** Health promotion programs focus on enabling people to take control over the determinants of their health (socioeconomic, infrastructure and environmental conditions; social, cultural and community networks; and individual and lifestyle factors) and therefore improve their overall health as well as addressing the social, environmental and economic conditions that impact on population and individual health. Health promotion programs are provided across the full continuum of wellness and disease/injury, with information, education and advocacy services for the general population, and targeting at risk populations and high risk individuals through a variety of	**Community Health Services** The total number of occasions of examination, consultation, treatment or other services provided as group sessions to non-admitted patients in the community health services functional unit of an establishment (METeOR 270491). Community health services include units primarily concerned with baby clinics, immunisation clinics, aged care assessment teams, and so on. Each group is to be counted once, irrespective of size or the number of staff providing services. A patient who first contacts the hospital and receives non admitted care, for example through emergency departments, and is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted occasions of service that are provided to patients who are subsequently admitted should be identified as a subset of the total occasions of service.	**Public health – Environmental health** This category relates to health protection education (for example safe chemical storage, water pollutants), expert advice on specific issues, development of standards, risk management and public health aspects of environmental health protection. The costs of monitoring and regulating are to be included where costs are borne by a regulatory agency and principally have a public health focus (for example radiation safety, and pharmaceutical regulation and safety).

Item	Proposed Service Line Definition	Program Lines	Alignment with CSF Definitions	Alignment with ABF Definitions	National Health Data Dictionary
	primary purpose is to meet social needs, and prevention and early intervention services which are in many cases funded by the Commonwealth Government. • Currently not BUT Submitted to IHPA for determination: • Step Up/Down Subacute mental health (Neami) • Moort Boodjari Mia (Aboriginal midwifery service) • Ventilator Dependent Quadriplegic Community Care Program • HATH, Priority Response Assessment, Residential Care Line (Silver Chain)		mediums.		
		Aboriginal Health Programs	**Targeted Aboriginal Health Services** Services targeted at improving the provision of health and medical services for Aboriginal people while ensuring services are provided in a culturally appropriate manner and work collaboratively with; Aboriginal communities, Aboriginal Community Controlled Health Organisations, General Practitioners, hospitals and NGOs. Includes various high priority projects that are aimed at improving the life expectancy for the WA Aboriginal population, these include prevention and management of chronic disease; maternal and child health; social and emotional wellbeing and mental health, and substance abuse.		**Aboriginal Health Service** Aboriginal health services include all non-residential health care services with a primary focus on the delivery of health care to Indigenous people.
		Community Dental Health Dental health services include the school dental service, providing dental health assessment and treatment for school children, the adult dental service for financially and/or geographically disadvantaged people, specialist and general dental, as well as oral health care provided by the Oral Health Centre of Western Australia to holders of a Health Care Card. Services are provided through government funded dental clinics, itinerant services and private dental practitioners participating in the metropolitan, country and orthodontic patient dental subsidy schemes. • Oral Health Care WA • Community • Perth Dental Hospital • Aged Care	**Dental Services – Eligible Children (0–4 years); School Aged Children (5–16 years), Adult Services, Specialty Services** Public services include the school dental service, providing dental health assessment and treatment for school children, the adult dental service for financially and/or geographically disadvantaged people and specialist and general dental and oral health care provided by the Oral Health Centre of Western Australia to eligible people. Services are provided through government funded dental clinics, itinerant services and private dental practitioners participating in the metropolitan, country and orthodontic patient dental subsidy schemes.	**Specialist clinic dedicated to the promotion of oral health.** Activity Inclusions: • general dentistry (orthodontics, prosthodontics and periodontics) • fitting of plates and braces • emergency oral, fitting of mandibular advancement devices • provision of gum disease therapy Activity Exclusions: • consultation pre- or post- surgery pertaining to the cranium and face (20.27)	
		Small Rural Hospitals Funding provided to WA Country Health Service for delivery of WACHS services across rural and remote WA Non ABF			
		Patient Assisted Travel Services (PATS) Provides funding support for travel and accommodation for patients of public health services.			
		Mental Health Programs (all programs exclusive of ABF / nonadmitted)			

Item	Proposed Service Line Definition	Program Lines	Alignment with CSF Definitions	Alignment with ABF Definitions	National Health Data Dictionary
		Health screening programs Health services that screen consumers for disease, illness and injury and thereby seek treatments and/or prevention			**Provision and administration of public health program** Organisations engaged in government or private administration and provision of public health programs such as health promotion, organised screening, immunisation and health protection programs.
		Pathology & Diagnostic Services Represents 'Net Cost of Service' for PathWest. The costs presented under this category include the net cost of operating the State's single provider of pathology services across Western Australia It excludes the cost of services provided to public hospitals (included within the ABF funding) and the cost of services provided to external client.		**Haematology** Assessment, diagnosis, planning, management, follow-up screening and testing of patients with diseases of the blood.	**Pathology** Pathology includes general pathology, anatomical pathology, chemical pathology, pathological haematology, pathological immunology and clinical microbiology.
6.	**Policy, Corporate and Support Services**	**Health Service Support Services** The cost of centrally provided support services such as ICT, accounting, payroll and transactional processing are allocated across health services and the Department of Health based on the number of FTEs. This includes recently approved ICT funding to be transferred to FSH and NCH. • HCN • HIN • QE2			
		Policy Services Expenditure under the Department of Health is net of direct program delivery initiatives. The costs include budgeted costs for the Office of the Director General, Performance Activity and Quality, System Policy and Planning, Resource Strategy and Public Health and Clinical Services. The key responsibilities of these directorates are briefly described below: • Office of the Director General - Support to the Director General in both the role as the Delegate of the Health Service Boards and as the head of the Department of Health. • Performance Activity & Quality Division - Purchasing of publicly funded health services through business and financial modelling of health needs, specifying and contracting for the delivery of health services, system reporting and monitoring of performance, plus establishment of safety and quality standards and the regulation and licensing of non-Government healthcare			

Item	Proposed Service Line Definition	Program Lines	Alignment with CSF Definitions	Alignment with ABF Definitions	National Health Data Dictionary
		providers. • System Policy & Planning Division - Analysing and understanding health service trends and directions; modelling and analysing health system data and the development of health system policies, plans and strategies. • Resource Strategy - Securing appropriate workforce, financial and infrastructure resources; coordinating the interface with the Commonwealth government and WA central agencies; ensuring effective governance; and promoting the work of WA Health. • Public Health & Clinical Services Division - Advisory, clinical regulation and advocacy and public health and regulatory services. • Budget for Royal Street			

Appendix 10 Proposed Sub-Service Descriptors – Evidence Matrix of Strategic Alignment

Proposed Sub Service Descriptors	Alignment with CSF Definitions	Admission, Readmission, Discharge and Transfer Policy for WA Health Services	Alignment with ABF (classifications provided by IHPA)	National Health Data Dictionary/METeOR
Service 1. Public Hospital Admitted Services (approx.$3.209M) **Descriptor:** The provision of healthcare services to patients in metropolitan and major rural hospitals that meet the criteria for admission and receive treatment and/or care for a period of time, including public patients treated in private facilities under contract to WA Health. Admission to hospital and the treatment provided may include access to acute and/or subacute inpatient services, as well as hospital in the home services. Public Hospital Admitted Services includes teaching, training and research activities provided by the public health service to facilitate development of skills and acquisition or advancement of knowledge related to admitted services.				
1. Public Hospital Admitted Services The provision of acute and sub-acute (admitted patient) care services in which the clinical intent or treatment goal is to: manage labour (obstetric); cure illness or provide definitive treatment of injury; perform surgery; relieve symptoms of illness or injury (including inpatient palliative care); reduce severity of an illness or injury; provision of specialised multidisciplinary care in which the primary need for care is optimisation of the patient's functioning and quality of life (including inpatient palliative care); protect against exacerbation and/or complication of an illness and/or injury which could threaten life or normal function, including involuntary psychiatric patients or perform diagnostic or therapeutic procedures. This sub service group includes some forms of rehabilitation care. This Service includes a component of Teaching, Training and Research activity to facilitate the acquisition of knowledge, or development of skills related to the provision of Admitted Services to the public.	**Acute Care** Acute care is generally hospital based.	**Admitted care** An admitted patient is defined as a person who meets the **criteria for admission and additional criteria specific to the applicable admission category and care type** (refer sections 3–5), and undergoes a hospital's formal admission process (documented) to receive inpatient treatment and/or care for a period of time. The patient's condition and planned treatment may meet admission criteria. This makes the patient eligible to be considered for admission; but it does not in itself constitute admitted care. Care which technically meets admission criteria may be provided as non-admitted care. The policy is not directing that patients should be admitted if they meet admission criteria. Commonwealth legislation directs what procedures can and cannot be admitted as same day cases. These considerations and resulting same day admission categories are outlined in section 4. The criteria for all admission categories reflect the intended level of treatment that the patient is to receive. The decision to admit is based on these criteria, which must be considered before a decision is made. The admission can occur in a hospital setting, or in the patient's home under specified programs such as Hospital in the Home (HITH). <u>Exclusion:</u> Non-admitted (emergency or outpatient) services provided to a patient who is subsequently admitted shall not be regarded as part of the admitted episode. **Hospital in the Home** Hospital in the home (HITH) provides care in the patient's home or usual place of residence that would otherwise need to be delivered within a hospital as admitted patient care. HITH care is classified as overnight 'admitted care' either as an alternative to admission to hospital or a continuation of an admission with the patient's relocation to home. **Acute Care** An episode of acute care for an admitted patient is one in which the principal clinical intent is to do one or more of the following: • manage labour (obstetric) • cure illness or provide definitive treatment of injury • perform surgery • relieve symptoms of illness or injury (excluding palliative care) • reduce severity of illness or injury • protect against exacerbation and/or complication of an illness and/or injury which could threaten life or normal functions • perform diagnostic or therapeutic procedures.	**Admitted acute care** Acute care is care in which the primary clinical purpose or treatment goal is to: • manage labour (obstetric); • cure illness or provide definitive treatment of injury; • perform surgery; • relieve symptoms of illness or injury (excluding palliative care); • reduce severity of an illness or injury; • protect against exacerbation and/or complication of an illness and/or injury which could threaten life or normal function; and • perform diagnostic or therapeutic procedures Acute care excludes care which meets the definition of mental health care. All public and private hospitals in Australia group admitted acute episodes of care to the Australian Refined Diagnosis Related Group (AR-DRG) classification system.	**Admitted patient** A person who undergoes a hospital's formal admission process to receive treatment and/or care. Such treatment or care is provided over a period of time and can occur in hospital and/or in the person's home (as a 'hospital-in-the-home' patient) (METeOR identifier 268957). **Care Type** The care type defines the overall nature of a clinical service provided to an admitted patient during an episode of care (admitted care), or the type of service provided by the hospital for boarders or posthumous organ procurement (other care). **Admitted patient care** consists of the following categories (METeOR identifier: 270174): • Acute care • Rehabilitation care • Palliative care • Geriatric evaluation and management • Psychogeriatric care • Maintenance care • Newborn care **Inpatient** Another term for admitted patient (METeOR identifier: 268957)
		Subacute care Subacute admitted care is specialised multidisciplinary care in which the primary need for care is optimisation of the patient's functioning and quality of life. A person's functioning may relate to their whole body or a body part, the whole person, or the whole person in a social context, and to impairment of a body function or structure, activity limitation and/or participation restriction. Subacute admitted care is overnight/multi day care in a specialised multidisciplinary care type of Rehabilitation, Palliative Care,	**Subacute care** Subacute care is defined as specialised multidisciplinary care in which the primary need for care is optimisation of the patient's functioning and quality of life. A person's functioning may relate to their whole body or a body part, the whole person, or the whole person in a social context, and to impairment of a body function or structure, activity limitation and/or participation restriction. Subacute care comprises the following care types:	**Inpatient** Another term for admitted patient (METeOR identifier: 268957).

Proposed Sub Service Descriptors	Alignment with CSF Definitions	Admission, Readmission, Discharge and Transfer Policy for WA Health Services	Alignment with ABF (classifications provided by IHPA)	National Health Data Dictionary/METeOR
		Geriatric Evaluation and Management (GEM), or Psychogeriatric care. There is no subacute care type applicable to mental health other than Psychogeriatric. Subacute care should be provided in a designated ward, unit or program, where the clinical staff are able to deliver the specialised care and will be trained in the necessary functional assessment tools and data reporting requirements. **Rehabilitation** Rehabilitation admitted care is provided to patients who require intensive multidisciplinary rehabilitation services. The patient is expected to require admission for two or more days. The primary clinical purpose or treatment goal is improvement in the functioning of a patient with impairment, activity limitation or participation restriction due to a health condition. The patient will be capable of actively participating in rehabilitation care. • Rehabilitation care is always: delivered under the management of or informed by a clinician with specialised expertise in rehabilitation • evidenced by an individualised multidisciplinary management plan, which is documented in the patient's medical record, that includes negotiated goals within specified time frames and formal assessment of functional ability.	• Rehabilitation care • Palliative care • Geriatric evaluation and management (GEM) care • Psychogeriatric care Non-acute care comprises the following care type: • Maintenance care	
2. Public, Private Partnership – Admitted Services The provision of acute and subacute admitted services to public patients, by private providers under contract to WA Health. This Service includes a component of Teaching, Training and Research activity to facilitate the acquisition of knowledge, or development of skills related to the provision of Admitted Services to the public.				**Public Hospital** A hospital controlled by a state or territory health authority. Public hospitals offer free diagnostic services, treatment, care and accommodation to all eligible patients. **Public Patient** A patient admitted to a hospital who has agreed to be treated by doctors of the hospital's choice and to accept shared accommodation. This means the patient is not charged. **Private Hospital** A privately owned and operated institution, catering for patients who are treated by a doctor of their own choice. Patients are charged fees for accommodation and other services provided by the hospital and relevant medical and paramedical practitioners. Acute care and psychiatric hospitals are included, as are private free-standing day hospital facilities. **Private Patients** Patients admitted to a hospital who decide to choose the doctor(s) who will treat them and/or to have private ward accommodation. They are charged for medical services, food and accommodation.
Service 2. Public Hospital Emergency Services (approx.$699M) **Descriptor**: The provision of services for the treatment of patients in emergency departments of metropolitan and major rural hospitals, inclusive of public patients treated in private facilities under contract to WA Health. The services provided to patients are specifically designed to provide emergency care, including a range of pre-admission, post-acute and other specialist medical, allied health, nursing and ancillary services. Public Hospital Admitted Services includes teaching, training and research activities provided by the public health service to facilitate development of skills and acquisition or advancement of knowledge related to emergency services.				
3. Public Hospital Emergency Department Services The provision of dedicated hospital based emergency services, inclusive of the diagnosis and treatment of acute and urgent illnesses and injuries. Patients being treated in emergency services/urgent care centres may subsequently become admitted. Care provided to patients in General Practitioner co-located units is excluded from the scope of this Sub-Service.			**Emergency care** EDs are dedicated hospital-based facilities specifically designed and staffed to provide 24 hour emergency care. The role of the ED is to diagnose and treat acute and urgent illnesses and injuries. Patients are seen in order of medical urgency with non-urgent patients being seen after more acute patients. On arrival in the ED, patients are assessed by a clinician and given a triage score. A triage score is a ranking from one to five (one being the most urgent and five being non-urgent) used to prioritise or classify patients on the basis of illness or injury severity and need for medical and nursing care. During the treatment phase of their time in ED patients are assessed by a clinician, a diagnosis is	**Emergency Department clinical care** Emergency department non-admitted clinical care can be commenced by a doctor, nurse, mental health practitioner or other health professional, when investigation, care and/or treatment is provided in accordance with an established clinical pathway defined by the emergency department. Placement of a patient in a cubicle and observations taken to monitor a patient pending a clinical decision regarding commencement of a clinical pathway, do not constitute commencement. **Emergency Services** The scope of this DSS is emergency services provided in activity based funded hospitals which do not meet any of the following criteria: • Purposely designated and equipped area with designated

Proposed Sub Service Descriptors	Alignment with CSF Definitions	Admission, Readmission, Discharge and Transfer Policy for WA Health Services	Alignment with ABF (classifications provided by IHPA)	National Health Data Dictionary/METeOR
			made and treatment is given, if required.	assessment; treatment and resuscitation areas. • Ability to provide resuscitation, stabilisation and initial management of all emergencies. • Availability of medical staff available in the hospital 24 hours a day. • Designated emergency department nursing staff 24 hours a day, 7 days a week, and a designated emergency department nursing unit manager. The care provided to patients in emergency services/urgent care centres is, in most instances, recognised as being provided to non-admitted patients. Patients being treated in emergency services/urgent care centres may subsequently become admitted. All patients remain in-scope for this collection until they are recorded as having physically departed the emergency service/urgent care centre, regardless of whether they have been admitted. For this reason there is an overlap in the scope of this DSS and the Admitted patient care national minimum data set (APC NMDS). The scope also includes services where patient did not wait or died on arrival. Patients with Department of Veterans' Affairs or compensable funding source are also included in the scope of the collection. Excluded from the scope are: • Care provided to patients in General Practitioner co-located units.
4. Public, Private Partnership – Emergency Services The provision of emergency services to public patients, by private providers under contract to WA Health. This Service includes a component of Teaching, Training and Research activity to facilitate the acquisition of knowledge, or development of skills related to the provision of Emergency Services to the public.				**Public Hospital** A hospital controlled by a state or territory health authority. Public hospitals offer free diagnostic services, treatment, care and accommodation to all eligible patients. **Public Patient** A patient admitted to a hospital who has agreed to be treated by doctors of the hospital's choice and to accept shared accommodation. This means the patient is not charged. **Private Hospital** A privately owned and operated institution, catering for patients who are treated by a doctor of their own choice. Patients are charged fees for accommodation and other services provided by the hospital and relevant medical and paramedical practitioners. Acute care and psychiatric hospitals are included, as are private free-standing day hospital facilities. **Private Patients** Patients admitted to a hospital who decide to choose the doctor(s) who will treat them and/or to have private ward accommodation. They are charged for medical services, food and accommodation.
Service 3. Public Hospital Non-Admitted Services (approx. $695M) **Descriptor**: The provision of metropolitan and major rural hospital services to patients who do not undergo a formal admission process, inclusive of public patients treated by private facilities under contract to WA Health. This Service includes services provided to patients in outpatient clinics, community based clinics or in the home, procedures, medical consultation, allied health or treatment provided by clinical nurse specialists. Public Hospital Non-Admitted Services includes teaching, training and research activities provided by the public health service to facilitate development of skills and acquisition or advancement of knowledge related to non-admitted services.				
5. Public Hospital Non-admitted Services The provision of services related to specialist outpatient clinics or other non-admitted patient services and non-medical specialist outpatient clinics. Categories of outpatient services include: procedures; medical consultation; standalone diagnostic and allied health and/or clinical nurse and/or midwife	**Non-admitted Outpatient Service Definitions** The generic service definition for non-admitted hospital outpatient services below outlines service levels from Level II to Level VI. This describes services that are related to a hospital admission (e.g. before and after care) OR services that require highly specialised expertise and/or expensive equipment (for details of how other non-admitted outpatient services are	**Non-admitted Care** Non-admitted patients do not usually meet the admission criteria, and do not undergo a hospital's formal admission process. Care which technically meets admission criteria may be provided as nonadmitted care within an Emergency or Outpatient service. It may be more convenient, less intrusive to the patient and a better use of resources to provide treatment in a non-admitted setting. Non-admitted patient categories include (but are not limited to): • patients attending for a procedure on the non-admitted procedures (Type C) list, without other	**Non-admitted care** Non-admitted care encompasses services provided to patients who do not undergo a formal admission process and do not occupy a hospital bed. For example, services provided by hospitals: • in hospital outpatient clinics • in community based clinics • in patients' homes. The classification system for non-admitted care is known as Tier 2 Non-Admitted Care Services.	**Non-admitted patients** Patients who receive care from a recognised non-admitted patient service/clinic of a hospital (METeOR identifier: 268973).

Proposed Sub Service Descriptors	Alignment with CSF Definitions	Admission, Readmission, Discharge and Transfer Policy for WA Health Services	Alignment with ABF (classifications provided by IHPA)	National Health Data Dictionary/METeOR
specialist intervention. This Service includes a component of Teaching, Training and Research activity to facilitate the acquisition of knowledge, or development of skills related to the provision of Non-admitted Services to the public.	described in the CSF please refer to section 6a Non-admitted (outpatient) services). Categories of outpatient services include: • Procedures • Medical consultation • Standalone diagnostic • Allied health and/or clinical nurse specialist intervention	• justification for admission documented by the treating medical officer in the medical record • patients who receive their entire care within the Emergency Department (excluding admissions to short stay units) • dead on arrival (no active resuscitation) • babies who are stillborn, or show no sign of life at birth • patients attending an outpatient clinic (refer to exclusions below) • rehabilitation in the home (RITH) • other non-admitted patients: o boarders o posthumous organ donor. <u>Exclusions:</u> Outpatient (non- admitted) care provided to an inpatient, within the same health care facility, is included as part of the admitted care episode. The non-admitted outpatient activity will be recorded but will not be reported as activity (service event) for ABF purposes, for example: • inpatients receiving non-admitted care during an admission, i.e.: attending an outpatient clinic appointment or receiving treatment in the emergency department • patients undergoing a procedure or having a consultancy/treatment in an outpatient clinic as part of their planned same day or overnight admission.	Tier 2 categorises a hospital's non-admitted services into classes which are generally based on the nature of the service provided and the type of clinician providing the service. The structure of the classification is first differentiated by the nature of the non-admitted service provided. The major categories are: • procedures • medical consultation services • diagnostic services • allied health and/or clinical nurse specialist intervention services. For example, a hospital outpatient clinic which performs endoscopies will be classified to a class in the procedures category. A clinic which performs computerised tomography (CT) scans will be classified to a class in the stand-alone diagnostic services category. A clinic run by a doctor who sees patients for consultations will be classified to a class in the medical consultation services category.	
6. Public, Private Partnership - Non-admitted Services The provision of non-admitted services to public patients, by private providers under contract to WA Health. This Service includes a component of Teaching, Training and Research activity to facilitate the acquisition of knowledge, or development of skills related to the provision of Non-admitted Services to the public.				**Public Hospital** A hospital controlled by a state or territory health authority. Public hospitals offer free diagnostic services, treatment, care and accommodation to all eligible patients. **Public Patient** A patient admitted to a hospital who has agreed to be treated by doctors of the hospital's choice and to accept shared accommodation. This means the patient is not charged. **Private Hospital** A privately owned and operated institution, catering for patients who are treated by a doctor of their own choice. Patients are charged fees for accommodation and other services provided by the hospital and relevant medical and paramedical practitioners. Acute care and psychiatric hospitals are included, as are private free-standing day hospital facilities. **Private Patients** Patients admitted to a hospital who decide to choose the doctor(s) who will treat them and/or to have private ward accommodation. They are charged for medical services, food and accommodation.
Service 4. Mental Health Services (approx. $648M) **Descriptor**: The provision of inpatient services where an admitted patient occupies a bed in a designated mental health facility or a designated mental health unit in a hospital setting; and the provision of non-admitted services inclusive of community and ambulatory specialised mental health programs such as prevention and promotion, community support services, community treatment services, community bed based services and forensic services. This Service includes the provision of state-wide mental health services such as perinatal mental health and eating disorder outreach programs as well as the provision of assessment, treatment, management, care or rehabilitation of persons experiencing alcohol or other drug use problems or co-occurring health issues. Mental Health Services includes teaching, training and research activities provided by the public health service to facilitate development of skills and acquisition or advancement of knowledge related to mental health or alcohol and drug services. This service includes public patients treated in private facilities under contract to WA Health.				
7. Public Hospital - Inpatient Mental Health Services The provision of acute and sub-acute inpatient services within a specialised mental health unit, inclusive of specialised mental health services that provide overnight care in a psychiatric hospital or a specialised mental health unit in an acute hospital. People with mental health problems can also be admitted to	**Mental Health Services – Child and Adolescent, Adult and Older Adult** Mental health clinical services are concerned with the assessment, diagnosis, monitoring and treatment for people who have a mental illness or disorder characterised by a clinically significant disturbance of thought, mood, perception, memory and/or behaviour. Mental health clinical services address the needs of individuals across the age	**Mental Health (Type P)** Mental health care is care in which the primary clinical purpose or treatment goal is improvement in the symptoms and/or psychosocial, environmental and physical functioning related to a patient's mental disorder. The Mental Health Care Type is a new care type. Patients being formally admitted to a Specialised Mental Health ward1 from the 1st July 2015 will be admitted with a mental health care type. The boundary between mental health and other care types has to be carefully defined. In 2015-2016 Mental Health Care type only applies to admitted patients receiving care in psychiatric hospitals or in designated specialised mental	**Mental Health Care** From 1 July 2013, IHPA has priced admitted mental health services using Australian Refined Diagnosis Related Groups (AR-DRGs) as the classification system. IHPA modified the pricing model on the basis that AR-DRGs do not predict resource consumption for mental health care as well as they do for other medical and surgical services. **Note:** The Pricing Authority has determined that non-admitted mental health care will be block funded until such time as the new mental health care classification is available.	**Inpatient** Another term for admitted patient (METeOR identifier: 268957).

Proposed Sub Service Descriptors	Alignment with CSF Definitions	Admission, Readmission, Discharge and Transfer Policy for WA Health Services	Alignment with ABF (classifications provided by IHPA)	National Health Data Dictionary/METeOR
other areas where health care workers are not specifically trained to care for the mentally ill. This Service includes a component of Teaching, Training and Research activity to facilitate the acquisition of knowledge, or development of skills related to the provision of Inpatient Mental Health Services to the public.	spectrum (children, adolescents, adults and older adults). A person's need for mental health services can be short, medium, long term or intermittent, and often spans various levels of care and service areas across the health continuum.	health units in acute hospitals. The scope does not currently include patients who may be receiving treatment for psychiatric conditions in acute hospitals who are not in psychiatric units. A specialised mental health service that provides overnight care in a psychiatric hospital or a specialised mental health unit in an acute hospital. Psychiatric hospitals and specialised mental health units in acute hospitals are establishments devoted primarily to the treatment and care of admitted patients with psychiatric, mental or behavioural disorders. These services are staffed by health professionals with specialist mental health qualifications or training and have as their principal function the treatment and care of patients affected by mental disorder/illness A service is not defined as a specialised mental health service solely because its clients include people affected by a mental illness or psychiatric disability	The care type definition approved by the Pricing Authority is: "Mental health care is care in which the primary clinical purpose or treatment goal is improvement in the symptoms and/or psychosocial, environmental and physical function relating to a patient's mental disorder." Mental health care: • is delivered under the management of, or regularly informed by, a clinician with specialised expertise in mental health; • is evidenced by an individualised formal mental health assessment and the implementation of a documented mental health plan; and • may include significant psychosocial components including family and carer support. Whilst not specifically stated, "assessment only" activities are considered in scope for the classification.	
8. Public Hospital - Non-Admitted Mental Health Services The provision of non-admitted patient mental health services within a specialised mental health unit or community based mental health services delivered either in the community or in the home.				
9. Public, Private Partnership - Inpatient Mental Health Services The provision of inpatient mental health services to public patients, by private providers under contract to WA Health, inclusive of specialised mental health services that provide overnight care or a specialised mental health unit in an acute hospital. This Service includes a component of Teaching, Training and Research activity to facilitate the acquisition of knowledge, or development of skills related to the provision of Mental Health Services to the public.				**Public Hospital** A hospital controlled by a state or territory health authority. Public hospitals offer free diagnostic services, treatment, care and accommodation to all eligible patients. **Public Patient** A patient admitted to a hospital who has agreed to be treated by doctors of the hospital's choice and to accept shared accommodation. This means the patient is not charged. **Private Hospital** A privately owned and operated institution, catering for patients who are treated by a doctor of their own choice. Patients are charged fees for accommodation and other services provided by the hospital and relevant medical and paramedical practitioners. Acute care and psychiatric hospitals are included, as are private free-standing day hospital facilities. **Private Patients** Patients admitted to a hospital who decide to choose the doctor(s) who will treat them and/or to have private ward accommodation. They are charged for medical services, food and accommodation.
10. Mental Health Specific Programs The provision of community based mental health specific programs purchased by the WA Mental Health Commission including suicide prevention, Aboriginal mental health, drug and alcohol, youth community treatment, court diversion, community living and domestic violence programs.				
Service 5. Aged and Continuing Care Services (approx.$527M) **Descriptor**: The provision of aged and continuing care services and community based palliative care services. Aged and continuing care services include programs that assess the care needs of older people, provide functional interim care or support for older, frail, aged and younger people with disabilities to continue living independently in the community and maintain independence, inclusive of the services provided by the WA Quadriplegic Centre. Aged and Continuing Care Services is inclusive of community based palliative care services that are delivered by private facilities under contract to WA Health, which focus on the prevention and relief of suffering, quality of life and the choice of care close to home for patients.				

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11. Aged and Continuing Care Services The provision of continuing care services for WA's ageing population, embedded in major health programs in a number of settings inclusive of community care (including the Home and Community Care Program); residential care (including Commonwealth funded high and low care residential facilities as well as the nursing home type patient units in the State's country hospitals); High Dependency Units in residential aged care facilities for people with behavioural problems associated with chronic mental disorders and/or advanced dementia and residential rehabilitation care programs for both the older population and younger individuals with disabilities to continue living independently in the community and maintain independence.	**Aged and Continuing Care** The provision of continuing care services for WA's ageing population is embedded in major health programs, most of which are relatively long-standing. They are undertaken within the context of a number of health settings including: • acute care (which is generally hospital based); • subacute care (inpatient and community based); • community care (including the Home and Community Care Program); • residential care (including Commonwealth funded high and low care residential facilities as well as the nursing home type patient units in the State's country hospitals); • High Dependency Units in residential aged care facilities for people with behavioural problems associated with chronic mental disorders and/or advanced dementia; and • Multi-Purpose Services (MPS). A number of statewide programs and initiatives are managed through WA Health to support hospital demand management strategies and the interface between hospital, community and residential care. **Ageing and Aged Care – Services that support National Aged Care Programs** These are services that support eligible persons to access Australian Government funded aged care services. They are currently jointly funded by the Australian and WA Governments and are administered by WA Department of Health. **Rehabilitation Services** Rehabilitation care aims to improve the functioning of a patient with impairment, activity limitation or participation restriction due to a health condition. Provides time limited and goal oriented multidisciplinary intervention and management to help patients to maximise their functional capacities and independence. Rehabilitation services should be coordinated across the continuum of care.	**Geriatric Evaluation and Management** Geriatric Evaluation and Management (GEM) is care in which the primary clinical purpose or treatment goal is improvement in the functioning of a patient with multi-dimensional needs associated with medical conditions related to ageing, such as tendency to fall, incontinence, reduced mobility and cognitive impairment. The patient may also have complex psychosocial problems. Geriatric Evaluation and Management is always: • delivered under the management of or informed by a clinician with specialised expertise in geriatric evaluation and management • evidenced by an individualised multidisciplinary management plan, which is documented in the patient's medical record that covers the physical, psychological, emotional and social needs of the patient and includes negotiated goals within indicative time frames and formal assessment of functional ability **Rehabilitation or Gem** Rehabilitation is typically more goal oriented than GEM. Patients are more appropriately classified as Rehabilitation where they have had a readily defined event which has led to the requirement for a Rehabilitation Program with clear goals such as a stroke, orthopaedic, traumatic injury or defined disability. Patients are more appropriately classified as GEM where they are assessed as suitable for a fast track rehabilitation program in a defined GEM Unit that will shorten the patient's length of stay in hospital and/or they have geriatric syndromes which require specialist geriatric medical input such as: • poor Cognitive status • falls without significant injury • frailty. The treatment received in the GEM unit may include: • improving functional level to allow discharge to the community or a lower level of residential care • evaluating the social situation and developing an appropriate discharge plan. Reconditioning can be classified as either Rehabilitation or GEM. If a patient is older with significant co-morbidities they fit more appropriately within the GEM care type.		**Aged Care** Nursing care to the elderly in community settings, residential aged care facilities, retirement villages and health care facilities. **Hospital in the home care** Provision of care to hospital admitted patients in their place of residence as a substitute for hospital accommodation. Place of residence may be permanent or temporary (METeOR identifier: 270305)
12. Palliative & Cancer Care Services Palliative Care specialist services are for patients who have progressive, life limiting or life threatening malignant and/or non-malignant disease. The focus of care is on the prevention and relief of suffering, quality of life and the choice of care close to home. Palliative care services can be delivered in any setting, such as home, residential care or in	**Palliative Care Services** Palliative Care specialist services are for patients who have progressive, life limiting or life threatening malignant and/or non malignant disease. The focus of care is on the prevention and relief of suffering, quality of life and the choice of care close to home. Patients who are having life prolonging treatment are not excluded from referral to palliative care. Palliative care services can be delivered in any setting, such as hospital, home, residential care or in hospice/palliative	**Palliative Care** Palliative care is care in which the primary clinical purpose or treatment goal is optimisation of the quality of life of a patient with an active and advanced life-limiting illness. The patient will have complex physical, psychosocial and/or spiritual needs. Palliative care is always: • delivered under the management of or informed by a clinician with specialised expertise in palliative care • evidenced by an individualised multidisciplinary assessment and management plan, which is documented in the patient's medical record that covers the physical, psychological, emotional, social and spiritual needs of the patient and negotiated goals.	**Palliative care** Palliative care is care in which the primary clinical purpose or treatment goal is optimisation of the quality of life of a patient with an active and advanced life-limiting illness. The patient will have complex physical, psychosocial and/or spiritual needs. Palliative care is always: • delivered under the management of or informed by a clinician with specialised expertise in palliative care; and • evidenced by an individualised multidisciplinary assessment and management plan which is	**Palliative care** Palliative care is care in which the clinical intent or treatment goal is primarily quality of life for a patient with an active, progressive disease with little or no prospect of cure. It is usually evidenced by an interdisciplinary assessment and/or management of the physical, psychological, emotional and spiritual needs of the patient; and a grief and bereavement support service for the patient and their carers/family. It includes care provided: • in a palliative care unit; or • in a designated palliative care program; or • under the principal clinical management of a palliative care physician or, in the opinion of the treating doctor, when the

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palliative care units. Specialist services provide consultancy, advice and support to the primary care providers; assessment/management of symptoms which are beyond the capacity of the primary care team to manage optimally; specialist assessment/ management of the patient and their families' psychological, social or spiritual needs; and direct patient care in an inpatient hospice/palliative care. This sub-service is inclusive of contracted palliative and cancer care services provided in partnership with GPs, NGOs, Medicare Locals, Private providers and State Government.	care units. Specialist services provide consultancy, advice and support to the primary care providers; assessment/management of symptoms which are beyond the capacity of the primary care team to manage optimally; specialist assessment/ management of the patient and their families' psychological, social or spiritual needs; and direct patient care in an inpatient hospice/palliative care. **Cancer Services** Cancer services include self-management through information and education to coordinated management planning and care that is community based and delivered in partnership with GPs, NGOs, Medicare Locals, Private providers and State Government.	A clinician with specialist expertise in palliative care includes: • Palliative Care Medical Consultant/Specialist. • Palliative Care Nurse Practitioner, Clinical Nurse Consultant, Clinical Nurse Specialist where there is medical agreement that the intent of ongoing treatment is palliative care. • In WACHS regions Palliative Care Nurse Manager in conjunction with treating Medical Practitioner, where there is agreement that the intent of ongoing treatment is palliative care.	documented in the patient's medical record. The plan must cover the physical, psychological, emotional, social and spiritual needs of the patient, as well as include negotiated goals.	principal clinical intent of care is palliation **Cancer treatment** The course of cancer directed treatment or treatments, with defined dates of commencement and cessation, given to the patient by a treatment provider or team of providers. It includes all treatments administered to the patient before disease progression or recurrence and applies to surgical treatment, radiation therapy and systemic agent therapy for cancer.
Service 6. Public and Community Health Services (approx. $1.354B) Descriptor: The provision of healthcare services and programs delivered to increase optimal health and wellbeing, encourage healthy lifestyles, reduce the onset of disease and disability, reduce the risk of long-term illness as well as detect, protect and monitor the incidence of disease in the population. Public and Community Health Services includes public health programs, Aboriginal health programs, environmental health, community based dental services, the provision of grants to non-government organisations for public and community health purposes, emergency road and air ambulance services, services to assist rural based patients travel to receive care, statewide pathology services provided to external WA Agencies and the services provided by small rural hospitals.				
13. Public Health Services Provision of primary, community, promotion and protection health care services, inclusive of environmental health education, monitoring and regulation programs; disaster preparedness and management services; immunisation clinics; maternity clinics and allied health care across the full continuum of wellness and disease/injury.	**Primary Health Care Services** Primary health care is provided by an array of people including general practitioners, dentists, public health professionals, community health nurses, midwives, nurse practitioners, Community Mental Health Practitioners, pharmacists, Aboriginal health workers, paramedics, audiologists, optometrists, allied health professionals, and carers across the local, state and Commonwealth government sectors, non-government organisations, Medicare Locals and the private sector (e.g. GP Super Clinics and other privately run practices). Primary health care may also include access to helpline services such as Health Direct. **Health promotion programs** Health promotion programs focus on enabling people to take control over the determinants of their health (socioeconomic, infrastructure and environmental conditions; social, cultural and community networks; and individual and lifestyle factors) and therefore improve their overall health as well as addressing the social, environmental and economic conditions that impact on population and individual health. Health promotion programs are provided across the full continuum of wellness and disease/injury, with information, education and advocacy services for the general population, and targeting at risk populations and high risk individuals through a variety of mediums.		**Community Health Services** The total number of occasions of examination, consultation, treatment or other services provided as group sessions to non-admitted patients in the community health services functional unit of an establishment (METeOR 270491). Community health services include units primarily concerned with baby clinics, immunisation clinics, aged care assessment teams, and so on. Each group is to be counted once, irrespective of size or the number of staff providing services. A patient who first contacts the hospital and receives non admitted care, for example through emergency departments, and is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted occasions of service that are provided to patients who are subsequently admitted should be identified as a subset of the total occasions of service. **Public health – Environmental health** This category relates to health protection education (for example safe chemical storage, water pollutants), expert advice on specific issues, development of standards, risk management and public health aspects of environmental health protection. The costs of monitoring and regulating are to be included where costs are borne by a regulatory agency and principally have a public health focus (for example radiation safety, and pharmaceutical regulation and safety).	**Provision and administration of public health program** Organisations engaged in government or private administration and provision of public health programs such as health promotion, organised screening, immunisation and health protection programs.

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14. Special Purpose Programs The provision of special purpose programs inclusive of blood contract programs containing the $30+M blood contract through the Department of Health other long stay patient care i.e. Lady Lawley, Catch program and Renal programs and community midwifery programs. This Sub-Service recognises that some health service programs have a specific purpose with a distinct expenditure profile.				
15. Patient Transport Services This item comprises transportation in a specially-equipped surface vehicle or in a designated air ambulance to and from facilities for the purposes of receiving medical and surgical care. Includes all government ambulance services and transport provided by the Royal Flying Doctors Service, care flight and similar services, emergency transport services of public fire rescue departments or defence that operate on a regular basis for civilian emergency services (not only for catastrophe medicine). Includes transport between hospitals or other medical facilities and transport to or from a hospital or other medical facility and a private residence or other non-hospital/medical services location. The provider of this service could be a public or private. This Sub-Service does not include inter-hospital patient transport services.		The Patient Assisted Travel Scheme (PATS) provides assistance to eligible residents of a WA Country Health Service (WACHS) region and their approved escorts who are required to travel more than 100km (one way) to access the nearest PATS eligible medical specialist services. Assistance is provided in the form of a travel and accommodation (where applicable) subsidy. It is not intended to meet the full costs of travel and accommodation, or to provide assistance with other costs associated with access to specialist appointments. Patients who are required to travel between 70-100km to access the nearest eligible medical specialist service for cancer treatment or dialysis are also eligible for limited PATS assistance. Applications for PATS assistance are made by an eligible referring practitioner. The application for PATS assistance needs to be lodged prior to travel via fax, mail, email or in person at the patient's nearest health service.		**Health related care – Patient transport** This item comprises transportation in a specially-equipped surface vehicle or in a designated air ambulance to and from facilities for the purposes of receiving medical and surgical care. Includes all government ambulance services and transport provided by the Royal Flying Doctors Service, care flight and similar services, emergency transport services of public fire rescue departments or defence that operate on a regular basis for civilian emergency services (not only for catastrophe medicine). Includes transport between hospitals or other medical facilities and transport to or from a hospital or other medical facility and a private residence or other non-hospital/medical services location. The provider of this service could be a public or private
16. Aboriginal Health Programs Provision of services targeted at improving the provision of health and medical services for Aboriginal people while ensuring services are provided in a culturally appropriate manner and work collaboratively with; Aboriginal communities, Aboriginal Community Controlled Health Organisations, General Practitioners, hospitals and NGOs. Includes various high priority projects that are aimed at improving the life expectancy for the WA Aboriginal population, these include prevention and management of chronic disease; maternal and child health; social and emotional wellbeing and mental health, and substance abuse.	**Targeted Aboriginal Health Services** Services targeted at improving the provision of health and medical services for Aboriginal people while ensuring services are provided in a culturally appropriate manner and work collaboratively with; Aboriginal communities, Aboriginal Community Controlled Health Organisations, General Practitioners, hospitals and NGOs. Includes various high priority projects that are aimed at improving the life expectancy for the WA Aboriginal population, these include prevention and management of chronic disease; maternal and child health; social and emotional wellbeing and mental health, and substance abuse.			**Aboriginal Health Service** Aboriginal health services include all non-residential health care services with a primary focus on the delivery of health care to Indigenous people.

Proposed Sub Service Descriptors	Alignment with CSF Definitions	Admission, Readmission, Discharge and Transfer Policy for WA Health Services	Alignment with ABF (classifications provided by IHPA)	National Health Data Dictionary/METeOR
17. Community Dental Health Dental health services include the school dental service, providing dental health assessment and treatment for school children, the adult dental service for financially and/or geographically disadvantaged people, specialist and general dental, as well as oral health care provided by the Oral Health Centre of Western Australia to holders of a Health Care Card. Services are provided through government funded dental clinics, itinerant services and private dental practitioners participating in the metropolitan, country and orthodontic patient dental subsidy schemes.	**Dental Services – Eligible Children (0–4 years); School Aged Children (5–16 years), Adult Services, Specialty Services** Public services include the school dental service, providing dental health assessment and treatment for school children, the adult dental service for financially and/or geographically disadvantaged people and specialist and general dental and oral health care provided by the Oral Health Centre of Western Australia to eligible people. Services are provided through government funded dental clinics, itinerant services and private dental practitioners participating in the metropolitan, country and orthodontic patient dental subsidy schemes.		**Specialist clinic dedicated to the promotion of oral health.** Activity Inclusions: • general dentistry (orthodontics, prosthodontics and periodontics) • fitting of plates and braces • emergency oral, fitting of mandibular advancement devices • provision of gum disease therapy Activity Exclusions: • consultation pre- or post- surgery pertaining to the cranium and face (20.27)	
18. Block Funded Small Rural Hospitals The provision of emergency care services and limited acute medical and minor surgical services in locations 'close to home' for country residents and the many visitors to the regions, by small and rural hospitals classified as block funded. The Services provided by small rural hospitals include community care services which align closely with the needs of local communities.	**Small Hospitals/Primary Health Care Centres** Small country hospitals and/or primary health care centres provide emergency care services, residential aged care services and limited acute medical and minor surgical services in locations 'close to home' for country residents and the many visitors to the regions. There are currently 50 of these facilities across WACHS and these are listed in the WACHS Hospital Matrix. It is well recognised that the network of WACHS small hospitals contribute to the sustainability of many small communities by delivering local health and aged care services, and by providing local employment options. WACHS small hospitals have been designed to deliver acute inpatient care, however over time there is a need to change focus at many facilities toward provision of residential aged care and limited emergency care and ambulatory care services which aligns more closely with the needs of local communities.	**Southern Inland Health Initiative** The Southern Inland Health Initiative is a $565 million program, funded under the Government's Royalties for Regions Program to improve health care for the people of the southern inland area covering a number of towns in the Midwest, Goldfields, Wheatbelt, and Great Southern. The initiative includes a $240 million investment to improve medical coverage and 24-hour emergency and acute care, and to deliver primary health service enhancements and service reforms as well as the establishment of the WA State-wide Telehealth Service to support emergency, outpatient and primary health care service delivery. Investment of $325 million has been allocated to an extensive capital works program including the redevelopment or refurbishment of district hospitals at Northam, Narrogin, Merredin, Katanning, Manjimup (Warren Hospital) and Collie small hospitals, nursing posts and primary health centres. The initiative will redesign the way health services are delivered in regional WA to meet growing demand and the changing health needs of local communities.		
19. Externally Provided Pathology Services The provision of state-wide external diagnostic services across the full range of pathology disciplines, inclusive of forensic biology and pathology services to other WA Government Agencies and services provided to the public by PathWest. This Sub-Service also includes the operational costs of Pathwest in delivering services to both Health Service Providers and the public, that are not charged out on a fee for service basis.				**Pathology** Pathology includes general pathology, anatomical pathology, chemical pathology, pathological haematology, pathological immunology and clinical microbiology. **Medical and diagnostic laboratory** Organisations primarily engaged in providing analytic or diagnostic services, including body fluid analysis and diagnostic imaging, generally to the medical profession or the patient on referral from a health practitioner. Includes diagnostic imaging centres; dental or medical X-ray laboratories ultrasound services; medical testing laboratories; medical pathology laboratories; medical forensic laboratories; and X-ray clinic services. Includes public and private medical and diagnostic laboratories.

Proposed Sub Service Descriptors	Alignment with CSF Definitions	Admission, Readmission, Discharge and Transfer Policy for WA Health Services	Alignment with ABF (classifications provided by IHPA)	National Health Data Dictionary/METeOR
Service 7. Health System Policy and Corporate Services (approx. $288M) Descriptor: The provision of strategic leadership, policy and planning services, system performance management and purchasing linked to the state-wide planning, budgeting and regulation processes. Health System Policy and Corporate Services includes corporate services inclusive of statutory financial reporting requirements, overseeing, monitoring and promoting improvements in the safety and quality of health services and system wide infrastructure and asset management services.				
20. Policy Services The provision of strategic leadership, policy and planning services, system performance management and purchasing linked to the state-wide planning, budgeting and regulation processes. Health System Policy and Corporate Services includes corporate services inclusive of statutory financial reporting requirements, overseeing, monitoring and promoting improvements in the safety and quality of health services and system wide infrastructure and asset management services.				
Service 8. Health Support Services (Approximately $220M) Descriptor: The provision of purchased health support services to WA Health entities inclusive of corporate recruitment and appointment, employee data management, payroll services, workers compensation calculation and payments and processing of termination and severance payments. Health Support Services includes finance and business systems services, IT and ICT services, workforce services, project management of system wide projects and programs and the management of the supply chain and whole of health contracts.				
21. Health Support Services The provision of purchased health support services to WA Health entities inclusive of corporate recruitment and appointment, employee data management, payroll services, workers compensation calculation and payments and processing of termination and severance payments. Health Support Services includes finance and business systems services, IT and ICT services, workforce services, project management of system wide projects and programs and the management of the supply chain and whole of health contracts.				

Appendix 11 Alignment of WA Health KPIs to other reporting obligations

Alignment of WA Health KPIs with national and jurisdication measurement systems

DoH = Dept of Health	HS = Health Service	HSPR = Health Service Performance Report (WA)			NHA = National Health Agreement	OBSS CFSA = Outcome Based Service Structure Current Future State Assessment	
MHS = Metro HS	WACHS = WA HS	NHPA PAF = National Health Performance Authority Performance Agreement Framework			ROGS = Report on Government Services	NSW = New South Wales	VIC = Victoria	QLD = Queensland	SA = South Australia
(B) = in budget papers	(A) = in annual report	(S) = in strategic report	(DoHB) = in Dept of Health budget papers	(DoH) = KPIs for system manager	(HS) = KPI for health service	DoPC = Dept of Premier and Cabinet	DoT = Dept of Treasury	DoF = Dept of Finance
DoTF = Dept of Treasury and Finance							

2014-15 DoH Annual Report Indicators	2014-15 MHS Annual Report Indicators	2014-15 WACHS Annual Report Indicators	HSPR 2015-16	NHPA PAF 2015	NHA 2016 Performance Indicators	NPA (NEST and NEAT) 2012	(NHCA) ROGS 2015	OBSS CFSA - NSW (Budget 2014-15; Annual report 2013-14)	OBSS CFSA - VIC (Budget 2014-15; Annual report 2013-14)	OBSS CFSA - QLD (Consolidated Budget 2014-15; DoH Budget 2014-15; Strategic Plan 2012-16)	OBSS CFSA - SA (Budget 2014-15; Annual report 2013-14; Strategic plan)	WA, NSW, VIC Central Agencies Annual Reports
Service Line 1: Public Hospital Admitted Services												
	Percentage of public patients discharged to home after admitted hospital treatment	Percentage of public patients discharged to home after admitted hospital treatment										
			Hospital standardised mortality ratio	6.2.1.1 Hospital Standardised Mortality Ratio			Mortality in hospitals					
	Rate of unplanned hospital readmissions within 28 days to the same hospital for a related condition	Rate of unplanned hospital readmissions within 28 days to the same hospital for a related condition	Unplanned hospital readmissions of patients discharged following management of (knee replacement, hip replacement, tonsillectomy & adenoidectomy, hysterectomy, prostatectomy, cataract surgery and appendicectomy)	6.2.1.4 Unplanned hospital readmission rates for patients discharged following management of Acute Myocardial Infarction, Heart failure, Knee and hip replacements, Paediatric tonsillectomy and adenoidectomy, Depression and Schizophrenia	Unplanned hospital readmission rates	Number of unplanned readmissions within 28 days of discharge from hospital following an episode of elective surgery	Unplanned readmissions within 28 days of selected surgical procedures: knee replacement, hip replacement, tonsillectomy and adenoidectomy, hysterectomy, prostatectomy, catract surgery, appendicectomy		Unplanned/ unexpected hospital readmission for: acute myocardial infarction, heart failure, hip replacement, knee replacement, paediatric tonsillectomy and adenoidectomy			
							Separation rate for selected procedures: cataract extraction, cholescystectomy, coronary artery bypass graft, coronary angioplasty, cycstoscopy, heamorrhoidectomy, hip replacement, inguinal herniorrhaphy, knee replacement, myringotomy, tonsillectomy, varicose veins stripping and ligation, septoplasty, prostatectomy and hysterectomy						
						Number of elective surgical episodes with one or more adverse events					No. of elective surgery procedures (HS); Patients overdue for elective surgery procedures as at 30 June (HS)	
	Elective surgery waiting times (Cases remaining within boundary (No. & %) Cases remaining over boundary (No. & %) Median wait time (days))	Elective surgery waiting times (Cases remaining within boundary (No. & %) Cases remaining over boundary (No. & %) Median wait time (days))	Elective surgery patients seen within boundary times by urgency category; Elective surgery average wait time of cases remaining over boundary by urgency category	6.2.3.4 Elective surgery patient waiting times by urgency category	Waiting times for elective surgery: proportion seen on time; waiting time in days	Number and percentage of patients seen within the clinically recommended time by urgency category; and median waiting times by urgency category	Overall elective surgery waiting times; Elective surgery waiting times by clinical urgency category	Hospital performance National Elective Surgery Targets (A)	Elective surgery waiting times by clinical urgency category	Percentage of elective surgery patients waiting within clinically recommended times by urgency category (B),(S); Median wait time for elective surgery (days) by urgency category (B),(S)	Percentage of elective surgery patients treated within accepted timeframes by urgency category (HS)	
			Percentage of selected elective cancer surgery cases treated within boundary time: a) Bladder cancer b) Bowel Cancer c) Breast Cancer	6.2.3.5 Cancer care pathway – waiting times for cancer care								
						Median waiting time for the 15 indicator procedures (including knee and hip replacements, cataract surgery, septoplasty, etc)						
						Number of additional patients receiving elective surgery from waiting lists						
						Number of patients removed from waiting lists for reasons other than admission as an elective patient						
				6.2.4.2 Day of surgery admission rates for non emergency multi-day stay patients							Day of surgery admission rate (by hospital) (HS)	
			Unplanned return to theatre									
	Survival rates for sentinel conditions (%) (Survival rate for stroke, acute myocardial infarction (AMI) and Survival rate for fractured neck of femur (FNOF))	Survival rates for sentinel conditions (%) (Survival rate for stroke, acute myocardial infarction (AMI) and Survival rate for fractured neck of femur (FNOF))	In Hospital mortality rates (for AMI, heart failure, stroke, fractured neck of femur & pneumonia)	6.2.1.3 In hospital mortality rates for Acute myocardial infarction, Heart failure, Stroke, Fractured neck of femur and Pneumonia								
			Death in low-mortality DRGs	6.2.1.2 Death in low-mortality Diagnostic Related Groups								
			Staphylococcus aureus bloodstream infection per 10,000 patient days	6.2.1.5 Healthcare associated *Staphylococcus aureus* (including MRSA) bacteraemia	Healthcare associated infections: *Staphlyoccouc aureus* bacteraemia		*Staphylococcus aureus* bacteraemia patient episodes associated with acute care public hospitals	Staphylococcus aureus bloodstream infections (A)	*Staphylococcus aureus* bacteraemia patient infections per 10,000 patient days	Rate of Staphylococcus aureus (including MRSA) bloodstream (SAB) infections/10,000 acute public hospital patient days (B),(S)		
									Public hospitals meeting cleaning standards, as assessed by external audit			
									Hospitals participating in Victorian Hospital Acquired Infection Surveillance System (VICNISS)			
							Adverse events in public hospitals (infections, falls resulting in injuries and problems with medication and medical devices that occurred during hospitalisation)					
							Falls resulting in patient harm in hospitals					
				6.2.1.6 Healthcare associated Clostridium difficile infections								

2014-15 DoH Annual Report Indicators	2014-15 MHS Annual Report Indicators	2014-15 WACHS Annual Report Indicators	HSPR 2015-16	NHPA PAF 2015	NHA 2016 Performance Indicators	NPA (NEST and NEAT) 2012	(NHCA) ROGS 2015	OBSS CFSA - NSW (Budget 2014-15; Annual report 2013-14)	OBSS CFSA - VIC (Budget 2014-15; Annual report 2013-14)	OBSS CFSA - QLD (Consolidated Budget 2014-15; DoH Budget 2014-15; Strategic Plan 2012-16)	OBSS CFSA - SA (Budget 2014-15; Annual report 2013-14; Strategic plan)	WA, NSW, VIC Central Agencies Annual Reports
									Intensive Care Unit central line associated blood stream infections (CLABSI) per 1000 device days			
			Hand Hygiene Compliance						Hand hygiene compliance			
	Percentage of live births with an APGAR score of three or less, five minutes after delivery (according to baby weight in gms (0-1499; 1500-1999; 2000-2499; 2500+)	Percentage of live births with an APGAR score of three or less, five minutes after delivery (according to baby weight in gms (0-1499; 1500-1999; 2000-2499; 2500+)					Percentage of live births with an APGAR score of three or less, five minutes after delivery					
									Eligible newborns screened for hearing deficit before one month			
							Fetal, neonatal and perinatal deaths		Perinatal morbidity notices received, processed and reported			
				6.3.3.11 Number of women with at least 1 antental visit in the first trimester				Antenatal visits - confinement for Aboriginal women when first antenatal vist was before 14wks gestation (B); First antenatal before 14 wks by Aboriginal and non-Aboriginal mothers (A)			% of Aboriginal mothers who gave birth and reported to have made 7 or more antenatal visits (DoH); % of Aboriginal mothers whose first antenatal care session occurred in the first trimester (<14wks) (DoH)	
			Rate of Severity Assessment Code (SAC) 1 clinical incident investigation reports received by Patient Safety Directorate (PSD) within 28 working days of the event notification date									
			Measures of patient experience (including satisfaction) with hospital services	6.2.2.1 Measures of the patient experience with hospital services	Patient satisfaction/ experience		Patient satisfaction		(Survey) index of patient's overall satisfaction with their hospital experience		Consumer experience level: involvement care, treatment, decision making; doctors; nursing; cleanliness; pain control; privacy; consistent, co-ordinated care; treated with respect and dignity; food; discharge (HS)	
			Standardised Rate Ratio of Hospitalisations of : a) Aboriginal People compared to non-Aboriginal People. b) Aboriginal children (0-4 years) compared to non-Aboriginal children (0-4 years)									
				6.2.4.1 Relative Stay Index for multi-day stay patients			Relative stay index				Relative stay index: by hospital (HS)	
									Major trauma patients transferred to a major trauma service			
								Hospital Beds: beds available for admission from the Emergency Department; Hospital beds: other hospitals; Other beds; Treatment spaces; Estimated bed/treatment space equivalents purchase from Local health networks/districts; total acute bed equivalents of additional activity (A)				
							Accreditaton (no. of beds in accredited hospitals as a percentage of total beds)		Public hospitals accredited			
							Number of sentinel events (medication error, inpatient suicide, maternal death, infant discharge to wrong family, procedures on wrong patient/body part, intravascular gas embolism, haemolytic blood transfusion reaction)					
									Weighted Inlier Equivalent Separations (WIES) - all hospitals except small rural health services	Total WAUs - acute inpatient (B)		
								Acute separations: same day; overnight (B); Separations, Planned Separations (%), Same day separations (%), Daily average of inpatients (A)	Total separations - all hospitals		Percentage change in hospital separations compared with last year (HS)	
								Acute weighted separations: same day; overnight (B)				
								Occupancy rate June 14 (A)				
								Average length of stay for overnight separations (B); Acute overnight bed days, Average length of stay (A)				
								Total bed days for acute patients (B); Total bed days, Acute bed days (A)	Sub-acute bed days			
								Interns (B)			No. of intern placements (DoH)	
								First year resident medical officers (B)	Total FTE (early graduate) medical positions in public system			
								Total clinical trials approved for conduct within NSW public health system (B)				

2014-15 DoH Annual Report Indicators	2014-15 MHS Annual Report Indicators	2014-15 WACHS Annual Report Indicators	HSPR 2015-16	NHPA PAF 2015	NHA 2016 Performance Indicators	NPA (NEST and NEAT) 2012	(NHCA) ROGS 2015	OBSS CFSA - NSW (Budget 2014-15; Annual report 2013-14)	OBSS CFSA - VIC (Budget 2014-15; Annual report 2013-14)	OBSS CFSA - QLD (Consolidated Budget 2014-15; DoH Budget 2014-15; Strategic Plan 2012-16)	OBSS CFSA - SA (Budget 2014-15; Annual report 2013-14; Strategic plan)	WA, NSW, VIC Central Agencies Annual Reports
										Percentage of admitted patients discharged against medical advice (B)	Percentage of Aboriginal people who leave hospital against medical advice or are discharged at their own risk (DoH)	
											Resource weighted hospital outputs (equisep equivalent - admitted, ED, outpatient - activity) (HS)	
									Total output cost for admitted services			
Cost per capita of supporting treatment of patients in public hospitals												
	Average cost per casemix adjusted separation for tertiary hospitals			6.2.4.3 Cost per weighted separation and total case weighted separations			Average recurrent cost per casemix adjusted separation; Average total (recurrent + capital) cost per casemix adjusted separation	Additional acute admitted patient activity (cost weighted separations)	Weighted Inlier Equivalent Separations (WIES) funded separations - all hospitals except small rural health services			
	Average cost per casemix adjusted separation for non tertiary hospitals	Average cost per casemix adjusted separation for non tertiary hospitals		6.2.4.3 Cost per weighted separation and total case weighted separations			Average recurrent cost per casemix adjusted separation; Average total (recurrent + capital) cost per casemix adjusted separation			Average cost per weighted activity unit for Activity Based Funded facilities (B)		
	Average cost of public admitted patient treatment episodes in private hospitals											
Average cost per home based hospital day of care and occasion of service	Average cost per home based hospital patient day											
											Percentage of patients charged for admission (HS)	
			Ratio of actual cost of specified public hospital services compared with the 'state efficient price'							HHS average cost per Qld weighted activity unit is < Qld efficient price (S)		
			YTD Activity to Threshold									
			YTD Private patient revenue									
			YTD Unit cost to Price									
Service Line 2: Public Hospital Emergency Department												
	Percentage of emergency department patients seen within recommended times	Percentage of emergency service patients seen within recommended times (major rural hospitals)	Proportion of emergency department patients seen within recommended times a) % Triage Cat 1 - 2 mins b) % Triage Cat 2- 10min c) % Triage Cat 3- 30 min d) % Triage Cat 4- 60 min e)% Triage Cat 5- 2 hours	6.2.3.2 Emergency Department waiting times by urgency category	Waiting times for emergency hospital care: proportion seen on time		Emergency Department waiting times by triage category	All triage categories treated within benchmark (A)	Emergency patients treated within time	Percentage of emergency department patients seen within recommended times: by category; by all categories (B),(S); Median wait time for treatment in emergency department (mins) (B),(S)	Percentage of patients attending emergency departments who were treated within accepted timeframes by urgency category (HS)	
	NEAT % of ED Attendances with length of stay <= 4 hours	NEAT % of ED Attendances with length of stay <= 4 hours	NEAT % of ED Attendances with LOE <=4 hours	6.2.3.3 Percentage of Emergency Department patients transferred to a ward or discharged within four hours, by triage category	Waiting times for emergency hospital care: proportion of patients whose length of ED stay is <= 4 hours	The percentage of ED patients, who either physically leave the ED for admission to hospital, are referred for treatment or are discharged, whose total time in the ED is within four hours	Proportion of Emergency Department presentations with length of stay <=4 hours	NEAT - percentage of patients with treatment completion time in the ED <= 4 hours	Emergency patients with a length of stay of <4 hours	Percentage of emergency department attendances who depart within 4 hours of their arrival in the department (B),(S)	% of visit times in emergency departments within 4 hours: Jul - Dec; Jan - Jun (HS); Health service standard (DoH S#84): By 2015, 90% of patients presenting to a public hospital emergency department will be seen, treated and either discharged or admited to hospital within 4 hours (S)	
	Percentage of admitted patients transferred to an inpatient ward within 8 hours of emergency department arrival							Emergency department attendances admitted(B)				
								Attendances in emergency departments (B)	Emergency presentations			
								Emergency department weighted attendances (B), (A)				
			Percentage of Emergency Department Attendances which are unplanned re-attendances in less than or equal to 48 hours of previous attendance.			The number, source and percentage of ED attendances which are unplanned re-attendances within 48 hours of previous attendances						
		Rate of emergency attendances with a triage score of four and five not admitted		6.3.3.13 Primary care type Emergency Department attendances	Selected potentially avoidable GP-type presentations to emergency departments							
	Average cost per emergency department attendance	Average cost per emergency department attendance										
									Time on hospital bypass	No. of occasions on Hosptial Early Warning System (HEWS); Operating time on HEWS		
									Total output cost for Emergency Services			
											Resource weighted hospital outputs (equisep equivalent - admitted, ED, outpatient - activity) (HS)	
									Weighted Inlier Equivalent Separations (WIES) funded emergency separations - all hospitals	Total Weighted Activity Units (WAUs): emergency department (B)		
								Ambulance to emergency department transfer of care (A)	Proportion of ambulance patient transfers within 40 minutes	Percentage of patients transferred off-stretcher within 30min (B)		
Service Line 3: Public Hospital Non-admitted Services												
	Average cost per doctor-attended outpatient episode for Metropolitan Health Service hospitals											

2014-15 DoH Annual Report Indicators	2014-15 MHS Annual Report Indicators	2014-15 WACHS Annual Report Indicators	HSPR 2015-16	NHPA PAF 2015	NHA 2016 Performance Indicators	NPA (NEST and NEAT) 2012	(NHCA) ROGS 2015	OBSS CFSA - NSW (Budget 2014-15; Annual report 2013-14)	OBSS CFSA - VIC (Budget 2014-15; Annual report 2013-14)	OBSS CFSA - QLD (Consolidated Budget 2014-15; DoH Budget 2014-15; Strategic Plan 2012-16)	OBSS CFSA - SA (Budget 2014-15; Annual report 2013-14; Strategic plan)	WA, NSW, VIC Central Agencies Annual Reports
	Average cost per non-admitted occasion of service for Metropolitan Health Service hospitals (excludes emergency and doctor attended outpatients occasions)											
									Total non-admitted services output cost			
									Sub-acute ambulatory care service clients contracted within 3 days of referral			
								Outpatient clinics occasions of service (B)	Sub-acute ambulatory care occasions of service			
									Patients treated in specialist outpatient clinics - unweighted			
								Non-admitted patient services (activity levels) (A)	Completed post-acute episodes	(Ambulatory Care) Total WAUs: Outpatients; Interventions; Procedures (B)		
										Percentage of specialist outpatients waiting within clinical recommended times by urgency category (B) (S)		
									Post-acute clients not readmitted to acute hospital			
											Resource weighted hospital outputs (equisep equivalent - admitted, ED, outpatient - activity) (HS)	
							Recurrent cost per non-admitted occasion of service					
Service Line 4: Mental Health Services												
			Percentage of ED Mental Health patients admitted within 8 hrs						Emergency patients admitted to a mental health bed within 8 hours			
	Rate of unplanned hospital readmissions within 28 days to the same hospital for a mental health condition	Rate of unplanned hospital readmissions within 28 days to the same hospital for a mental health condition	Rate of **total** hospital readmissions within 28 days to an acute designated mental health inpatient unit	6.2.1.4 Unplanned hospital readmission rates for patients discharged following management of Acute Myocardial Infarction, Heart failure, Knee and hip replacements, Paediatric tonsillectomy and adenoidectomy, Depression and Schizophrenia			Readmission to hospital (public psychiatric acute inpatient services) within 28 days of discharge		(Mental Health) Clients readmitted (unplanned) within 28 days	Proportion of re-admissions to actue psychiatric care within 28 days of discharge (B)		
	Percent of contacts with community-based public mental health non-admitted services within seven days post discharge from public mental health inpatient units	Percent of contacts with community-based public mental health non-admitted services within seven days post discharge from public mental health inpatient units	Rate of community follow up within first 7 days of discharge from psychiatric admission	6.2.1.7 Rate of community follow up within the first seven days of discharge from a psychiatric admission	Rate of community follow up within first seven days of discharge from a psychiatric admission		Post discharge care - rate of community follow up within first 7 days of discharge from a psychiatric admission		Post discharge (mental health) community care	Rate of community follow- up within 1 - 7 days following discharge from an acute mental health inpatient unit (B)		
	Percent of contacts with community-based public mental health non-admitted services within seven days prior to admission to a public mental health inpatient unit	Percent of contacts with community-based public mental health non-admitted services within seven days prior to admission to a public mental health inpatient unit							Pre-admission (mental health) community care			
									(Psychiatric disability rehabilitation and support services PDRSS): Client support units			
									(Mental health) Clinical inpatient separations			
									(Mental health clinical care) community service hours			
									(Mental health clinical care) registered communiy clients; (Mental health PDRSS) clients receiving community mental health support services			
										Ambulatory mental health service contact		
	Average cost per three month period of care for community mental health	Average cost per three month period of care for community mental health					Average treatment days per episode of ambulatory (community based) care; Average cost per treatment day of ambulatory care					
							Cost of community based residential care					
	Average cost per bed-day in a specialised mental health unit	Average cost per bed-day in a specialised mental health unit					Cost of inpatient care - average recurrent cost per specialised mental health inpatient bed day					
							Cost of inpatient care - average length of specialised mental health inpatient stay					
									Total output cost: a) clinical care, b) PDRSS			
					Treatment rates for mental illness			Acute mental health service overnight separations (B); MH Act Section 108 Mental health acute inpatient care (separation from overnight stays) (A)		Total WAUS - Mental Health (B)		
				6.3.3.14 Percentage of the population receiving primary mental health care	Treatment rates for mental illness		Mental health service use by total population	Non-acute mental health inpatient days (B); MH Act Section 108 Mental health non-acute inpatient care occupied bed days (A)		Total WAUS - Mental Health (B); Percentage of the population receiving clinical mental health care (B)		
					Proportion of adults with very high levels of psychological distress						(DoH S#86 Psychological wellbeing) Equal or lower the Australian average for psychological distress by 2014 and maintain thereafter (S)	

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				6.3.3.15 Rates of contact with primary mental healthcare by children and young people			Primary mental health care for children and young people					
								(Public hospitals mental health) funded bed days at 30 June 2014: acute, non-acute (A)	(Mental health) Bed days a) (clinical care) sub-acute, b) (clinical care) residential, c) PDRSS			
								(Public hospitals mental health) Average available beds (2013-14): acute, non-acute (A)				
								(Public hospitals mental health) Activity levels: Funded beds, Average available bed, Average occupied beds, Same day seaprations in 12 months, Overnight separations in 12 months, Summary - bed type and subprogram (A)				
								(MH Act Section 108) Total beds and activity - Funded capacity, Average availalbiilty (full year), Average occupancy (full year) (A)				
							New client index (mental health)		New client index (mental health clinical care)			
							Mental health service use by selected community groups	MHAct Section 108 Ambulatory mental health care (A)				
							Services reviewed against the National Standards		Clinical care: No. of area mental health services achieving or maintaining accreditation under the National Standards for Mental Health Services; PDRSS: proportion of major agencies accredited			
							Services provided in the appropriatesetting					
							Collection of information on consumers outcomes					
							Rate of seclusion - acute inpatient units	Seclusion rate, average duration, hospitalisation (%); MH Act Section 108 - Seclusion rate in acute mental health facilities (A)				
							Consumer and carer involvement in decision making					
							Prevalence of mental illness					
							Mortality due to suicide					
							Social and economic inclusion of people with a mental illness: a) participation in employment of working age population; b) participation in education and employment by young people					
							Mental health outcomes of consumers of specialised public mental health services					
Service Line 5: Aged and Continuing Care Services												
Rate per 1,000 HACC target population who receive HACC services									Clients receiving HACC services (quantity, quality)			
								Home nursing occasions of service (B)	HACC service delivery hours: a) HACC primary health, community care and support, b) Small Rural			
									Standard equivalent value units: a) HACC primary health, community care and support, b) Small Rural Services HACC			
								Total separations to usual place of residence (B)				
								Total non-inpatient occasions of service (B)		Rehabilitation and Extended care: Total WAUS subacute (B)		
Specific HACC contract provider client satisfaction survey												
							Proportion of older people whoreceived a health assessment					
Percentage of clients maintaining or improving functional ability while in transition care									(Quantity of) aged care assessments		No. of people receiving ACAT assessments (HS)	
									Aged care assessments: % of priority 1,2, 3 clients assessed within the appropriate time - i) community based assessment, ii) hospital based assessment			
					Residential and community aged care places per 1,000 population aged 70+ years (and Aboriginal and Torres Strait Islander aged 50 - 69 years)				i) Small Rural Services - Aged Care, ii) Ageing, Aged and Home Care - Residential aged care: a) available bed days, b) standard equivalent value units			
					Number of hospital patient days used by those eligible and waiting for residential aged care							

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					Proportion of residential aged care services that are three year re-accredited				Residential aged care services certified and accredited: a) Small Rural Services - Aged Care, b) Ageing, Aged and Home Care - Residential aged care			
					Proportion of residential aged care days on hospital leave due to selected preventable causes							
					Elapsed times for aged care services							
					Proportion of aged care residents who are full pensioners relative to the proportion of full pensioners in the general population.							
									(Quantity) Individuals provided with respite and support services; No. of hours of respite and support services			
									Pension level supported Residential services residents provided with service co-ordination and support/brokerage services			
									Pension level beds available in assisted Supported residential			
									Personal alert units allocated			
									Aged support services: Victorian EyeCare Service (occasions of			
	Rate of hospitalisation for falls in older persons (per 1,000) (includes Emergency Department Attendance Rate for a fall per 1,000 population)	Rate of hospitalisation for falls in older persons (per 1,000)						Fall related injury overnight stay hospitalisations by sex, persons aged 65 & over (A)				
Average cost per person of HACC services delivered to people with long term disability									Total output cost: a)HACC Primary health, community care and support, b) Small Rural Services Home and Community Care Services			
Average cost per transition care day												
Average cost per day of care for non-acute admitted continuing care												
Average cost to support patients who suffer specific chronic illness and other clients who require continuing care												
		Average cost per bed-day for specified residential care facilities, flexible care (hostels) and nursing home type residents							Total output cost: a) residential aged care (i) ageing, aged and home care, ii) small rural services - aged care), b) aged care assesment, c) aged			
									Aged Support Services: Funded research and service development projects for which satisfactory reports have been received			
					Survival of people diagnosed with notifiable cancers							
				6.3.5.1 Incidence of selected cancers	Incidence of selected cancers							
Proportion of people with cancer accessing admitted palliative care services [patient admissions (2489) per cancer deaths (3862)]									Palliative care bed days			
Average cost per client receiving contracted palliative care services	Average cost per client receiving contracted palliative care services											
Service Line 6: Public and Community Health Services												
					Life expectancy		Life expectancy					
				6.3.5.8 Infant/young child mortality rate	Infant and young child mortality rate		Infant and child mortality rates					
					Major causes of death		Mortality rates by major cause of death					
				6.3.5.2 Incidence of ishemic heart disease	Incidence of heart attacks		Selected potentially preventable diseases: b) incidence of heart attacks					
				6.3.5.3 Prevalance of diabetes	Prevalence of type 2 diabetes		Selected potentially preventable diseases: c) prevelance of type 2 diabetes					
					Effective management of diabetes		Chronic disease management - Management of diabetes - HbA1c level				(DoH S#85 Chronic diseases) Increase by 5% points the proportion of people living with a chronic disease whose self-assessed health status is good or better (S)	
				6.3.5.6 Incidence of end stage kidney disease								
Loss of life from premature death due to identifiable causes of preventable diseases or injury (potential years of life lost) (per 1,000 population)	Loss of life from premature death due to identifiable causes of preventable disease (per 1,000)				Potentially avoidable deaths		Selected potentially preventable diseases: a) incidence of selected cancers, b) incidence of heart attacks, c) prevelance of type 2 diabetes					
					Selected potentially preventable hospitalisations			Potentially preventable hospitalisations by sex (A)		Rate of potentially preventable hospitalisations (rate of Aboriginal and Torres Strait Islander hospitalisations to rate of non-Aboriginal and Torres Strait Islander hospitalisations) (B),(S)	Selected potentially preventable hospitalisations	

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Rate of hospitalisations for selected potentially preventable diseases (per 100,000) for Whooping cough, Measles, Mumps, Rubella, Diphtheria, Poliomyelitis, Tetanus and Hepatitis B							Selected potentially preventable hospitalisations: a) vaccine preventable conditions - penumonia and influenza, other vaccine preventable conditions (e.g. tetanus, measles, mumps, rubella), total					
							Notifications of selected childhood diseases (measles, pertussis, Hib)					
							Selected potentially preventable hospitalisations: b) acute conditions - cellutlitis, convulsions & epilepsy, dental conditions, ear, nose & throat infections, eclampsia, gangrene, pelvic inflammatory disease, perforated/bleeding ulcer, pneumonia (not vaccine preventable), urinary tract infections, total.					
	Rate of hospitalisation for gastroenteritis in children (0-4 years) (per 1,000)	Rate of hospitalisation for gastroenteritis in children (0-4 years) (per 1,000)										
										Percentage of women who during their pregnancy were smoking after 20wks: non-Aboriginal and Torres Strait Islander; Aboriginal and Torres Strait Islander (B),(S)	Percentage of Aboriginal mothers who smoke during pregnancy (DoH)	
										No. of in-home visits, families were newborns (in accordance with Mums and Bubs commitment) (B),(S)	Child and family services: % of universal home visits (HS); no. of client services (HS); % of clients who are Aboriginal and/or Torres Strait Islander (HS); No. of families receiving sustained home visiting services (HS), (DoH)	
				6.3.5.7 Estimated life expectancies at birth								
								Infant deaths by Aboriginality (A)			Aboriginal infant mortality rate per 1000 Aboriginal and Torres Strait Islander births (DoH)	
				6.3.5.9 Proportion of babies born with low birth weight	Proportion of babies born of low birth weight		Babies born of low birth weight			Percentage of babies born of low birthweight to: non-Aboriginal and Torres Strait Islander; Aboriginal and Torres Strait Islander (B)	(HS S#26 Early childhood - birthweight) Reduce the proportion of low birthweight babies in the total population and halve the proportionof Aboriginal and/or Torres Strait Islander low birth weight babies by 2020 (S)	
	Rate of hospitalisation for respiratory conditions (per 1,000) for Acute Asthma, Bronchiolitis, Acute Bronchitis and Croup	Rate of hospitalisation for respiratory conditions (per 1,000) for Acute Asthma, Bronchiolitis, Acute Bronchitis and Croup					Selected potentially preventable hospitalisations: c) Chronic conditions - angina, asthma, bronchiectasis, chronic obstructive pulmonary disease, hypertension, iron deficiency anaemia, nutritional deficiencies, rhematic heart disease.					
							Chronic disease management - Management of Asthma					
							Influenza vaccination coverage for older people	Adults aged 65 & over vaccinated against influenza in the last 12 months (A)	Immunisation coverage: at 65+ years of age (influenza)			
									Immunisation coverage: Adolescent (yr 10) students fully immunisaed for DTPa (diptheria, tetanus & pertussis)			
Percentage of fully immunised children (at 12 months (12-<15 months), 2 years (24-<27 months) and 5 years (60-<63 months))			Childhood immunisation: percentage of children fully immunised at 12-15 months: a) Aboriginal b) Total	6.3.3.8 Vaccination rates for children			Child immunisation coverage: prortion fully vaccinated at 12 - 15 months, 24 - 27 months, 60 - 63 months	Children fully immunised at 1 year (A)	Immunisation coverage: at 2 yrs of age, at school entry	Vaccination rates at designated milestones for children at 12 -15months, 24 - 27 months, 60 - 63 months (B)	% of children fully immunised at age: 12 months; 2 years. (DoH)	
											No. of vaccines dispensed (DoH); No. of providers participating in the Australian Childhood Immunisation Register (DoH)	
				6.3.3.10 Proportionof children with 3 year old developmental health check			Proportion of children receiving a fourth year develomental health check					
				6.2.3.5 Waiting times for GP services	Waiting times for GPs		GP waiting times					
					People deferring access to selected health care due to financial barriers		People deferring visits to GPs due to financial barriers					
				6.3.3.12 After hours GP service utilisation								
									No. of filled rural generalist GP procedural position			
											Percentage change in GP Plus Services Program sensitive conditions compared with last year (HS)	
							GPs with vocational registration					
							General practices with accreditation					
							Cost per government of general practice per person					
											Aboriginal adult and child health checks per 1000 people (DoH)	

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							Early detection and early treatment for Indigenous people				Primary health care services: no. of hours of service / % of clients who are Aboriginal or Torres Strait Islander clients (HS)	
				6.3.5.5 Prevealence of overweight and obese status	Prevalence of overweight and obesity		Prevelance of risk factors to the health of Australians - prevelance of overweight and obesity	Overweight or obesity in adults aged 16 & over (A)		Percentage of Qld population who are overweight or obese: person; male; female (B)	(DoH S#82: Healthy weight) Increase by 5% points the proportion of SA adults and children at a healthy body weight by 2017 (S)	
											No. of expiration notices served under Tobacco Products Regulation Act 1997 (DoH); No. of premises inspected for compliance with the Tobacco Products Regulation Act 1997 (DoH); % of compliance with legislation standards for tobacco: metropolitan / country (DoH)	
				6.3.5.4 Prevalence of smoking	Rates of current daily smokers		Prevalence of risk factors to the health of Australians - Rates of current daily smokers	Current (daily or occasional) smoking in: a) Adults aged 16 & over, b) Aboriginal adults aged 16 & over; Smoking during preganncy by mother's Aboriginality (A)		Percentage of Qld population who smoke daily: person; male, female (B), (S)	(HS S#80: Smoking) Reduce the smoking rate ot 10% of the population and halve the smoking rate of Aboriginal South Austrlians by 2018 (S); Daily smoking prevalence 15+ (HS); Aboriginal daily smoking prevalence 18+ (HS)	
					Levels of risky alcohol consumption		Prevalence of risk factors to the health of Australians - levels of risk alcohol consumption	Alcohol consumption at levels posing a lifetime risk to health (adults aged 16 & over) (A)		Percentage of Qld population who consume alcohol at risky and high risk levels: person; male; female (B)	(HS S#81 Alochol consumption) Reduce the proportion of SAs who drink at risky levels by 30% by 2020 (S); Risky alcohol consumption rates (HS)	
										Percentage of Qld population (person; male; female): a) engage in levels of physical activity for health benefit, b) who were sunburnt in the last 12 months. (B)		
										Percentage of Qld population who consume recommended amounts of: fruit, vegetable (B)		
									Community health: Better Health Channel visits			
									Community health: No. of referrals made using secure electronic referral			
									Primary care partnerships with reviewd and updated			
									Service delivery hours in community health care: a) Community health care, b) Small Rural Services - Primary health			
									Standard equivalent value units: a) Community health care, b) Small Rural Services - Primary health			
									Community health: Agencies with an Integrated Health Promotion (IHP) plan that meets the stipulated planning requirements			
									Total output cost: a) Community health care, b) Small Rural Services - Primary health			
Cost per capita of providing preventative interventions, health promotion and health protection activities									Total output cost: a) Health protection, b) Health advancement, c) Public Health development, research			
	Average cost per capita of Population Health Units	Average cost per capita of Population Health Units										
	Average cost per breast screening											
				6.3.3.7 Screening rates for breast, cervical and bowel cancer			Participation rates for women in breast cancer screening	2 yearly participation rate of women within breast cancer screening target group (50-69 & 70 -74) (B)	Persons screened for prevention and early detection of health conditions - breast cancer screening; Target population screened within specified timeframe for breast cancer	Percentage of target population screened for: breast cancer; Percentage of invasive cancers detected through BreastScreen Qld that are small (<15mm) in diameter (B)	Total No. of women screened for breast cancer (HS); Breast screening participation rate for women aged 50 - 69 years of age (every 24 months) (HS)	
				6.3.3.7 Screening rates for breast, cervical and bowel cancer			Participation rates for women in cervical cancer screening	2 yearly participation rate of women within cervical cancer screening target group (20-69) (B)	Persons screened for prevention and early detection of health conditions - cervical cancer screening; Target population screened within specified timeframe for cervical cancer	Percentage of target population screened for: cervical cancer; bowel cancer (B)	No. of women screening for cervical cancer (DoH); No. of women screened for cervical cancer in target population (aged 20-69) every 24 months (DoH)	
									Persons screened for prevention and early detection of health conditions - newborn and maternal serum			
									Persons screened for prevention and early detection of health conditions - pulmonary tuberculosis (TB)			
									Inspections: a) of cooling towers, b) of radiation safety management licenses			

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									Calls to food safety hotlines (quantity, no. answered, avg time from notification to commencement of appropriate action)		% of food business in compliance with food safety standards (DoH); No. of food samples analysed (DoH); No. of food inspections conducted in areas not covered by local governments (DoH)	
									No. of built, demountable and natural shade projects funded under the Shade Grants			
									No. of HIV rapid test trial appointments used	No. of rapid HIV tests performed (B); Annual notification rate of HIV infection (B)		
									Public health emergency response calls dealt with within designated plans and procedure timelines			
									Public Health development, research and support: No. of people trained in emergency response			
									Infectious disease outbreaks responded to within 24 hours			
									Persons completing the Life! - Diabetes and Cardiovascular Disease Prevention program			
									Workplaces and pubs and clubs complying with smoke free environment laws			
									Local Government authorities with municipal public health and wellbeing plans			
											No. of wastewater system approvals under the Public and Environmental Health Act 1987 (DoH)	
											No. of water quality Type 1 incidents that were actioned within 24h (DoH)	
											Proportion of licenses issued for poisons reviewed, inspected and/or investigated (DoH)	
											Proportion of pest control license exemptions reviewed (DoH)	
											% of initial health risk assessments provided to the EPA within 2 months of receipt of soil contamination data (DoH)	
											No. of red blood cell packs issued to SA (DoH)	
			Percentage of SJAA patients with Off Stretcher time within 20mins									
								Emergency road transport cases (B)	No. of cases for each of 1) Ambulance Emergency, 2) Ambulance Non-Emergency Services: a) Country road, b) Metropolitan road, c) Pensioner & Concession card holder, d) State-wide air		Ambulance: total no. of responses by priority; ambulance intervention response time in urban centres by priority (HS)	
									Ambulance Emergency: audited cases attended by Community Emergency Response Team (CERT) meeting clinical practice standards			
									Audited cases meeting state- wide clinical practice standards: a) Ambulance Emergency b) Ambulance non-emergency services			
									Ambulance Emergency: Percentage of adult ventricular fibrillation/ventricular tachycardia cardic arrest patients with vital signs at hospital			
									Ambulance emergency: Percentage of adult patients suspected of having a stroke who were transported to a stroke unit with thrombolysis facilities within 60 minutes			
									Ambulance emergency: Proportion of patients experiencing severe cardiac or traumatic pain whose level of pain is reduced significantly	Ambulance Services: Percentage of patients who report a clinically meaningful pain reduction (B)		
									Ambulance emergency: Proportion of patients satisfied or very satisfied with quality of care provided by paramedics			
									CERT arrival occurs prior to ambulance			
										Time within which code 1 incidents are attended 50th/90th percentil response time (B)		
									Proportion of emergency (code 1) incidents responded to within 15min: a) state-wide, b) in centres with >7500 population	Percentage of 000 calls answered within 10 seconds (B); Percentage of non-urgent incidents attended to by the appointment time (B)		

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Response times for patient transport services (SJOGA and RFDS) & Inter-hospital transfers for Priority 1 calls meetingthe target contract patient response time by the RFDS												
Cost per capita of Royal Flying Doctor Service Western Operations and St John Ambulance Australia – WA Ambulance Service Agreements									Total output cost: a) ambulance emergency, b) ambulance non-emergency services	Ambulance services: Gross cost per incident (B); Gross cost per head of population (B)		
	Average cost per trip of Patient Assisted Travel Scheme	Average cost per trip of Patient Assisted Travel Scheme										
	Average cost per bed-day for admitted patients (small hospitals)	Average cost per bed-day for admitted patients (selected small rural hospitals)							Small Rural Services - Acute Health: total output cost			
		Average cost per non-admitted occasion of service in a rural nursing post										
											Resource weighted hospital outputs for grant funded hospitals (country health - admitted, ED, outpatient) (HS)	
									Small Rural Services - Acute health (quantity): a) separations, b) standard equivalent units, c) WIES separations			
									Small Rural Services - Acute health: Beds accredited			
Eligible patients on the oral waiting list who have received treatment during the year											SA Dental Service total hours of service (HS)	
										Percentage of oral health weighted occasions of service provided by private dental health partners (B)		
	Rate of childhood dental screening (includes Rate of dental screening of pre-primary, primary and secondary school children(%) and Rate of children free of dental caries when recalled)									Percentage of oral health weighted occasions of service which are preventative (B)		
	Dental health status of target clientele (includes Average number of decayed, missing or filled teeth for school children and Average number of decayed, missing or filled teeth for adults (financially disadvantaged)											
	Access to dental treatment services for eligible people (Eligible people who access Dental Health Services and Rate of completed dental care)											
								Dental health non-inpatient weighted occasions of service (B)	Dental health: a) persons treated, b) standard equivalent value units, c) ratio of emergency to general courses of dental care	No. of adult oral health weighted occasions of service (ages 16+) (B); No. of children and adolescent oral health weighted occasions of service (B)		
	Average waiting times for dental services (months)				Waiting times for public dentistry		Public dentistry waiting times		Waiting time for dentures; Waiting time for restorative dental care	Percentage of public general dental care patients seen within the recommended timeframe of 2 years (B)	SA Dental Service average adult waiting time (months) (HS)	
							Availability of Public dentists					
Average cost per dental service provided by the Oral Health Centre WA												
	Average cost of service for school dental care											
	Average cost of completed course of adult dental care											
									Dental Services: total output cost			
Service Line 7: Health System Clinical and Corporate Support Services												
										Increased collaboration with unversities and/or research institutions to underpin development of innovative models of care (S)		
												NSW public sector employee perceptions of: innovation within the sector; integrity, accountability in their workplace (NSW DoPC, 2013-14)
												(Survey) The Dept of Premier and Cabinet is a centre for excellence that fosters an efficient, ethical and responsible public sector (VIC DoPC, 2013-14)
										No. of data sets released under the Open Data Initiative (S)		
										Percentage of agreed red tape reduction initiatives on track for delivery (S)		
										Increase in service provision contracts released to open tender (S)		

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												Extent to which client agencies agree that their agency contracts and CAUs achieved value-for-money (WA
										Percentage of Hospital and Health Services improving or maintaining their performance (DoHB)		
										% of Hospital and Health Services participating in State-wide Clinical Networks (DoHB)		
										% of formal reviews undertaken on Hospital and Health service responses to significant negative variance in Variable Life Adjusted Displays and other National Safety and Quality indicators (DoHB)		
												Percentage of the Department's material resoure allocation recommendations complying with the Service Provision Analysis Framework (WA DoT, 2014- 15)
												Percentage of the highest value agencies complying with the Strategic Asset Management Framework or equivalent accredited mechanism (WA DoT
										% of correct, on time pays (DoHB)		
												% of financial year's enterprise agreements that were assessed as compliant with wages policy (VIC DoTF 2013-14)
										% of calls to 13HEALTH answered within 20 seconds (DoHB)		
												(Survey) Service recipient's confirmation that high quality and timely policy advice is provided (WA DOPC,
												(Survey) DoPC leads policy development on key priority issues, responds effectively to significant state
												(Survey) Services provided to the state relating to development, drafting, publication and implementation of legislation are comprehensive, integrated and of the highest quality (VIC
												Number of ministerials, briefings or reports provided
										% of ICT availability for major enterprise applications Metro; Regional; Remote (DoHB)		
										% of all high level ICT incidents resolved within targets defined in the Service Catalogue (DoHB)		
										% of all initiatives with a status reported as critical (Red) (DoHB)		
												Unqualified audit opinion on the Annual Report on State Finances (WA
			YTD Expenditure to Budget	6.2.4.4 Financial Performance against activity funded budget (annual operating result)				Total expenses excluding losses (B); Total expenses including the following: employee related, other operating expenses, grants and subsidies, other expenses (B)	Total health expenditure (real; acute) per capita			Deviation of underlying expenses from budget (10yr trend); Variation from controllable expenses (NSW DoTF, 2013-14)
			Overall own source Revenue to Budget									
												Maintain expense growth below long-term revenue growth (NSW DoTF,
								Capital expenditure (B)		% of capital infrastructure projects deliverd on budget and within time and scope within a 5% unfavourable tolerance (DoHB)		% of all approved capital projects over $10M which received an assessment resulting in a cost benefit
												Cost as a percentage of the total annual value of planning and delivery of capital works projects (WA DoT, 2014-15)
			YTD distance to net cost of service to budget									
									Total hospital surplus at 30 June for the two prior financial years			

2014-15 DoH Annual Report Indicators	2014-15 MHS Annual Report Indicators	2014-15 WACHS Annual Report Indicators	HSPR 2015-16	NHPA PAF 2015	NHA 2016 Performance Indicators	NPA (NEST and NEAT) 2012	(NHCA) ROGS 2015	OBSS CFSA - NSW (Budget 2014-15; Annual report 2013-14)	OBSS CFSA - VIC (Budget 2014-15; Annual report 2013-14)	OBSS CFSA - QLD (Consolidated Budget 2014-15; DoH Budget 2014-15; Strategic Plan 2012-16)	OBSS CFSA - SA (Budget 2014-15; Annual report 2013-14; Strategic plan)	WA, NSW, VIC Central Agencies Annual Reports
									Reduce variation in health service administrative costs (VIC Melbourne Health strategic report, 2013-14)			
												Average cost of policy and program tasks: routine, project (WA DoF, 2013-14)
							Use of Pathology tests and diagnostic imaging	Diagnostics occasions of service (B)				
Other												
				6.2.3.1 Access to services by type of service compared to need			Access to services compared to need					
					Full time equivalent employed health practitioners per 1,000 population (by age group and profession type)			Number of FTE (B),(A)	Total FTE (early graduate) in publicsystem: a) allied health, c) nurses			
									Clinical placement student days for medicine, nursing and allied health			
									Percentage of public health services utilising the Best Practice Clinical learning Environment (BPCLE) tool			
									Post graduate nursing places at Diploma and Certificate level			
								Registered health professionals in NSW by occupation (A)				
			WA Health Aboriginal employment headcount					Aboriginal staff as a proportion of total against target (A)			Aboriginal employment activities implemented: No. of new recipients; No. of scholarship graduates; No. of Aboriginal employees (DoH); No. of scholarship participants (DoH S#53): Increase the participation of Aboriginal people in the SA public sector, spread across all classifications and agencies to 2% by 2014 and maintain or better those levels through to 2020 (S)	
								Sick leave - annual average per FTE (hours) (A)				
								Non-casual staff turnover rate (A)				
							Profile of employed health workforce (age - nurse, midwife, medical practioner, allied health practioner)					
							Workforce sustainability (age profiles for nurse, midwife, medical practioner, dental practioner and allied health practitioner)					
			Percentage of cases coded and available for reporting within a) 2 weeks b) 4 weeks									
			Injury management: a) Lost time injury severity rate, b) Percentage of managers and supervisors trained in occupational safety and healht (OSH) and injury management responsibilities									
					All performance indicators, where it is possible and appropriate to do so, to be disaggregated by Indigenous status, disability status, remoteness area and socio-economic status to assess whether these social inclusion groups achieve comparable health outcomes and service delivery outcomes to the broader population							

This document can be made available in alternative formats on request for a person with a disability.