SESLHD GUIDELINE COVER SHEET

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SUMMARY	The Framework provides an integrated, district-level process for performance measure review and assessment, forming an integral part of the business cycle for the LHD. It outlines a transparent monitoring process, defining the process for business performance assessment, escalation, and support to be given to manage risk and enable achievement of the NSW Health and locally defined performance measures.

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Section 1 – Overview and purpose of the Performance and Accountability Framework

1.1 Purpose

The Performance and Accountability Framework (The Framework) is the governance mechanism that will enable South Eastern Sydney Local Health District (SESLHD) to execute its operational, divisional and service line plans in order to realise its strategic objectives. The Framework outlines the governance structure, business performance management processes and performance metrics in place to achieve our objectives.

The Framework provides an integrated, district level process for business performance review and assessment, forming an integral part of the business cycle for the LHD. It outlines a transparent monitoring process, defining the process for performance assessment, escalation, and support to be given to manage risk and enable achievement of the NSW Health and locally defined performance measures.

The Framework supports a culture of local continuous improvement and the achievement of performance expectations. Recognition of local good practice and strong performance against measures should be acknowledged. By recognising leading practice within the LHD and sharing lessons learnt across the facilities and services, the LHD can progress in its journey of continuous improvement. Equally, when areas of improvement are highlighted, organisational support teams will be made available to assist and support performance improvement.

The Framework covers performance management of the following NSW Ministry of Health (NSW Health) and SESLHD locally defined measures and objectives:

- Strategic priorities
- Key Performance Indicators (KPIs) and service measures
- Budget and financial performance
- Service/activity volumes and levels
- Governance requirements

1.2 Context

SESLHD is funded by and accountable to NSW Health for the provision of inpatient and community based health care services to:

- Promote, protect and maintain the health of its community;
- Provide safe, quality, timely and efficient care to those who need it; and
- Address gaps in health service access and health status.

The ***NSW Health Performance Framework*** sets out how NSW Health monitors and assesses the performance of public sector health services. It includes the performance expected of LHDs to achieve the level of health improvement, service delivery and financial performance as set out in the annual LHD ***Service Agreement***.

The annual Service Agreement is signed by the Chief Executive, documenting accountability for meeting the defined service obligations and performance requirements, including:

- Strategic priorities
- KPIs and service measures
- Budget and financial performance
- Service/activity volumes and levels
- Governance requirements

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The NSW Health Performance Framework governs that each LHD must have an effective internal performance framework and process which: maps measures included in the Service Agreement down to facility and clinical stream level, monitors performance against these measures, and identifies and manages emerging performance issues.

The LHD must meet the performance requirements as set out in the Service Agreement, within the allocated budget, and specifically:

- Successfully implement agreed plans that address the strategic priorities and governance requirements, including having appropriate governance arrangements for performance management;
- Meet activity targets within the set tolerance bands; and
- Achieve KPI targets.

The *National Health Reform Agreement* also requires each LHD to develop and implement a strategic and operational plan.

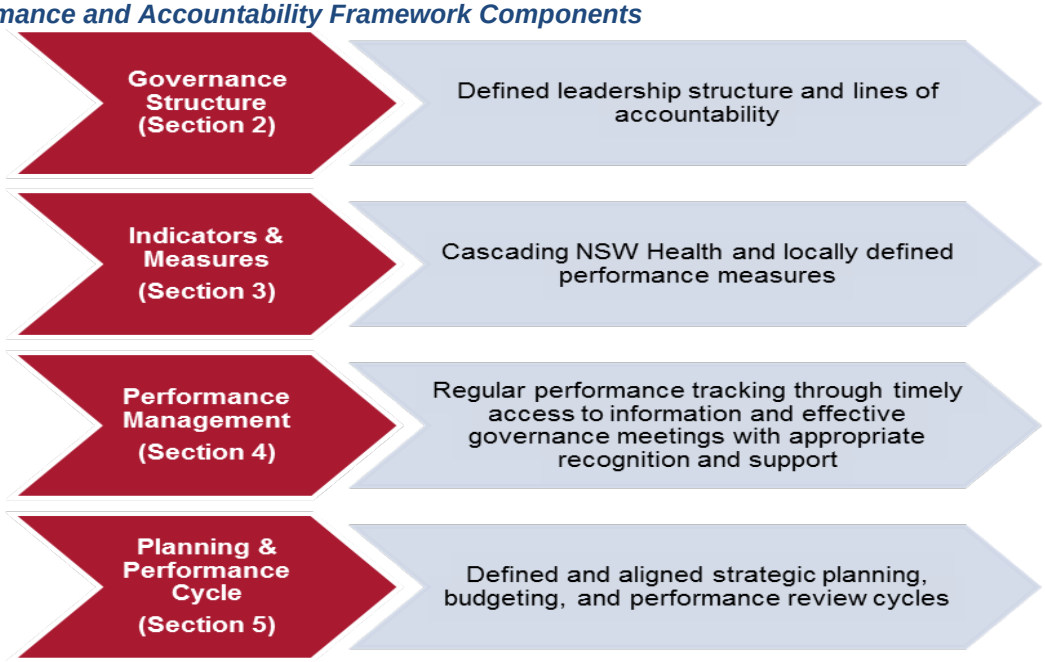
SESLHD's *Roadmap to the delivery of excellence 2014-2017* also outlines the organisation's key priorities and actions to deliver safe, effective, patient centred and efficient health service delivery and improve the health and wellbeing of the community.

To comply with the NSW Health performance requirements, and to support the successful implementation of the SESLHD strategic and operational plans, the SESLHD Performance and Accountability Framework was created.

1.3 Core components of the Framework

The Framework consists of four core components which are set out in the diagram below.

Performance and Accountability Framework Components



1.4 Attributes of the Framework

The Framework was designed to reflect a series of attributes, mirroring those of the NSW Performance Framework. These attributes support the utility of the Framework – driving the achievement of both NSW Health and LHD strategic objectives. The attributes and how they are realised through the Framework are as follows:

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- **Transparency** – clear agreed performance targets and responses to performance issues;
- **Accountability** – clear roles and responsibilities for the Board, Executives and Service Lines;
- **Responsiveness** – performance issues are identified early and responses are timely;
- **Predictability** – highlighting good performance and when a performance concern arises;
- **Recovery** – the focus is on having a clear and practical path of recovery and improvement;
- **Integrated** – the Framework incorporates SESLHD's *Roadmap to the delivery of excellence 2014-2017* which outlines the organisation's key priorities and actions to deliver safe, effective, patient centred and efficient health service delivery and improve the health and wellbeing of the community;
- **Consistency** – responses to poor performance are proportionate to the issue being addressed;
- **Recognition** – sustained and/or superior performance is appropriately recognised; and
- **Informed Purchasing** – performance information is used to inform planning and decision making.

The intention of the Framework is to ensure accountabilities are cascaded appropriately from Board to departments and necessary action can be taken to correct performance that is outside the expected ranges. Targets and measures are set during the annual planning process, when strategic and operational plans are set. These targets and measures are then measured and monitored over the course of the year, via monthly meetings and committees.

Measurement of performance, outcomes and transparency of performance is critical. The Framework sets out how we will do this and how we can manage and mitigate any risks to performance by identifying risks early and agreeing robust improvement plans, with support, to make the required improvements.

The Framework supports a culture of local continuous improvement and the achievement of performance expectations. Recognition of local good practice and strong performance against measures should be shared across the LHD and acknowledged in committees and meetings, quality forums, Clinical Councils, Chief Executive newsletters. Where performance improvements are highlighted, support will be available to assist teams to make the improvements.

1.5 Service Line Management

SESLHD's *Road Map – to the delivery of excellence 2014-2017* outlines the priorities and strategies which will deliver on its vision in the coming years. One such strategy involves establishing greater transparency in financial and operational metrics at the service level. This transparency will allow clinicians and service leaders to make more informed decisions, and ultimately increase the quality and safety of the services we provide.

Service Line Management (SLM) is being implemented across the LHD's facilities over 2016 and 2017 and will allow for the devolution of accountability and responsibility to service lines, and in doing so service lines will have ownership of their own performance and outcomes, including:

- Service lines will have access to data on financial performance, activity, quality and staffing and be encouraged to set their own local KPIs to proactively manage performance. Performance will be monitored in monthly service line meetings;
- SLM allows for the devolution of accountability and responsibility to the front line, as reflected in the business rules within the delegations manual; and
- Clinicians and managers are involved in budget setting and how their service lines are run.

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1.6 Ownership

The Director, Programs and Performance is accountable for the ownership of the Framework and all subsequent updates.

1.7 Related documents

- NSW Health Performance Framework 2013/14
- NSW Health SESLHD Service Agreement 2016/17
- National Health Reform Agreement
- Roadmap to the delivery of excellence 2014-2017
- SESLHD Healthcare Services Plan 2012-2017
- Clinical service and population health strategies and plans
- Delegations manual

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Section 2 – Governance Structure

2.1 Overview

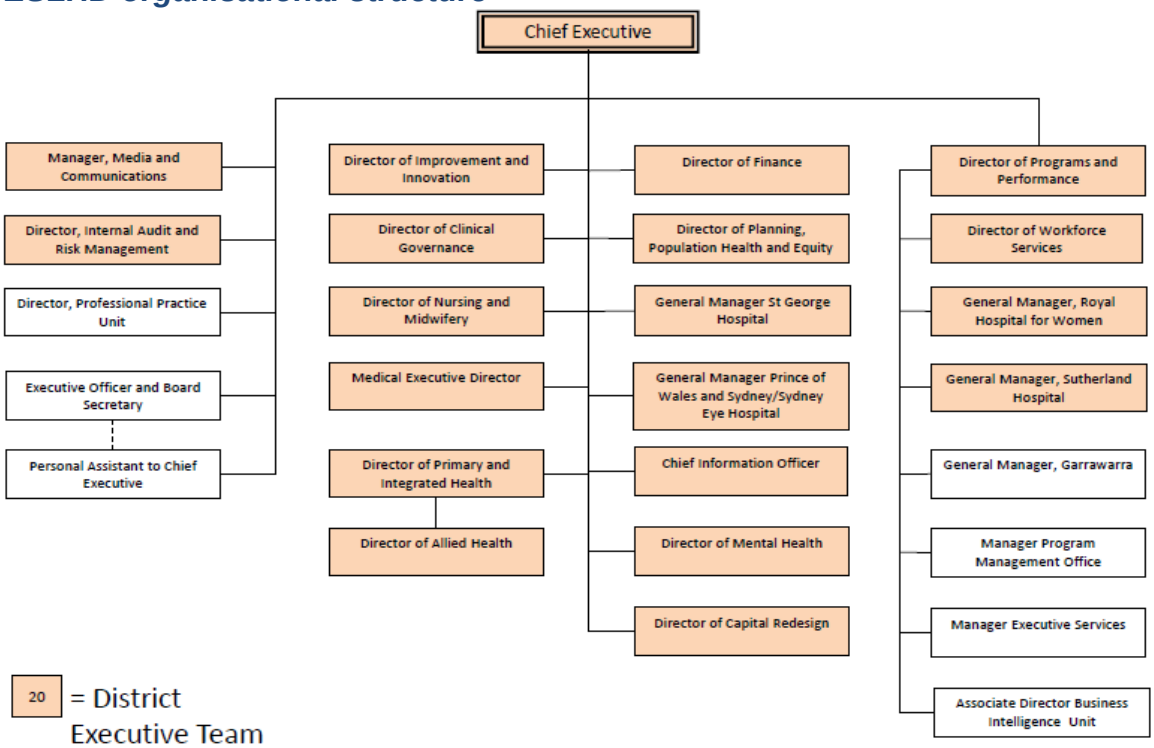
This section outlines the organisational and governance structure that sets, supports and monitors the achievement of SESLHD's objectives. Performance is reported and monitored through a series of cascading committees and meetings, with each meeting serving as the input to the subsequent supervising committee.

2.2 SESLHD organisational structure

The LHD has been structured to optimally meet the service delivery and performance expectations. The organisational structure is outlined below and comprises:

1. Board
2. Executive Team
3. Health Services:
   - Facilities
   - Mental health
   - Primary and Integrated Health
   - Planning, Population Health and Equity
4. Leadership, Advisory and Monitoring functions – Clinical Governance, Medical Executive, Nursing and Midwifery, Improvement and Innovation, Programs and Performance, Population health, Internal Audit
5. Corporate and Support functions – Finance, Workforce Services, Communications, Executive Services

SESLHD organisational structure



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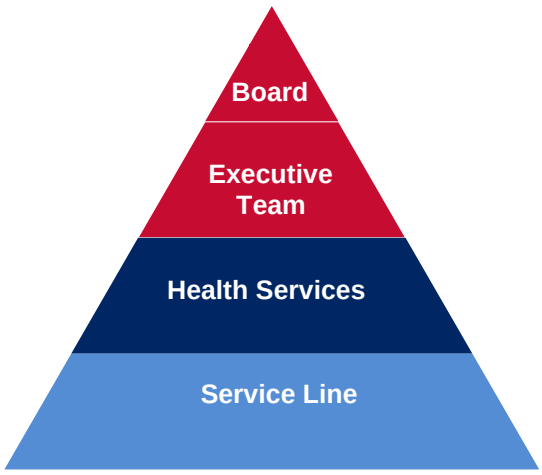
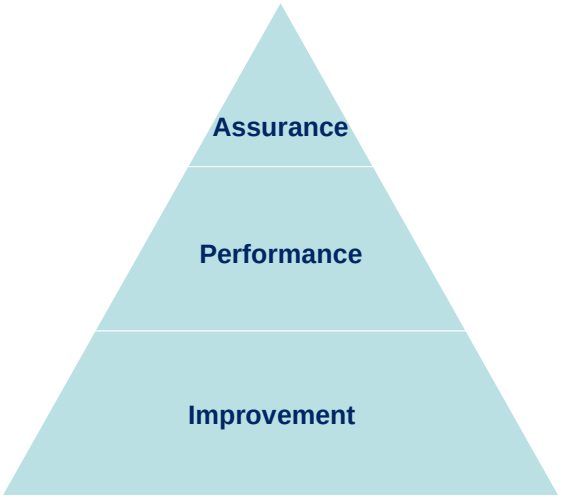
2.3 Governance structure

There are four tiers of governance that oversee performance management and the intention of the Framework is to ensure accountabilities are cascaded appropriately from Board to Ward and that necessary action can be taken to correct any performance outside the expected ranges.

There are also three types of data and information that support this governance structure.





1. Board level
2. Executive Team level
3. Health Service level
4. Service Line level

1. **Assurance** – Validated data for six domains: Access, Efficiency, Infection and Prevention, Quality and Patient Experience, Patient Safety and Data Quality;
2. **Performance** – Validated and un-validated data across six domains: Clinical Excellence, Finance and Activity, Valuing staff, Capacity and Activity planning, Patient Experience and Patient Safety;
3. **Improvement** – Un-validated data provided in real time through unified patient tracking, Clinical Portal and operational dashboard, with metrics covering Patient Flow, Inpatient Activity, Outpatients, Waiting Times, Patient Safety, Infection Control, Clinical Outcomes.

The governance process acts as follows:

- The annual Service Agreement for the following year is negotiated with NSW Health in the fourth quarter, including the annual budget and service/activity volumes and levels. The Service Agreement also sets out the strategic priorities, KPIs, service measures and governance requirements to be monitored in the following year.
- During the fourth quarter, the LHD performs a risk assessment of likely performance against the Service Agreement to highlight any key areas of risk to be addressed.
- Performance against all relevant KPIs and targets is reported on a monthly or quarterly basis (as appropriate) at the appropriate governing committee.

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The governance structure provides the performance management mechanisms to:

- Cascade, translate, and allocate the SESLHD performance expectations and accountabilities throughout the organisation – so that targets can be devolved and managed by the appropriate service or individual
- Clearly define the points of accountability for each performance target
- Devolve decision making and control in alignment with accountability, to support achievement of each performance target
- Monitor and manage performance (revising measures and targets as appropriate)
- Defined data measures easily accessible through 'one source of truth' – the ORBIT Portal.

There are a number of committees and meetings that take place on a monthly or regular basis to monitor and review performance across SESLHD. The diagram overleaf depicts these and also the flow of accountability throughout the LHD, with the above-mentioned performance management mechanisms occurring at each level of the organisation. The key governance committees under the Chief Executive include;

Productivity Improvement Board (PIB), the purpose of which is to provide accountability and oversight, through a board of peers, of performance and efficiency measures, projects of reform and collectively to build capability and capacity.

The District Executive Team (DET), the purpose of which includes the broader leadership team of the LHD and provides strategic leadership and governance of policy, procedure, and development of new initiatives under the five programs of work in the Journey to Excellence.

Clinical Quality Council (CQC), the purpose of which is to provide oversight of clinical quality and safety. The CQC is the peak clinical engagement forum, with chairs of facility clinical councils and DET members coming together to engage in discussion and decision making.

For further detail of the purpose of each committee and meeting and full membership, please refer to their Terms of Reference.

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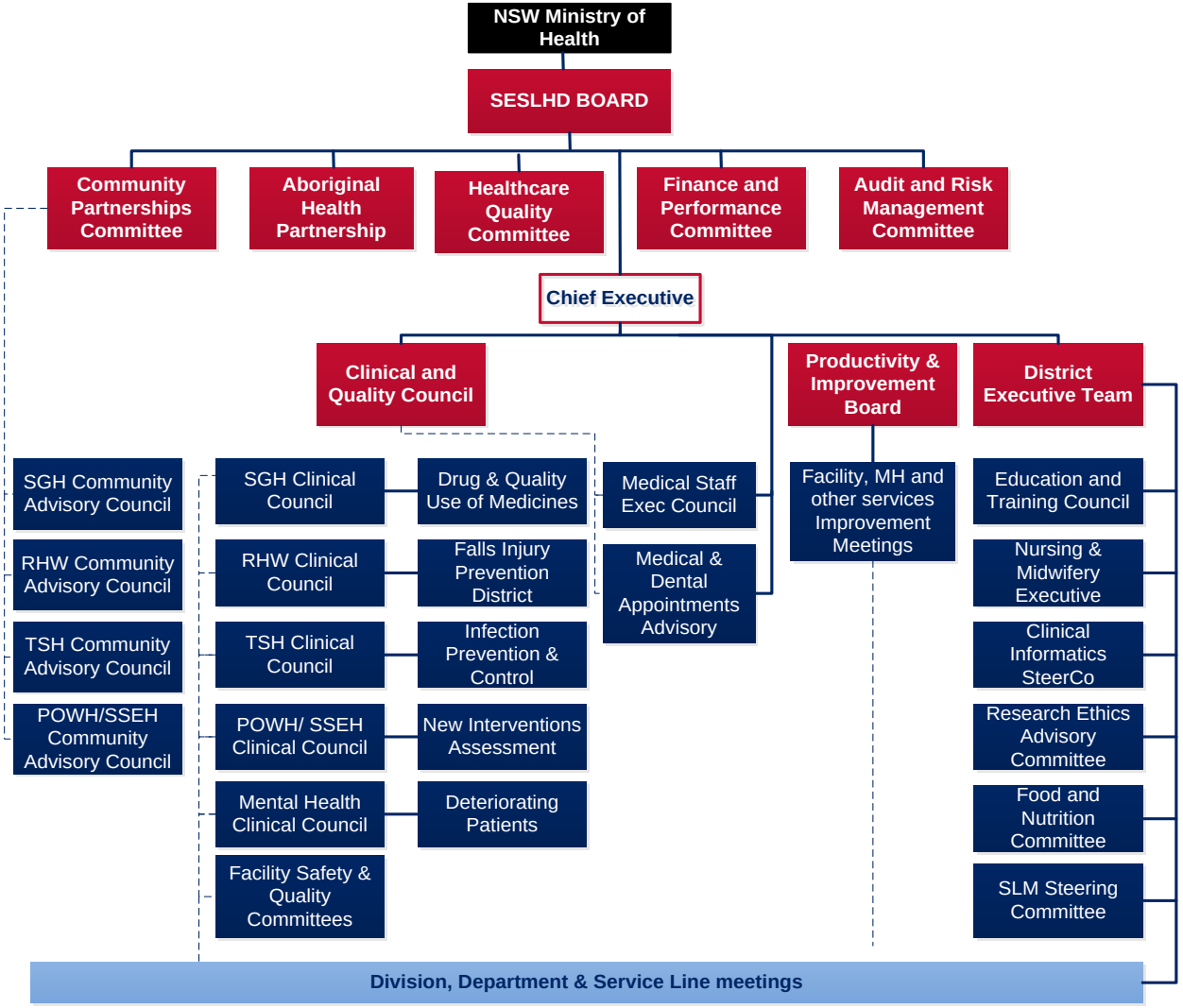
Governance structure and flow of accountability



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Section 3 – Indicators and Measures

3.1 Overview

This section outlines the performance indicators and measures that are monitored and reported to ensure the achievement of SESLHD's objectives.

The Framework covers performance management of both the **NSW Health performance measures**, as set out in the annual Service Agreement and **SESLHD local measures**, developed locally to reflect LHD, health service/facility or service line/departmental priorities. The table below sets out the performance indicators and measures and the regular governance committees and meetings in which each performance measure is monitored.

Indicators and Measures	
NSW Health performance measures	
The annual Service Agreement defines the following types of performance requirements which are monitored via the Framework:	
NSW Health Strategic Priorities	NSW Health has set out in the 2016/2017 Service Agreement key priorities to be reflected in the LHD's Strategic and Operational Plans, as follows: 1. Deliver NSW: Making it Happen, including the Premier's and State Priorities, and the election commitments of the NSW Government 2. Achieve the key goals, directions and strategies articulated within the NSW State Health Plan: Towards 2021 and the NSW Rural Health Plan 3. Harmonise the implementation and delivery of key plans and programs across NSW Health 4. Support the LHD's to deliver optimal and efficient frontline services 5. Provide leadership in NSW Health's contribution to the process of Federation reform and review of primary healthcare and resulting reforms 6. Whole of Health Program 7. Integrated Care strategy 8. Reducing Unwarranted Clinical variation 9. Living Well: A strategic Plan for Mental health in NSW 2014-2024 10. Reducing smoking rates amongst Aboriginal populations 11. National Disability Insurance Scheme 12. Public Specialist Outpatient Services 13. Local accountability and clinician engagement 14. Workplace culture **Progress against these priorities is measured [quarterly] by the District Executive Team. Progress against the NSW Health Strategic Priorities is reported in the second quarter performance meetings with NSW Health.**
Service Measures	A range of service measures have been identified by NSW Health to assist the organisation to improve provision of safe and efficient patient care and to provide the contextual information against which to assess performance. These are grouped under one of six headings: - Safety and Quality - Service Access and Patient Flow - Finance and Activity - People and Culture - Population Health

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Indicators and Measures	
	- Maternity, Child, Youth and Family Services There are no NSW Health set targets for these measures. For a detailed list, refer to **Appendix A**.
	Progress against these priorities is measured in the Service Improvement Meetings. Some measures are monitored through the Finance and Performance Committee and Facility Improvement Meetings (see Appendix C).
NSW Health KPIs	NSW Health has defined in the Service Agreement KPIs to be measured. Each NSW Health KPI is categorised as a Tier 1 or Tier 2 KPI and is grouped under one of five headings: - Safety and Quality - Service Access and Patient Flow - Finance and Activity - People and Culture - Population Health The target and thresholds for performing, underperforming and not performing are defined for each KPI. A 'traffic light' reporting approach has been adopted for all KPIs whereby indicator performance is assessed as Red, Amber or Green (RAG) depending on how that indicator is tracking against target performance for the month and year, as follows:

Performance Level	RAG	Description
Performing	Green	Performance at, or better than, target
Underperforming	Amber	Performance within a tolerance range
Not Performing	Red	Performance outside tolerance threshold

	For a detailed listing of NSW Health performance measures including: Committee responsible for monitoring, accountable owner and target and thresholds, refer to **Appendix B**.
	These KPIs are monitored in a variety of committees and meetings. For a detailed listing of where NSW Health performance measures are monitored, refer to Appendix B.
Budget and Financial performance	The Service Agreement sets out the operating and capital budget allocated to the LHD for the provision of its services, operations and capital works as well as the applicable funding under the National Health Funding Body Service Agreement.
	Metrics to assess performance are included in the Finance and Activity NSW Health KPIs. For a detailed listing of where these measures are monitored, refer to Appendix B.
Service/ activity volumes and levels	The Service Agreement sets out the activity volumes or levels of each LHD service purchased by NSW Health.
	Metrics to assess performance are included in the Finance and Activity NSW Health KPIs. For a detailed listing of where these measures are monitored, refer to Appendix B.
Governance	The Service Agreement sets out the structures and processes the LHD is to have in place to fulfil its statutory obligations and ensure good corporate and

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Indicators and Measures

clinical governance, as outlined in relevant legislation, NSW Health policy directives and policy and procedure manuals.

Performance against these requirements is monitored by exception to the Board.

SESLHD local performance measures

Local Strategic Priorities

The LHD has the following five local priorities, as set out in the ***Journey to Excellence***.

In addition, the Roadmap to the delivery of excellence 2014-17 sets out the following strategic priorities:

1. Improving the quality of care we provide
2. Improving the health of the population
3. Value and sustainability

From April 2016, progress against these priorities will be measured monthly by the District Executive Team.

SESLHD local KPIs

In addition, the LHD has developed local performance measures to reflect LHD, health service/facility or service line/departmental priorities. Through the introduction of Service Line Management in the facilities and increased local decision-making by clinicians and staff, Service Lines have defined the local service metrics that are important to them.

Towards Zero Together. The program aims to reduce harm to patients in hospital and those accessing our mental health services through initiatives, such as improving the reliability of our clinical processes. The Patient Safety Program, has commenced with eight clinical teams from across the District coming together to work on reducing harm and improving reliability for ventilator associated pneumonia, catheter associated urinary tract infections and recognition and management of the deteriorating patient. More teams and points of care will come on board every three months.

For a detailed listing of local performance measures including the committee responsible for monitoring and accountable owner, refer to **Appendix C**.

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Indicators and Measures

Performance aims and targets are set for each measure. For local quality and safety KPIs, the following RAG rating is applied:

RAG	Description
A	Improvement: Nil incidents reported or significant decrease in reported incidents
B	No significant change in performance in the reporting month or over time
C	Significant increase in reported incidents in the reporting month relative to facility average
D	Significant upward trend in reported incidents overtime
E	Significant increase in reported incidents in reporting month as well as Significant upward trend over time

KPIs are monitored in a variety of committees and meetings. For a detailed listing of where local performance measures are monitored, refer to Appendix C.

3.2 Changes to KPIs

KPIs can change from time to time, for example due to strategic priorities, the addition of new service lines and the requirements of NSW Health. The Director, Programs and Performance is responsible for agreeing any changes to the Performance Scorecards and ensuring:

- Performance targets for local KPIs and priorities are agreed between the lead responsible for achieving performance, the respective governing committee and the LHD Executive Team
- The data quality of any new KPIs has been assured
- Any variations to the measurement or reporting of indicators are highlighted in the relevant reports to minimise interpretation error

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Section 4 – Performance Management

4.1 Overview

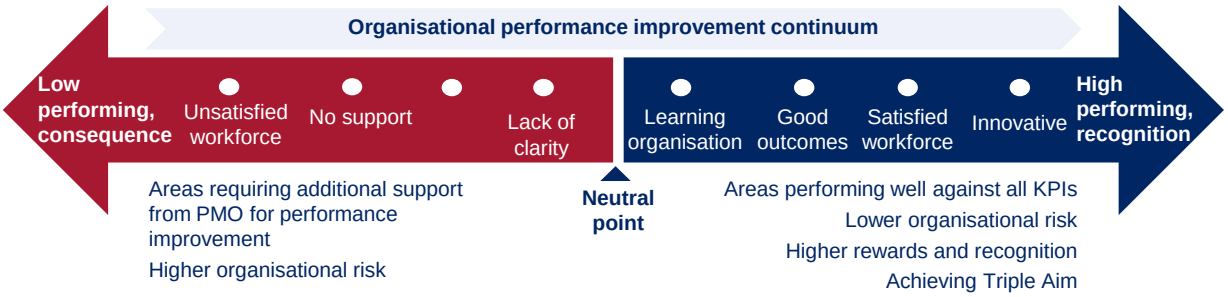
Performance against the indicators and measures discussed in ***Section 3*** is monitored by the LHD through the regular governance committees and meetings detailed in ***Section 2***.

This section outlines the process and forums for monitoring, reporting and escalating performance to ensure the achievement of SESLHD's objectives.

4.2 Continuous improvement

Aligned with the LHD's organisational performance approach (as set out in the diagram below), the Framework supports a culture of continuous improvement and the achievement of performance expectations. Recognition of good practice and strong performance against measures should be acknowledged in committees and meetings, quality forums, clinical councils, Chief Executive newsletters and shared across the LHD. By recognising leading performance and practice within the LHD and sharing lessons learnt across the facilities and services, the LHD can progress in its journey of continuous improvement.

When areas of improvement are highlighted or triggered, organisational support teams will be made available to assist.



4.3 Performance triggers

A performance concern will be raised when one or more of the performance measures/indicators do not meet the required target, threshold or milestone. The table overleaf sets out the decision logic for the trigger of a performance concern. The intention of this approach is to ensure there is timely escalation and appropriate action taken where there is a risk of indicator performance not meeting the specified targets.

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Measure	Performance trigger for concern
NSW Health performance measures	
NSW Health Strategic Priorities	Concerns that the strategic priority has failed to make sufficient progress.
Service Measures	Identified risk relating to performance, resources, quality and safety, reputation or other.
NSW Health KPIs	Tier 1 - KPI performance is outside the tolerance threshold (i.e. Red) during the reporting period (monthly or quarterly). Tier 2 - KPI performance is outside the tolerance threshold (i.e. Red) for more than one reporting period.
Budget and Financial performance	Included in NSW Health KPIs above.
Service/ activity volumes and levels	Included in NSW Health KPIs above.
Governance	Evidence that the LHD has not fulfilled its statutory obligations regarding corporate and clinical governance, as outlined in relevant legislation, NSW Health policy directives and policy and procedure manuals.
SESLHD local performance measures	
Local Strategic Priorities	Concerns that the strategic priority has failed to make sufficient progress.
SESLHD local KPIs	Identified risk relating to performance, resources, quality and safety, reputation or other.

4.4 Escalation and de-escalation

When a performance concern has been triggered following the decision logic above, the following actions should be undertaken to escalate and address the issue.

a) Improvement

When a performance concern has been triggered, the Accountable Owner for that milestone/KPI/measure should perform the following:

- Discuss the issue with the appropriate governing committee/meeting to assess the severity of the performance issue, including the reasons that led to the performance issue, and whether any action is required and if so the intended action and timeframe;
- If required, develop an action plan, with a trajectory back to target, timeframes and a mitigation strategy, to address the issue;
- Identify if an organisational support team is required to assist and support performance improvement;
- If required, provide regular status updates to the appropriate governing committee/ meeting.

The level of concern in each case is determined by the particular indicator(s), the seriousness of the issue, the speed with which the situation could deteriorate further, the time it would take to achieve turnaround and whether or not an indicator is on trajectory to meet target within a reasonable time frame.

In order to determine the level of response and intervention required, performance trends will also be considered. For example, a KPI that is not performing in the current period but is trending in the right

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direction (improving) and the required performance is likely to be achieved within a reasonable timeframe, will require less intervention than a KPI that is showing no improvement trend or is unlikely to achieve the required performance within the required timeframe.

The issue will be de-escalated when the issue is resolved.

b) Under-performance

If the Committee and Accountable Owner determine that the performance of a particular KPI or measure is consistently under-performing and not improving, or that the under-performance is compromising the delivery of the aggregate LHD performance, then the following should occur:

- Undertake an in-depth assessment of the problem
- Identify solutions to address the problem
- Provide a detailed recovery plan and timetable for resolution/trajectory to recovery
- Organisational support teams are available to assist in the recovery plan
- Progress on the recovery plan will be formally monitored by the appropriate governing committee over an agreed time frame

The issue will be de-escalated when the issue is resolved and does not re-emerge for at least one more reporting period.

4.5 Performance reports

Performance reports with dashboards and narrative of performance against the KPIs and targets are prepared and tabled in the designated committee/meeting for review and discussion, showing performance in the month/quarter and year to date, and where applicable, a RAG rating.

4.6 Delegations Manual

The purpose of the delegations manual is to establish the levels of authority delegated to duly appointed office holders and staff of the South Eastern Sydney Local Health District, as approved by the SESLHD Board and delegated by the Chief Executive. The underlying intention of the manual is to clarify accountability and responsibility for the day-to-day operation of South Eastern Sydney Local Health District.

The current review of the delegations manual takes into account one of the key deliverables of the *SESLHD Road Map to Excellence* which was to overhaul our information systems and measurement of performance and give clinicians the right information to inform decisions on their services. Thus providing more autonomy.

As part of that process, moving to a ***Service Line Management*** system will add value to managing performance and help secure financial sustainability. The goal of managing an organisation as a portfolio of service lines is to enable the devolution of ownership to the front line - where the capabilities, information, and patient relationships reside, which enables the Hospital to fulfil its overall objectives.

Earned autonomy occurs when permission to make decisions is given, through delegations, when there is evidence of service directors/managers managing responsibly e.g. addressing quality and safety issues, managing within resources, improving processes and systems for patient care. General Managers will manage the delegation of this through their service lines. LHD Workforce Advisory Services and Finance and Corporate Services are developing agility to allow higher delegations and one up approval processes for those service lines working within defined business rules and identified as having Earned Autonomy.

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Table 1 reflects SLM delegation within allocated Earned Autonomy.

Table 1 Delegation within earned autonomy

4.2	Recruitment & Selection (SLM earned Autonomy)						
Schedule	**Delegation**	CE	GM	SLM	HoD	NUM	**Other**
4.2.1	Approval of new base grade award positions		✓				
4.2.2	Approval to recruit existing staff vacancies (within budget funds/FTE targets)				✓		One up approval
4.2.3	Approval to recruit outside budget & FTE target			✓			Two up approval
4.2.4	Appointment of casual/temporary staff within budget and FTE target					✓	

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Section 5 – Planning and Performance Cycle

5.1 Overview

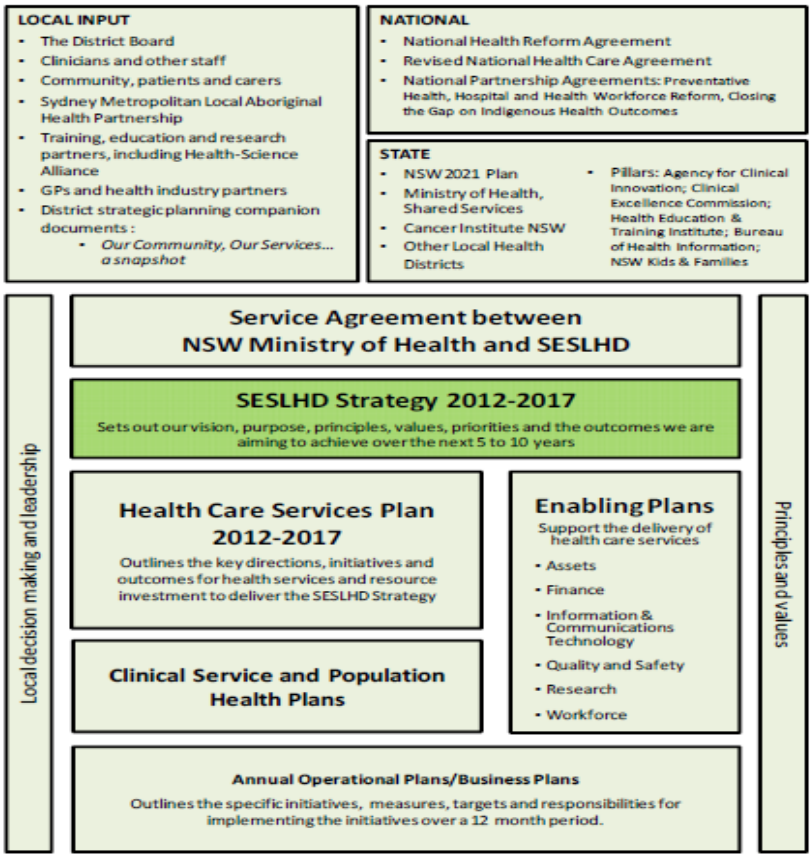
This section outlines the annual planning and performance cycle that sets SESLHD's strategic, operational and performance objectives. The performance targets and measures outlined in ***Section 3*** are set during the annual planning process.

This cycle provides a clear and robust process to assess past and current performance, as well as to refresh strategy for SESLHD and each of the Health Services (reflecting updated NSW Health and local priorities).

5.2 LHD planning framework

Aligned to the National Health Reform Agreement requirements, SESLHD has a robust Planning Framework that guides the development of a cascading and integrated series of plans, including SESLHD's Roadmap to the delivery of excellence 2014-2017.

These plans are informed by and operationalise the SESLHD-NSW Health Service Agreement and collectively outline both the NSW Health and locally developed SESLHD priorities, and the corresponding performance objectives.



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5.3 Service Line plans

Service Line Management is being implemented across the LHD's facilities over 2016 and 2017 and will allow for the devolution of accountability and responsibility to the front line, and in doing so service lines will have ownership of their own performance and outcomes. Service lines will develop their own annual business plans and objectives, and set their own local KPIs to proactively manage performance.

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5.4 Annual business cycle

The diagram below details the key dates of the planning and performance cycle across the financial year.

<table>
<tr><th rowspan="2">Financial Year</th><th colspan="3">Q4</th><th colspan="3">Q1</th><th colspan="3">Q2</th><th colspan="3">Q3</th></tr>
<tr><th>Apr</th><th>May</th><th>Jun</th><th>Jul</th><th>Aug</th><th>Sep</th><th>Oct</th><th>Nov</th><th>Dec</th><th>Jan</th><th>Feb</th><th>Mar</th></tr>
<tr><td>NSW Health</td><td>Draft SLA from NSW Health to LHD with
- Activity targets
- KPIs
- Strategic Priorities</td><td>16/17 Budget allocation to SESLHD</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td rowspan="3">SESLHD</td><td rowspan="3"></td><td>Finalise 16/17 Strategic Priorities</td><td>16/17 VIP status approved</td><td>Final SLA signed by LHD and sent to NSW Health</td><td rowspan="3"></td><td rowspan="3"></td><td rowspan="3"></td><td rowspan="3">Mid Year Board performance stocktake</td><td rowspan="3"></td><td rowspan="3"></td><td rowspan="3"></td><td rowspan="3"></td></tr>
<tr><td>Finalise 16/17 Annual Operational Plan</td><td>16/17 Budget finalised</td><td>15/16 Year end performance stocktake</td></tr>
<tr><td>Set LHD KPIs</td><td></td><td></td></tr>
<tr><td rowspan="2">Health Services</td><td rowspan="2"></td><td rowspan="2"></td><td>Set Local KPIs</td><td>16/17 Budget finalised</td><td>16/17 Performance Agreement finalised</td><td rowspan="2"></td><td rowspan="2"></td><td rowspan="2"></td><td rowspan="2"></td><td rowspan="2"></td><td rowspan="2"></td><td rowspan="2"></td></tr>
<tr><td></td><td>15/16 Year end performance stocktake</td><td></td></tr>
<tr><td>Service Lines</td><td></td><td></td><td>Set Local KPIs</td><td>15/16 Year end performance stocktake</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td colspan="12">Monthly performance meetings</td></tr>
</table>

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Revision and Approval History

Date	Revision no:	Author and approval
15/03/16	3	Author: Jenna McGrath, PwC Consultant Approval: Mark Shepherd, Director Programs and Performance
24/03/16	4	Author: Jenna McGrath, PwC Consultant Approval: Mark Shepherd, Director Programs and Performance
31/03/16	5	Author: Jenna McGrath, PwC Consultant Approval: Mark Shepherd, Director Programs and Performance
April 2020	5	Executive Sponsor updated.

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Appendix A: NSW Health Service Measures

Service Measure
Safety and Quality
Deteriorating Patients (rate per 1,000 separations): • Rapid response calls • Cardio respiratory arrests
Unplanned hospital readmission rates (%) for patients discharged following management of: • Acute Myocardial Infarction • Heart Failure • Knee and hip replacements • Paediatric tonsillectomy and adenoidectomy
ICU Central Line Associated Bloodstream (CLAB) Infections (number)
Incorrect procedures: Operating Theatre - resulting in death or major loss of function (number)
Hospital acquired venous thromboembolism (rate per 1,000 separations)
Inpatients who were discharged against medical advice (%): Aboriginal and Non-Aboriginal
Re-treatment following restorative treatment: Number of permanent teeth re-treated within 6 months of an episode of restorative treatment. Performance target: less than 6% (less than 6 teeth re-treated per 100 teeth restored).
Denture remakes: Number of same denture type (full or partial) and same arch remade within 12 months. Performance target: less than 3% (less than 3 per 100 dentures).
Patient Experience Survey — Emergency Department Patients: Overall rating of care - good and very good (%)
Mental Health: • Outcomes readiness (HoNOS completion rates) - (% of mental health episodes with completed HoNOS outcome measures) • Consumer Experience Measure (YES) Completion Rate - (% of episodes) • Average duration of seclusion - (Hours) • Frequency of seclusion - (% of acute mental-health admitted care episodes with seclusion)
Service access and patient flow
Patients with total time in ED <= 4 hrs (%): • Admitted (to a ward/ICU/theatre from ED) • Not Admitted (to an Inpatient Unit from ED) • Mental Health Patients (admitted to a ward from ED)
ED attendances treated within benchmark times (%): • Triage 1/ Triage 2/ Triage 3/ Triage 4/ Triage 5
Elective Surgery: Activity compared to previous year (Number)
Elective Surgery Theatre Utilisation: Operating Room Occupancy (%)
Surgery for Children - Proportion of children (to 16 years) treated within their LHD of residence:

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Service Measure
• Emergency Surgery (%) • Planned Surgery (%)
Average Length of Episode Stay - Overnight Patients (days)
Acute to Aged-Related Care Services patients seen (number)
Aged Care Services in Emergency Teams patients seen (number)
Breast Screen Participation Rates, disaggregated by Aboriginality and cultural and linguistic diversity (%): • Women, aged 50-69 • Women, aged 70-74
Home Based Dialysis: Proportion of all dialysis patients that receive: • Home peritoneal dialysis (%) • Home haemodialysis (%)
Integrated care
Unplanned hospital readmissions: all admissions within 28 days of separation (%): • All persons • Aboriginal persons • ABF hospitals (rate in NWAU)
Unplanned and Emergency Re-Presentations to same ED within 48 hours (%): • All persons • Aboriginal persons • ABF hospitals (rate in NWAU)
Hospital in the Home (HITH): Admitted activity (%)
Potentially Preventable Hospitalisations (Rate per 100,000 population)
Electronic Discharge Summaries (%): • accepted by a General Practitioner (GP) system • acknowledged by a patient's GP
Chronic Disease Management (CDM) Program enrollees transitioned into Integrated Care (%)
Finance and Activity
Specialist Outpatient Services (Service events) • Initial • Subsequent
Patient Fee Debtors > 45 days as a percentage of rolling prior 12 months Patient Fee Revenues (%)
Coding timeliness: % uncoded acute separations
ED records unable to be grouped: • to URG with a breakdown for error codes: EI, E2, E3, E6, E7 and E8 (number and %)

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Service Measure
• to UDG with a breakdown for error codes: El and E2 (number and %)
NAP data completeness: • Patient Level (%)
Wait List Enterprise Data Warehouse data errors, reported separately and disaggregated by error source (%): • Source System error (issues related to the EDW extract or mappings defects) • Data collection error (issues related to the actual data collected or reported) • System Vendor error (issues related to source system defects)
Sub and Non Acute Inpatient Services - Grouped to an AN-SNAP class (%)
People and Culture
Workplace Injuries: • Claims (rate per 100 FTEs) • Return to work experience -Continuous Average Duration (days)
Premium staff usage - average paid hours per FTE (Hours): • Medical • Nursing
Reduction in the number of employees with accrued annual leave balances of more than 30 days (Number)
Recruitment: improvement on baseline average time taken from request to recruit to decision to approve/decline/defer recruitment (days)
Aboriginal Workforce as a proportion of total workforce (%)
Public Service Commission (PSC) People Matter Survey (%) • Estimated Response Rate • Engagement Index
Population Health
Quit for New Life Program (%) • Referred to the Quitline • Provided Nicotine Replacement Therapy (NRT) • Booked follow-up Appointment
Healthy Children's Initiative - Children's Health Eating and Physical Activity Program (centre based children's service sites) — Adopted (% cumulative)
Healthy Children's Initiative — Children's Healthy Eating and Physical Activity Program (primary school sites) - Adopted (% cumulative)
Children fully immunised (%) • At one year of age: Non- Aboriginal children • At one year of age: Aboriginal children • At four years of age: Non- Aboriginal children • At four years of age: Aboriginal children
Human papillomavirus vaccine — year 7 students receiving the third dose through the NSW Adolescent Vaccination Program (%)

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Service Measure
Comprehensive antenatal visits for all pregnant women before 14 weeks gestation (%) • Who are Aboriginal • Who are non-Aboriginal with an Aboriginal baby • Who are non-Aboriginal with a non-Aboriginal baby • All women
Women who smoked at any time during pregnancy (%): • Aboriginal women • Non-Aboriginal women
Tobacco compliance monitoring: compliance with the Smoke-free Health Care Policy (%)
Organ and Tissue donation: • Family requested (%) • Family consented (%)
Maternal, Child, Youth and Family Services
Domestic and Family Violence Screening - Routine Domestic Violence Screens conducted (%)
Out of Home Care Health Pathway Program - Children and young people that complete a primary health assessment (%)
Sexual Assault Services – High priority referrals to Sexual Assault Services receiving an initial psychosocial assessment (%)

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Appendix B: NSW Health KPIs

Indicator	Tier	Target	Not performing	Under performing	Performing	PoW	SGH	TSH	RHW	SSEH	WMH	CAL	MH	Accountable owner	Monitored in Committee
Safety and Quality															
Staphylococcus aureus bloodstream infections (SABSI) (per 10,000 occupied bed days)	1	<2	≥ 2.0	N/A	<2	✔	✔	✔	✔	✔	-	-	-	Facility – GM LHD – Trish Bradd	Finance and Performance Committee Facility Improvement Meetings Facility Safety and Quality Committees
Patient Experience Survey following treatment: Overall care received - good and very good (%)	2	Increase	Decrease from previous Year	No change	Increase from previous Year	✔	✔	✔	✔	✔	-	-	-	Facility – GM LHD – Trish Bradd	Facility Improvement Meetings Facility Safety and Quality Committees
Hospital acquired pressure injuries (rate per 1,000 completed inpatient stays)	2	Decrease	Increase from previous Year	No change	Decrease from previous Year	✔	✔	✔	✔	✔	-	-	-	Facility – GM LHD – Trish Bradd	Facility Improvement Meetings Facility Safety and Quality Committees
Mental Health:	2	≤13	≥ 20	> 13 and	≤13	-	-	-	-	-	-	-	✔	Facility – GM	Finance and

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Indicator	Tier	Target	Not performing	Under performing	Performing	PoW	SGH	TSH	RHW	SSEH	WMH	CAL	MH	Accountable owner	Monitored in Committee
Acute readmission within 28 days (%)				<20										LHD – Trish Bradd	Performance Committee Facility Improvement Meetings Facility Safety and Quality Committees Productivity and Improvement Board
Mental Health: Acute Post-Discharge Community Care – follow up within seven days (%)	2	≥70	<50	≥50 and <70	≥70	-	-	-	-	-	-	-	✔	Facility – GM LHD – Trish Bradd	Finance and Performance Committee Facility Improvement Meetings Facility Safety and Quality Committees Productivity and Improvement Board
Mental Health: Acute Seclusion rate (episodes per 1,000 bed days)	2	< 6.8	≥9.9	≥6.8 and <9.9	< 6.8	-	-	-	-	-	-	-	✔	Facility – GM LHD – Trish Bradd	Finance and Performance Committee Facility Improvement Meetings Facility Safety and Quality Committees
Service Access and Patient Flow															
Transfer of Care – Patients transferred	1	≥90	<80	≥80 and <90	≥90	✔	✔	✔	✔	✔	✔	✔	-	Facility – GM LHD – Mark Shepherd	Finance and Performance Committee Facility

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Indicator	Tier	Target	Not performing	Under performing	Performing	PoW	SGH	TSH	RHW	SSEH	WMH	CAL	MH	Accountable owner	Monitored in Committee
from Ambulance to ED <30 minutes (%)															Improvement Meetings Productivity and Improvement Board
Emergency Treatment Performance - Patients with total time in ED <= 4 hrs (%)	1	≥81	<71	≥71 and <81	≥81	✔	✔	✔	✔	✔	✔	✔	-	Facility – GM LHD – Mark Shepherd	Finance and Performance Committee Facility Improvement Meetings Productivity and Improvement Board
Presentations staying in ED > 24 hours (number)	2	0	>5	≥1 and ≤5	0	✔	✔	✔	✔	✔	✔	✔	-	Facility – GM LHD – Mark Shepherd	Finance and Performance Committee Facility Improvement Meetings Productivity and Improvement Board
Elective Surgery Access Performance: Elective Surgery Patients Treated on Time (%)															
Category 1	1	100	<100	N/A	100	✔	✔	✔	✔	✔	✔	✔	-	Facility – GM LHD – Mark Shepherd	Finance and Performance Committee Facility Improvement Meetings Productivity and Improvement Board
Category 2	1	≥97	<93	≥93 and <97	≥97	✔	✔	✔	✔	✔	✔	✔	-		
Category 3	1	≥97	<95	≥95 and <97	≥97	✔	✔	✔	✔	✔	✔	✔	-		
Overdue Elective Surgery Patients (number)															
Category 1	1	0	≥1	N/A	0	✔	✔	✔	✔	✔	✔	✔	-		
Category 2	1	0	≥1	N/A	0	✔	✔	✔	✔	✔	✔	✔	-		
Category 3	1	0	≥1	N/A	0	✔	✔	✔	✔	✔	✔	✔	-		
Mental Health: Presentations staying in ED > 24 hours	2	0	>5	≥1 and ≤5	0	-	-	-	-	-	-	-	✔	Facility – GM LHD – Mark Shepherd	Finance and Performance Committee Facility

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Indicator	Tier	Target	Not performing	Under performing	Performing	PoW	SGH	TSH	RHW	SSEH	WMH	CAL	MH	Accountable owner	Monitored in Committee
(number)															Improvement Meetings Productivity and Improvement Board
Non-Urgent Patients waiting > 365 days for an initial specialist outpatient services appointment (Number)	2	0	Increase from previous Year	Decrease from previous Year	0	✔	✔	✔	✔	✔	✔	✔	-	Facility – GM LHD – Mark Shepherd	Facility Improvement Meetings Productivity and Improvement Board
Electronic Discharge Summaries Completed (%)	2	TBD	TBD	TBD	TBD	✔	✔	✔	✔	✔	✔	✔	-	Facility – GM LHD – Mark Shepherd	Facility Improvement Meetings Productivity and Improvement Board
Finance and Activity											✔				
Variation against purchased volume (%)															
Acute Inpatient Services (NWAU)	1	See Schedule D of Service Agreement	> +/- 2.0 variation from target	+/- >1.0 - <2.0 variation from target	+-1.0 variation from target	✔	✔	✔	✔	✔	✔	✔	-	Facility – GM LHD – Karen Foldi	Finance and Performance Committee Facility Improvement Meetings
Emergency Department Services (NWAU)	1	See Schedule D of Service Agreement	> +/- 2.0 variation from target	+/- >1.0 - <2.0 variation from target	+-1.0 variation from target	✔	✔	✔	✔	✔	✔	✔	-	Facility – GM LHD – Karen Foldi	Finance and Performance Committee Facility Improvement Meetings
Sub and	1	See	> +/- 2.0	+/- >1.0 -	+-1.0	✔	✔	✔	✔	✔	✔	✔	-	Facility – GM	Finance and

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Indicator	Tier	Target	Not performing	Under performing	Performing	PoW	SGH	TSH	RHW	SSEH	WMH	CAL	MH	Accountable owner	Monitored in Committee
Non Acute Inpatient Services (NWAU)		Schedule D of Service Agreement	variation from target	<2.0 variation from target	variation from target									LHD – Karen Foldi	Performance Committee Facility Improvement Meetings
Non Admitted Patient Services – Tier 2 Clinics (NWAU)	1	See Schedule D of Service Agreement	> +/- 2.0 variation from target	+/- >1.0 - <2.0 variation from target	+-1.0 variation from target	✔	✔	✔	✔	✔	✔	✔	-	Facility – GM LHD – Karen Foldi	Facility Improvement Meetings
Mental Health Inpatient Activity Acute Inpatients (NWAU)	1	See Schedule D of Service Agreement	> +/- 2.0 variation from target	+/- >1.0 - <2.0 variation from target	+-1.0 variation from target	-	-	-	-	-	-	-	✔	Facility – GM LHD – Karen Foldi	Finance and Performance Committee Facility Improvement Meetings
Mental Health Inpatient Activity Non Acute Inpatients (NWAU)	1	See Schedule D of Service Agreement	> +/- 2.0 variation from target	+/- >1.0 - <2.0 variation from target	+-1.0 variation from target	-	-	-	-	-	-	-	✔	Facility – GM LHD – Karen Foldi	Finance and Performance Committee Facility Improvement Meetings
Mental Health Non Admitted occasions of service (NWAU)	2	See Schedule D of Service Agreement	> +/- 2.0 variation from target	+/- >1.0 - <2.0 variation from target	+-1.0 variation from target	-	-	-	-	-	-	-	✔	Facility – GM LHD – Karen Foldi	Facility Improvement Meetings
Public Dental Clinical Service (DWAU)	2	100	<100	N/A	≥100	✔	✔	✔	✔	✔	✔	✔	✔	Facility – GM LHD – Karen Foldi	Facility Improvement Meetings
Expenditure matched to															

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Indicator	Tier	Target	Not performing	Under performing	Performing	PoW	SGH	TSH	RHW	SSEH	WMH	CAL	MH	Accountable owner	Monitored in Committee
budget (General Fund):															
a) Year to date - General Fund (%)	1	On budget or Favourable	> 0.5 Unfavourable	> 0 but ≤0.5 Unfavourable	On budget or Favourable	✔	✔	✔	✔	✔	✔	✔	✔	Facility – GM LHD – Karen Foldi	Finance and Performance Committee Facility Improvement Meetings Productivity and Improvement Board
b) June projection - General Fund (%)	1	On budget or Favourable	> 0.5 Unfavourable	> 0 but ≤0.5 Unfavourable	On budget or Favourable	✔	✔	✔	✔	✔	✔	✔	✔	Facility – GM LHD – Karen Foldi	Facility Improvement Meetings
Own Source Revenue Matched to budget (General Fund):															
a) Year to date - General Fund (%)	1	On budget or Favourable	> 0.5 Unfavourable	> 0 but ≤0.5 Unfavourable	On budget or Favourable	✔	✔	✔	✔	✔	✔	✔	✔	Facility – GM LHD – Karen Foldi	Finance and Performance Committee Facility Improvement Meetings Productivity and Improvement Board
b) June projection - General Fund (%)	1	On budget or Favourable	> 0.5 Unfavourable	> 0 but ≤0.5 Unfavourable	On budget or Favourable	✔	✔	✔	✔	✔	✔	✔	✔	Facility – GM LHD – Karen Foldi	Facility Improvement Meetings
Liquidity															
Recurrent Trade Creditors > 45 days correct and ready for payment ($)	1	0	>0	N/A	0	✔	✔	✔	✔	✔	✔	✔	✔	Facility – GM LHD – Karen Foldi	Finance and Performance Committee Facility Improvement Meetings
Small	1	100	<100	N/A	100	✔	✔	✔	✔	✔	✔	✔	✔	Facility – GM	Finance and

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Indicator	Tier	Target	Not performing	Under performing	Performing	PoW	SGH	TSH	RHW	SSEH	WMH	CAL	MH	Accountable owner	Monitored in Committee
Business Creditors paid within 30 days from receipt of a correctly rendered invoice(%)														LHD – Karen Foldi	Performance Committee Facility Improvement Meetings
People and Culture															
Staff who have had a performance review within the last 12 months (%)	2	100	<85	≥85 and < 90	≥90	✔	✔	✔	✔	✔	✔	✔	✔	Facility – GM LHD – Trish Bradd	Facility Improvement Meetings
Population Health															
HIV testing increase within publicly funded HIV and sexual health services (% increase)	2	See Data Dictionary item	> 5.0 % variation below Target	≤5.0 % variation below Target	Met or exceeded Target	-	-	-	-	-	-	-	-	LHD – Julie Dixon	
Get Healthy Information and Coaching Service — Health Professional Referrals (% increase)	2	See Data Dictionary item	> 10.0 % variation below Target	≤10.0 % variation below Target	Met or exceeded Target	-	-	-	-	-	-	-	-	LHD – Julie Dixon	

Legend: PoW: Prince of Wales, SGH: St George Hospital, TSH: The Sutherland Hospital, RHW: Royal Hospital for Women, WMH: War Memorial Hospital, CAL: Calvary, MH: Mental Health

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Appendix C: SESLHD Local KPIs

C1: Clinical Health Service level

Note: KPIs in red are also NSW Health Service Measures, KPIs in blue are also NSW Health KPIs.

Indicator	PoW	SGH	TSH	RHW	SSEH	WMH	CAL	MH	Accountable owner	Monitored in Committee/ Meeting
Safety and Quality										
Clinical Management Incidents	✔	✔	✔	✔	✔	✔	✔	-	Facility – GM LHD – Trish Bradd	Facility Improvement Meetings Facility Safety and Quality Committees
Blood and Blood Products Incidents	✔	✔	✔	✔	✔	-	-	-	Facility – GM LHD – Trish Bradd	Facility Improvement Meetings Facility Safety and Quality Committees
Complaints	✔	✔	✔	✔	✔	-	-	✔	Facility – GM LHD – Trish Bradd	Facility Improvement Meetings Facility Safety and Quality Committees
Documentation Incidents	✔	✔	✔	✔	✔	✔	✔	-	Facility – GM LHD – Trish Bradd	Facility Improvement Meetings Facility Safety and Quality Committees
Inadequate Hand Over Incidents	✔	✔	✔	✔	✔	-	-	-	Facility – GM LHD – Trish Bradd	Facility Improvement Meetings Facility Safety and Quality Committees
Medication Incidents	✔	✔	✔	✔	✔	✔	✔	-	Facility – GM LHD – Trish Bradd	Facility Improvement Meetings Facility Safety and Quality Committees
Falls	✔	✔	✔	✔	✔	✔	✔	-	Facility – GM LHD – Trish Bradd	Facility Improvement Meetings Facility Safety and Quality Committees
HAI: Infections reported in IIMS by staff	✔	✔	✔	✔	✔	✔	✔	-	Facility – GM LHD – Trish Bradd	Facility Improvement Meetings Facility Safety and Quality Committees
HAI: Staphylococcus aureus Bloodstream Infection	✔	✔	✔	✔	✔	-	-	-	Facility – GM LHD – Trish Bradd	Facility Improvement Meetings Facility Safety and Quality Committees
HAI: ICU Central Line Assoc. BSIs	✔	✔	✔	-	-	-	-	-	Facility – GM LHD – Trish Bradd	Finance and Performance Committee Facility Improvement Meetings Facility Safety and Quality Committees
HAI: Clostridium difficile	✔	✔	✔	✔	✔	-	-	-	Facility – GM LHD – Trish Bradd	Facility Improvement Meetings Facility Safety and Quality Committees
Incorrect procedures: Operating Theatre - resulting in death or	✔	✔	✔	✔	✔	-	-	-	Facility – GM LHD – Trish Bradd	Finance and Performance Committee

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Indicator	PoW	SGH	TSH	RHW	SSEH	WMH	CAL	MH	Accountable owner	Monitored in Committee/ Meeting
major loss of function										
Rapid Response Calls (PACE)	✔	✔	✔	✔	✔	-	-	-	Facility – GM LHD – Trish Bradd	Facility Improvement Meetings Facility Safety and Quality Committees
Cardiac Arrests in patients for Active Resuscitation	✔	✔	✔	-	-	-	-	-	Facility – GM LHD – Trish Bradd	Facility Improvement Meetings Facility Safety and Quality Committees
Vaginal Birth Assoc. Perineal Trauma: Cat 4	✔	✔	✔	✔	-	-	-	-	Facility – GM LHD – Trish Bradd	Facility Improvement Meetings Facility Safety and Quality Committees
Vaginal Birth Assoc. Perineal Trauma: Cat All 3 and 4	✔	✔	✔	✔	-	-	-	-	Facility – GM LHD – Trish Bradd	Facility Improvement Meetings Facility Safety and Quality Committees
48 hours Unplanned ED revisits	✔	✔	✔	-	✔	-	-	-	Facility – GM LHD – Trish Bradd	Facility Improvement Meetings Facility Safety and Quality Committees
Hospital Acquired Pressure Injuries - All	✔	✔	✔	✔	✔	✔	✔	-	Facility – GM LHD – Trish Bradd	Facility Improvement Meetings Facility Safety and Quality Committees
Hospital Acquired Pressure Injuries – (Stage 3,4 and Uns)	✔	✔	✔	-	✔	✔	✔	-	Facility – GM LHD – Trish Bradd	Facility Improvement Meetings Facility Safety and Quality Committees
Venous thromboembolisms associated with hospitalisation (MoH)	✔	✔	✔	✔	✔	-	-	-	Facility – GM LHD – Trish Bradd	Facility Improvement Meetings Facility Safety and Quality Committees
Surgical Site Infection - Hip	✔	✔	✔	-	-	-	-	-	Facility – GM LHD – Trish Bradd	Facility Improvement Meetings Facility Safety and Quality Committees
Surgical Site Infection - Knee	✔	✔	✔	-	-	-	-	-	Facility – GM LHD – Trish Bradd	Facility Improvement Meetings Facility Safety and Quality Committees
Surgical Site Infection - CABG	✔	✔	✔	-	-	-	-	-	Facility – GM LHD – Trish Bradd	Facility Improvement Meetings Facility Safety and Quality Committees
28 Days Unplanned Readmissions	✔	✔	✔	✔	✔	-	-	-	Facility – GM LHD – Trish Bradd	Facility Improvement Meetings Facility Safety and Quality Committees
UR for DRG AMI within 30D	✔	✔	✔	-	-	-	-	-	Facility – GM LHD – Trish Bradd	Facility Improvement Meetings Facility Safety and Quality Committees
UR for DRG heart failure within 30D	✔	✔	✔	-	-	-	-	-	Facility – GM LHD – Trish Bradd	Facility Improvement Meetings Facility Safety and Quality Committees
UR for DRG Hip replacement within 60D	-	✔	✔	-	-	-	-	-	Facility – GM LHD – Trish Bradd	Facility Improvement Meetings Facility Safety and Quality Committees
UR for DRG Knee replacement within 60D	-	-	✔	-	-	-	-	-	Facility – GM LHD – Trish Bradd	Facility Improvement Meetings Facility Safety and Quality Committees
UR for Tonsillectomy/Adenoidectomy	✔	✔	-	-	-	-	-	-	Facility – GM LHD – Trish Bradd	Facility Improvement Meetings Facility Safety and Quality Committees

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Indicator	PoW	SGH	TSH	RHW	SSEH	WMH	CAL	MH	Accountable owner	Monitored in Committee/ Meeting
within 15D										
Seclusions – No of seclusion episodes	-	-	-	-	-	-	-	✔	Facility – GM LHD – Trish Bradd	Finance and Performance Committee Facility Improvement Meetings Productivity and Improvement Board
Seclusions – No of seclusion episodes per 1000 bed days (MH)	-	-	-	-	-	-	-	✔	Facility – GM LHD – Trish Bradd	Finance and Performance Committee Facility Improvement Meetings Productivity and Improvement Board
Inpatient Physical Exam completed < 24h (MH)	-	-	-	-	-	-	-	✔	Facility – GM LHD – Trish Bradd	Finance and Performance Committee Facility Improvement Meetings
Community Physical Exam completed < 12m (MH)	-	-	-	-	-	-	-	✔	Facility – GM LHD – Trish Bradd	Finance and Performance Committee Facility Improvement Meetings
Physical Exam not completed – Inpatient	-	-	-	-	-	-	-	✔	Facility – GM LHD – Trish Bradd	Finance and Performance Committee Facility Improvement Meetings Productivity and Improvement Board
Physical Exam not completed - Community	-	-	-	-	-	-	-	✔	Facility – GM LHD – Trish Bradd	Finance and Performance Committee Facility Improvement Meetings Productivity and Improvement Board
Service Access and Patient Flow										
Connecting Care Program – People Currently enrolled	-	-	-	-	-	-	-		Facility – GM LHD – Mark Shepherd	Finance and Performance Committee Facility Improvement Meetings
Overnight – ALOS total and private health	✔	✔	✔	✔	✔	✔	✔	-	Facility – GM LHD – Mark Shepherd	Facility Improvement Meetings
MAA bed days – indicator for NWAU	✔	✔	✔	✔	✔	-	-	-	Facility – GM LHD – Mark Shepherd	Facility Improvement Meetings
DVA bed days – indicator for NWAU	✔	✔	✔	✔	✔	-	-	-	Facility – GM LHD – Mark Shepherd	Facility Improvement Meetings
Finance and Activity										
Value Improvement Plan – actual cost savings realised to date	✔	✔	✔	✔	✔	-	-	✔	Facility – GM LHD – Karen Foldi	Facility Improvement Meetings Productivity and Improvement Board
Net cost of services and FY projection	✔	✔	✔	✔	✔	-	-	✔	Facility – GM LHD – Karen Foldi	Facility Improvement Meetings
People and Culture										
Workforce • Total and proposed FTE • Agency FTE	✔	✔	✔	✔	✔	✔	✔	✔	Facility – GM LHD – Mark Shepherd	Facility Improvement Meetings Productivity and Improvement Board

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Indicator	PoW	SGH	TSH	RHW	SSEH	WMH	CAL	MH	Accountable owner	Monitored in Committee/ Meeting
• Overtime FTE • Paid Sick FTE										
Workforce • Casual Nurse FTE • Agency Nurse FTE • Medical locum FTE	✔	✔	✔	✔	✔	-	-	-	Facility – GM LHD – Mark Shepherd	Facility Improvement Meetings
Workforce • Overtime hours per FTE • Sick leave hours per FTE	-	-	-	-	-	-	-	✔	Facility – GM LHD – Mark Shepherd	Facility Improvement Meetings
Annual leave liabilities	✔	✔	✔	✔	✔	✔	✔	✔	Facility – GM LHD – Mark Shepherd	Facility Improvement Meetings Productivity and Improvement Board
Long Service Leave liabilities	✔	✔	✔	✔	✔	✔	✔	✔	Facility – GM LHD – Mark Shepherd	Facility Improvement Meetings Productivity and Improvement Board
Excess leave liability	✔	✔	✔	✔	✔	✔	✔	✔	Facility – GM LHD – Mark Shepherd	Facility Improvement Meetings Productivity and Improvement Board
Workers Compensation and Injury management KPIs	✔	✔	✔	✔	✔	✔	✔	✔	Facility – GM LHD – Mark Shepherd	Facility Improvement Meetings
Your Say Survey results	✔	✔	✔	✔	✔	✔	✔	✔	Facility – GM LHD – Trish Bradd	Facility Improvement Meetings

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C2: Service Line Indicators

The below is an example of the Service Line Reporting tool.

Finance		Dec-15	Budget	15/16 YTD	Budget
Expenditure	Total Expenditure	$132,456 ▲	0.1%	$803,901 ▼	
	510. Employee Related	$88,199 ▲	1.1%	$521,907 ▼	
	515. Visiting Medical Officer	$3,691 ▼	-12.1%	$25,132 ▼	
	520. Other Working	$30,288 ▼	-1.0%	$192,456 ▼	
	525. Maintenance	$2,063 ▲	47.1%	$12,545 ▼	
	530. Depreciation	$4,441 ▼	-0.0%	$26,446 ▼	
	540. Grants	$405 ▼	-52.4%	$6,839 ▼	
Revenue	Total Revenue	$20,959 ▼	-3.4%	$142,125 ▼	
	620. Patient Fees Revenue	$11,115 ▼	-13.2%	$67,790 ▼	
	625. Other User Charges	$6,598 ▲	11.0%	$50,266 ▼	
	630. Other sources of revenue	$363 ▼	-56.0%	$3,018 ▼	
	640. Rev Industry Contribution	$2,246 ▲	42.7%	$16,911 ▼	
	710. Other Items	$0 ▲		$0 ▼	
	750. Govt Contributions	$0 ▲		$0 ▼	
	750. State & Industry Contrib...	$0 ▲		$0 ▼	
Efficiency	Expenditure by bed days	2 ▲	0.1%	2 ▼	

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