

Monitoring the effects of implementing the  
South Australian Health and Wellbeing Strategy  
Indicator report

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Health Performance Council



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### **Acknowledgment of the Aboriginal peoples of South Australia**

The Health Performance Council acknowledges the Aboriginal peoples of South Australia and their ongoing contributions to and participation in the life of South Australia. We acknowledge and respect their spiritual relationship with their respective countries.

We also acknowledge the diversity of Aboriginal people in South Australia. Our Australian continent is known to have been inhabited for at least 55,000 years. The first inhabitants comprised over 270 different Aboriginal language/cultural groups across Australia, with 40 independent groups living in South Australia. Each group occupied its own territory and had its own unique culture, beliefs, laws, language, stories, ceremonies and art (Reconciliation SA, 2017). Aboriginal peoples in their diversity have demonstrated resilience and have made significant contributions to South Australia despite the ongoing effects of colonisation and dispossession.

## Executive summary

The Health Performance Council produced this indicator report to monitor implementation of the *South Australian Health and Wellbeing Strategy 2020–2025*. More broadly, this indicator report presents baseline indicators for SA Health to consider in its own regular and publicly available performance monitoring. The strategy only relates to the public sector and is not a strategy about South Australian health services as a whole. The Council’s monitoring in this report therefore only considers public hospital services.

Indicators in this report are presented over time, by local health network, and specific population group for monitoring implementation of the strategy’s four goals of: Trusted, Targeted, Tailored, and Timely.

### TRUSTED—“trusted to provide safe, reliable and high quality treatment and care”

- More than nine in ten (90.8%) of patients say they were ‘always or mostly’ confident in the **safety of their treatment and care** during their hospital stay in 2018-19. [SECTION 1.1](#)
- During 2018-19, a total of 12,684 instances of feedback—including complaints, compliments, suggestions and advice—were recorded as received (and not rejected) by SA Health in relation to public health services. Of this **total feedback**, over half (54.0%) is classified by SA Health as **complaints**. [SECTION 1.2](#)
- Overall, the rate of hospital inpatient **self-discharge-against-medical-advice** is relatively low at less than one in a hundred (0.8%) hospitalisations (inpatient separations). However, the rate for Aboriginal persons is three times higher than the all-persons rate at 2.4%. [SECTION 1.3](#)
- As at the 2016 Census, the Aboriginal population of South Australia represented 2.0% of the state’s population. In comparison, 1.2% of the SA Health **workforce identify as Aboriginal**. [SECTION 1.4](#)

### TARGETED—“targets priority health needs and disparities”

- Around one out of every 11 (8.8%) of the public hospital **hospitalisations** (inpatient separations) in South Australia are **potentially preventable**. [SECTION 2.1](#)
  - 3.5% are potentially preventable **acute** conditions—illnesses of short duration.
  - 4.2% are potentially preventable **chronic** conditions—illnesses lasting more than three months.
  - 1.1% are potentially **vaccine-preventable** conditions—illnesses potentially avoided via immunisation.
- Approximately one in 63 (1.6%) public hospital hospitalisations (inpatient separations) in South Australia is linked to at least one of the 16 nationally-agreed, high priority **hospital-acquired complications** which clinicians, managers and others can work together to address and improve patient care. [SECTION 2.2](#)

### TAILORED—“tailors services to meet the diverse and complex needs of individuals”

- More than a third (34.9%) of patients say they were asked whether they had any **cultural or religious beliefs that might affect the way they were treated** in hospital in 2018-19. [SECTION 3.1](#)
- Over four in five (85.0%) of patients say they were ‘always or mostly’ **involved, as much as they wanted**, in making decisions about their treatment and care during their hospital stay in 2018-19. [SECTION 3.2](#)
- Almost the same percentage (84.9%) of patients say they were ‘always or mostly’ **kept informed, as much as they wanted**, about their treatment and care during their hospital stay in 2018-19. [SECTION 3.3](#)

### TIMELY—“optimises health and wellness outcomes, delivering timely and appropriate health care”

- More than two in five (41.6%) people presenting to South Australian major public hospital **emergency departments** were **not ‘seen on time’**—their waiting time to the beginning of their clinical care was outside nationally recognised benchmarks. 58.4% were seen on time. [SECTION 4.1](#)
- Median (mid-point) **wait times for elective surgery** are trending up, to 41 days in 2018-19. [SECTION 4.2](#)
- In 2018-19 the median (mid-point) **ambulance response time** in South Australia for a code 1 dispatch (the ambulance leaving to help someone in an urgent or life-threatening situation) was 10.1 minutes.
  - **Ambulance ‘ramping’**—Over two-thirds (68.9%) of patients arriving by ambulance at metropolitan Adelaide public hospitals are transferred to the facility within 30 minutes of arrival. [SECTION 4.3](#)
- **Outpatient wait times**—the time people wait for an outpatient appointment is around 11 months as at 30 September 2019. [SECTION 4.4](#)

## Summary of identified gaps in the data

The Health Performance Council recognises there is data missing, under-reported and misreported in administrative datasets that can and do impact the analysis in this report, and therefore how well the Council can report on the current indicators of health and wellbeing in South Australian public hospitals. A more detailed data quality statement is provided at the back of this report.

The Health Performance Council has identified several areas where the data is not available to report on the indicators listed in the South Australian Health and Wellbeing Strategy 2020-2025. These data gaps are highlighted throughout this report and summarised here. Data sources referred to in the summary list below are explained in more detail at the back of this report.

### Consumers who felt confident in the safety of their treatment and care during their hospital stay

**DATA GAP** Due to changes in the South Australian Consumer Experience Surveillance System (SACCESS) survey, time series data is not available for this indicator. Sample sizes were not large enough to report data for specific population groups at the individual local health network level.

### Consumer complaints as a proportion of all feedback by specific population group

**DATA GAP** Complaints and feedback data could not be extracted from the Safety Learning System (SLS) for the specific population groups of: Persons aged 65 years and over; Rural and remote residents; and lowest SES residents. There may be significant under-reporting of demographic details to SA Health in the SLS.

### SA Health staff that identify as an Aboriginal or Torres Strait Islander person by local health network

**DATA GAP** The Council continues to encourage SA Health to more consistently and accurately record in its human resources systems where employees identify as an Aboriginal and/or Torres Strait Islander person.

### Consumers were asked whether they had any cultural or religious beliefs that might affect the way they were treated in hospital

**DATA GAP** Sample sizes were not large enough to report data for specific populations by local health network. Specific population data is reported for South Australia overall for this indicator.

### Consumers were involved, as much as they wanted, in making decisions about their treatment and care

**DATA GAP** Due to changes in the SACCESS survey, time series data is not available for this indicator. Sample sizes were not large enough to report data for specific population groups at the individual local health network level. Specific population data is reported for South Australia overall for this indicator.

### Consumers were kept informed, as much as they wanted, about their treatment and care

**DATA GAP** Due to changes in the SACCESS survey, time series data is not available for this indicator. Sample sizes were not large enough to report data for specific population groups at the individual local health network level. Specific population data is reported for South Australia overall for this indicator.

### Hospital elective surgery wait times by specific population group

**DATA GAP** SA Health advises that elective surgery wait time data for culturally and linguistically diverse (CALD) persons is not available.

### Ambulance 'code 1' dispatch-to-arrival times by local health network

**DATA GAP** Data for specific population groups at the individual local health network level is not available for this indicator.

### Ambulance 'ramping'—by local health network

**DATA GAP** The SA Ambulance Service records the time it takes between arrival at the hospital and handover of care to hospital staff in metropolitan hospitals only. Data for regional hospitals is not available.

**DATA GAP** Data for specific population groups at the individual local health network level is not available for this indicator.

### Hospital outpatient wait times by metropolitan specialist outpatient clinics

**DATA GAP** The Council notes the unavailability of outpatient wait times information by specific population groups is a significant data gap in SA Health's published material.

**DATA GAP** The Council has no information on the cumulative total wait that a person might experience—that is, the time they wait for an outpatient consultation *plus* surgery.

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## Introduction

### Purpose of this report

The Health Performance Council produced this statistical indicator report to monitor implementation of the *South Australian Health and Wellbeing Strategy 2020–2025*.

### Background to the strategy

The Department for Health and Wellbeing and the local health networks (together incorporated as SA Health) support South Australians to be as healthy as possible, and protect and improve the health and wellbeing of all South Australians. The quality of the working relationship between these agencies and with consumers and communities is a key driver of the outcomes achieved.

SA Health developed the *South Australian Health and Wellbeing Strategy 2020–2025* to set a new direction of health service delivery. The strategy focuses on the statewide health priorities for South Australia over the next five years and also looks to adopt a longer term perspective (to 2030), to enable the system to be better prepared for the future. The strategy's vision is that "South Australians experience the best health in Australia", envisaging a future where South Australia's health system is: (SA Health 2020, p. 5)

- trusted and highly valued by all South Australians
- recognised and respected for excellence in Australia and around the world
- a preferred work destination for local, interstate and overseas clinicians
- a source of learning and inspiration for health systems and workers everywhere.

The strategy aims to provide the framework for the more detailed service level planning undertaken by each local health network with their communities. The strategy also aims to assist individuals and organisations to focus and work together effectively even while addressing the daily issues the state's complex health system routinely faces.

### Summary framework for consultation

Following a workshop in November 2018, SA Health released the strategy as a 'summary framework for consultation' in February 2019. The summary framework for consultation incorporated workshop feedback, state government election commitments, and priorities from the *Public Health Plan 2019–2024*.

Consultation on the strategy was conducted by SA Health between March and April 2019. SA Health released a summary of feedback document on its website in May 2019.

### Final release

The final strategy was released on 2 March 2020. It is available for download from the SA Health website via the site in the footer below.

There are no targets in the strategy. However, a number of themes emerged from SA Health's consultation on the strategy around working together and forming strong partnerships. Strategy theme priorities are grouped under the banner of TOGETHER into four themes: TRUSTED, TARGETED, TAILORED, and TIMELY.

### Statistical measures presented in this report

The strategy's themes guide the selection and arrangement of the statistical measures presented in this Health Performance Council report. Select summary statistical measures were chosen by the Council for inclusion in this report based on 'possible indicator groups' listed in the summary framework for consultation strategy. Indicators are presented over time and by local health network and specific population group where data availability allows.

This indicator report will be used by the Council to monitor implementation of the strategy. More broadly, this indicator report is intended to act as a "foundation document", presenting select baseline indicators for SA Health to consider in its own regular and publicly available performance monitoring.

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More information about the *South Australian Health and Wellbeing Strategy 2020–2025* is available on the SA Health website at: <https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/about+sa+health/health+and+wellbeing+strategy+2019-2023>



## 1. Strategy goal 1: Trusted

*“The South Australian community trusts the public health sector to respond appropriately whenever they need care, treatment, advice, guidance or support to optimise their health.” (SA Health 2020, p. 12)*

### SA Health’s supporting statement for the strategy’s goal

“Trust in our health system has been eroded in the eyes of the community by a number of serious issues that have occurred in recent years. Errors in chemotherapy prescribing, serious shortcomings in the quality of care that was provided to residents at the Oakden facility, ongoing examples of long waits for service or elective surgery and ambulance ramping at Emergency Departments all contribute to the loss of trust in our system.” (SA Health 2020, p. 12)

### Why SA Health considers this strategy goal as important

“Lack of trust can cause people to delay seeking care, treatment or advice, putting their health and wellbeing at risk. Rebuilding trust by demonstrating improvements for our patients and the community is fundamental to achieving the best outcomes.” (SA Health 2020, p. 12)

### SA Health’s indicators for monitoring

The strategy does not present baseline quantitative measures for monitoring implementation of the trusted goal. It lists five broad indicator groups to measure progress:

1. Emergency department wait times
2. Elective surgery wait times
3. Ambulance ramping indicators
4. Community engagement indicators
5. Patient experience and outcomes indicators.

### The Health Performance Council’s indicators for monitoring

The Health Performance Council proposes four *specific* baseline indicators—with time series data at the local health network level—for monitoring implementation of the strategy’s **trusted** goal:

1. Consumers who felt confident in the safety of their treatment and care during their hospital stay
2. Consumer complaints as a proportion of all feedback
3. Hospital inpatient self-discharges-against-medical-advice
4. SA Health staff that identify as an Aboriginal or Torres Strait Islander person.

Emergency department wait times, elective surgery wait times and ambulance ramping indicators are monitored by the Health Performance Council in CHAPTER 4: TIMELY of this report, starting on page 19.

### 1.1 Consumers who felt confident in the safety of their treatment and care during their hospital stay

The Health Performance Council considers consumer confidence in the safety of hospital care a measure of how perception of a “trusted” health system may be changing over time.

The South Australian Consumer Experience Surveillance System (SACESS) is a survey administered by SA Health to monitor experiences of inpatients of the state’s public hospitals. The SACESS survey was revised in 2018 and, due to changes in the questionnaire, time series monitoring for this measure is not available.

In 2018-19, 90.8% of SACESS survey respondents said they were ‘always or mostly’ confident in the safety of their treatment and care during their hospital stay. The rate was highest in the Eyre and Far North Local Health Network (98.3%) and lowest in the Riverland and Mallee Coorong Local Health Network (85.2%).

Looking at SACESS survey respondents by specific population group in South Australia—the rate of consumer confidence in the safety of hospital care is highest amongst Aboriginal persons (93.2%), culturally and linguistically diverse (CALD) persons and lowest for persons who reside in geographical areas in the lowest quintile (lowest 20%) socio-economic status (SES) areas of South Australia at 90.0%.

**DATA GAP** Due to changes in the SACESS survey, time series data is not available for this indicator. Sample sizes were not large enough to report data for specific population groups at the individual local health network level. Specific population data is reported for South Australia overall for this indicator.

Table 1: Consumers who felt confident in the safety of their treatment and care during their hospital stay, 2018-19

Local health network	Persons who responded ‘always’ or ‘mostly’ confident
Descending order by %	2018-19
1. Eyre and Far North	98.3%
2. Limestone Coast	93.1%
3. Women’s and Children’s	92.3%
4. Southern Adelaide	91.2%
5. Central Adelaide	90.8%
6. Flinders and Upper North	90.7%
7. Yorke and Northern	90.3%
8. Northern Adelaide	89.6%
9. Barossa Hills Fleurieu	86.2%
10. Riverland Mallee Coorong	85.2%
<b>SOUTH AUSTRALIA</b>	<b>90.8%</b>

Source: South Australian Consumer Experience Surveillance System (SACESS) customised extract  
 Percentages exclude answers of ‘can’t remember’, ‘doesn’t apply’, ‘refused’  
 Percentages calculated from weighted data which can result in rounding discrepancies

Table 2: Consumers who felt confident in the safety of their treatment and care during their hospital stay—by specific population group, 2018-19

Specific population group	Persons who responded ‘always’ or ‘mostly’ confident
Descending order by %	South Australia, 2018-19
1. Aboriginal persons	93.2%
2. CALD persons	91.9%
3. Rural and remote residents	91.5%
4. Persons aged 65+ years	90.8%
5. Lowest SES residents	90.0%
<b>ALL PERSONS</b>	<b>90.8%</b>

Source: South Australian Consumer Experience Surveillance System (SACESS) customised extract  
 Percentages exclude answers of ‘can’t remember’, ‘doesn’t apply’, ‘refused’  
 Percentages calculated from weighted data which can result in rounding discrepancies

## 1.2 Consumer complaints as a proportion of all feedback

The Health Performance Council considers SA Health-recorded consumer feedback directed at public health services a measure of how perception of a “trusted” health system may be changing over time.

SA Health’s Safety Learning System (SLS) records details of consumer feedback received from members of the public who have received health care—including emergency, admitted, outpatient and rehabilitation—either as consumers themselves or on behalf of family and friends. Not all feedback is negative, and SA Health categorises SLS feedback as complaints, compliments, suggestions or advice. The Health Performance Council puts complaints data into context here by expressing it as a percentage of all SA Health-recorded feedback received by local health network of the health service.

During 2018-19, a total of 12,684 instances of feedback—including complaints, compliments, suggestions and advice—were recorded as received (and not rejected) by SA Health in relation to public health services. Of this total feedback, over half (54.0%) is classified by SA Health as complaints. The complaints-to-all-feedback trend has been down since the time series began.

The complaints-to-all-feedback rate recorded in 2018-19 varies by local health network, from 83.0% for health services in the Central Adelaide Local Health Network down to 35.0% for health services in rural and regional South Australia. Individual regional local health network data was not available at the time of preparing this report.

Table 3: Consumer complaints as a proportion of all feedback by local health network, 2010-11 to 2018-19

LOCAL HEALTH NETWORK Descending order by %	Central Adelaide	Women’s and Children’s	Southern Adelaide	SA Ambulance Service	Northern Adelaide	Country Health SA*	TOTAL^
TREND x-axis: 2010-11 to 2018-19 y-axis: 0% to 100%							
<b>2018-19 complaints<sup>1</sup> as a proportion of all feedback (%)</b>	<b>83.0%</b>	<b>74.5%</b>	<b>63.9%</b>	<b>55.0%</b>	<b>42.5%</b>	<b>35.0%</b>	<b>54.0%</b>
2018-19 all feedback <sup>2</sup> (no.)	2,705	615	1,825	746	2,584	4,168	12,684

Source: SA Health Safety Learning System (SLS) customised extract

\* Regional local health network data not available

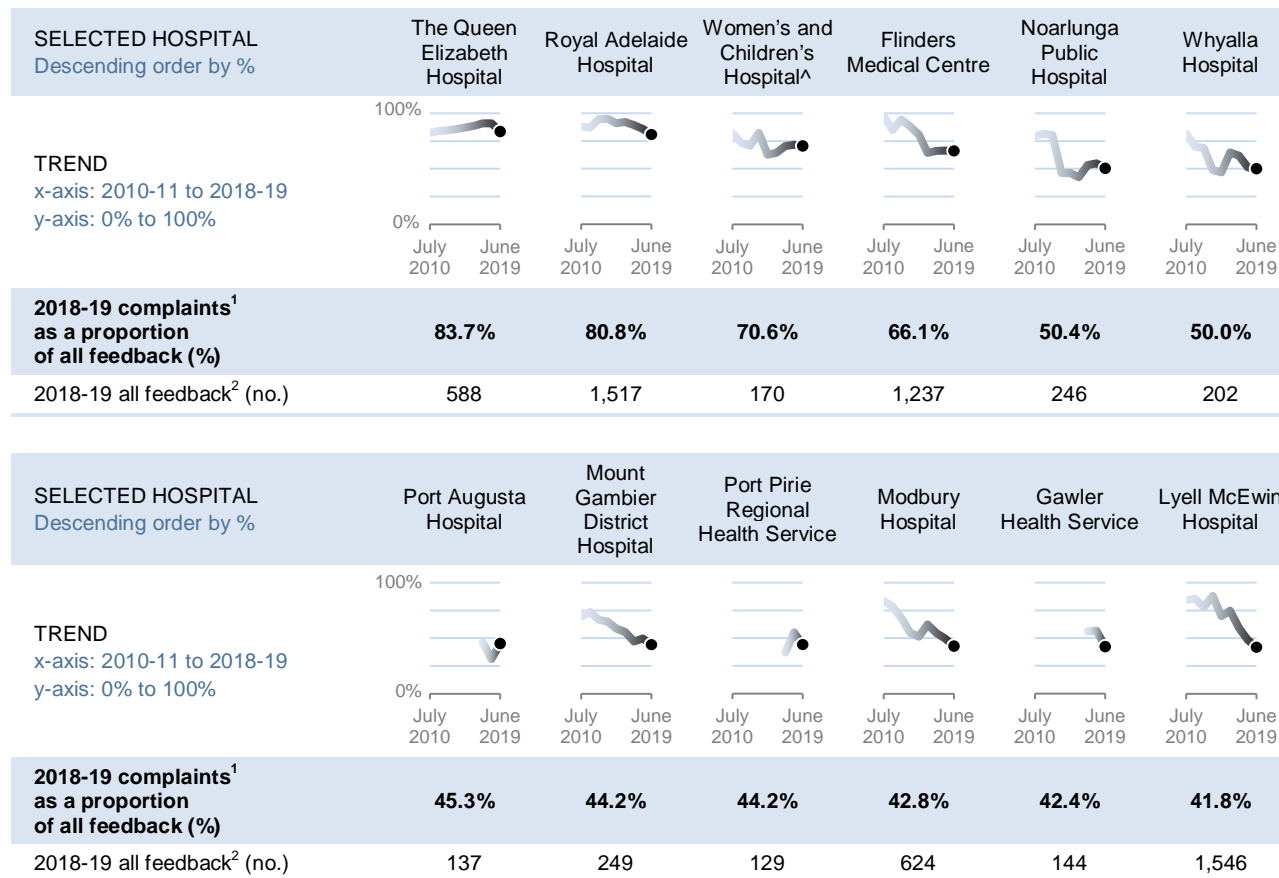
^ Complaints and feedback data for Central Office not listed separately here as volume of data insufficient to support reporting meaningful results. However, Central Office data is included in the total.

1. Instances of feedback recorded as received (and not rejected) and classified by SA Health as a complaint as a proportion of all feedback (see 2. below) during 2018-19.

2. Number of instances of feedback—including complaints, compliments, suggestions and advice—recorded as received (and not rejected) by SA Health during 2018-19.

To provide detail of differences between services in metropolitan Adelaide and Country SA, Table 4 presents complaints-to-all-feedback rates by selected major public hospitals in South Australia (where data allows).

Table 4: Consumer complaints as a proportion of all feedback by selected public hospital, 2010-11 to 2018-19



Source: SA Health Safety Learning System (SLS) customised extract

Only major hospital listed here. Data for Berri Hospital, Port Lincoln Health Service and Repatriation General Hospital not listed as volume of data insufficient to support publishing meaningful results. However, these hospitals are included in the total. Limited volume of data only supports reporting partial time series for some hospitals.

<sup>^</sup> Women's and Babies Services at the Women's and Children's Hospital.

1. Instances of feedback recorded as received (and not rejected) and classified by SA Health as a complaint as a proportion of all feedback (see 2.) during 2018-19.
2. Number of instances of feedback—including complaints, compliments, suggestions and advice—recorded as received (and not rejected) by SA Health during 2018-19.

SA Health’s Safety Learning System (SLS) records select demographic details of the consumer referred to in the feedback—either when provided as consumers themselves or on their behalf provided by a family member, carer or friend.

The complaints-to-all-feedback rate recorded in 2018-19 is much higher for select specific population groups reportable out of the SLS—ranging from 87.8% for persons living with a disability to 97.2% for culturally and linguistically diverse (CALD) persons—compared to the all persons benchmark (54.0%).

**DATA GAP** Complaints and feedback data could not be extracted from the SLS for the specific population groups of: Persons aged 65 years and over; Rural and remote residents; and lowest SES residents. There may be significant under-reporting of demographic details to SA Health in the SLS.

Table 5: Consumer complaints as a proportion of all feedback by specific population group, 2018-19

Specific population group	Complaints as a proportion of all feedback <sup>1</sup>	All feedback <sup>2</sup>
Descending order by %	South Australia, 2018-19 (%)	South Australia, 2018-19 (no.)
1. CALD persons	97.2%	72
2. Aboriginal persons	93.1%	29
3. Persons living with a disability	87.8%	221
<b>ALL PERSONS</b>	<b>54.0%</b>	<b>12,684</b>

Source: SA Health Safety Learning System (SLS) customised extract

1. Instances of feedback recorded as received (and not rejected) and classified by SA Health as a complaint as a proportion of all feedback (see 2.) during 2018-19.
2. Number of instances of feedback—including complaints, compliments, suggestions and advice—recorded as received (and not rejected) by SA Health during 2018-19.

### 1.3 Hospital inpatient self-discharges-against-medical-advice

The Health Performance Council considers rates of hospital inpatient self-discharge-against-medical-advice a measure of how health consumer perception of a “trusted” health system may be changing over time. Leaving the hospital earlier than medically advisable may be an indicator that the person was not satisfied with their experience of clinical care. It is also a safety issue—exposing the person to risks of an inadequately treated medical problem, returning home with incomplete discharge advice and could result in the need for re-admission to hospital.

Overall, the rate of hospital inpatient self-discharge-against-medical-advice is relatively low. The rate varies across specific population groups, with Aboriginal persons and persons who live in the lowest socio-economic areas recording relatively higher rates (2.4% and 1.1%, respectively). Rates for 2018-19 also vary across local health networks (LHNs), from 1.8% in the Flinders and Upper North LHN down to 0.2% for the Women’s and Children’s Health Network.

Table 6: Hospital self-discharge-against-medical-advice rates by local health network and population group, 2008-09 to 2018-19

LOCAL HEALTH NETWORK Descending order by all persons %	Flinders and Upper North	Eyre and Far North	Yorke and Northern	Riverland Mallee Coorong	Northern Adelaide	Southern Adelaide	Limestone Coast	Central Adelaide	Barossa Hills Fleurieu	Women’s and Children’s	TOTAL <sup>^</sup>
TREND x-axis: 2008-09 to 2018-19 y-axis: 0% to 3%											
<b>2018-19 self-discharge rate (%)</b>											
<b>All persons</b>	<b>1.8%</b>	<b>1.4%</b>	<b>1.2%</b>	<b>1.1%</b>	<b>1.0%</b>	<b>0.9%</b>	<b>0.8%</b>	<b>0.7%</b>	<b>0.3%</b>	<b>0.2%</b>	<b>0.8%</b>
Specific population group (sorted descending on total)											
1. Aboriginal persons	2.1%	3.5%	n.p.	n.p.	2.9%	2.9%	n.p.	2.5%	n.p.	n.p.	2.4%
2. Lowest SES residents	1.8%	n.p.	1.4%	1.4%	1.2%	1.0%	n.p.	0.9%	n.p.	n.p.	1.1%
3. Rural and remote residents	1.7%	1.4%	1.2%	1.1%	0.8%	0.8%	0.8%	0.7%	0.4%	n.p.	0.9%
4. CALD persons	n.p.	n.p.	n.p.	n.p.	0.8%	0.4%	n.p.	0.3%	n.p.	n.p.	0.4%
5. Persons aged 65+ years	n.p.	n.p.	n.p.	n.p.	0.3%	0.4%	n.p.	0.2%	n.p.	—	0.3%
<b>2018-19 hospitalisations (no.)</b>	<b>18,937</b>	<b>10,106</b>	<b>19,107</b>	<b>19,826</b>	<b>66,269</b>	<b>98,366</b>	<b>15,936</b>	<b>136,523</b>	<b>30,496</b>	<b>33,627</b>	<b>449,391<sup>^</sup></b>

Source: SA Health Integrated South Australian Activity Collection (ISAAC) customised extract. Totals may not match exactly with nationally reported figures due to timing differences in extraction. x.x% Value is in top 10 of table cells

<sup>^</sup> South Australia total includes Southern Districts War Memorial Hospital.

n.p. Not published. Volume of data at the local health network level insufficient to support publishing meaningful results.

#### 1.4 SA Health staff that identify as an Aboriginal or Torres Strait Islander person

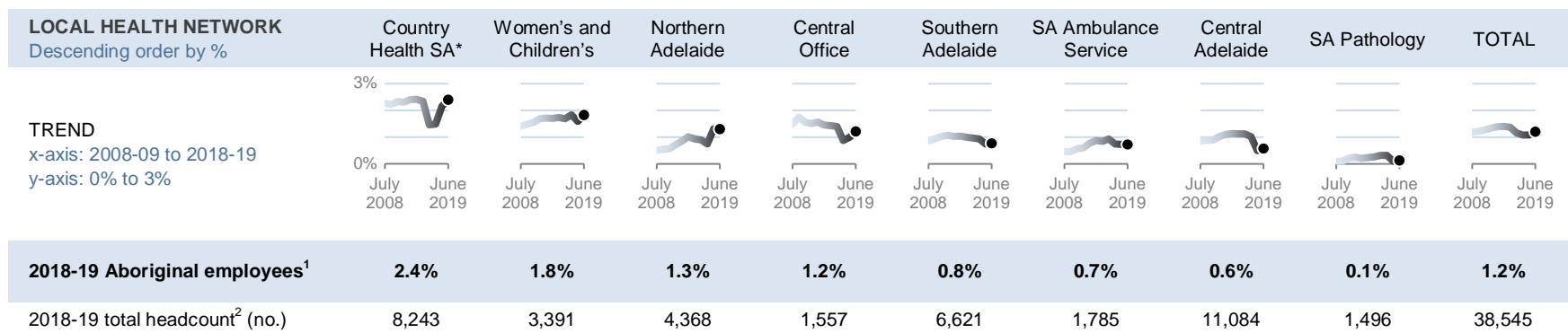
The Health Performance Council considers Aboriginal workforce participation a measure of trust in the cultural competence of SA Health to deliver appropriate healthcare to specific population groups in our community.

In this report, the Health Performance Council respectfully uses the term ‘Aboriginal’, rather than ‘Indigenous’, to refer to people who identify as Aboriginal, Torres Strait Islander, or both. The Council recognises Aboriginal and Torres Strait Islander people as two separate groups. However, this document refers to Aboriginal persons in recognition that Aboriginal people are the original inhabitants of South Australia. The Council also acknowledges the complexity and diversity of the Aboriginal communities of South Australia, recognising each has its own beliefs and practice.

As at the 2016 Census, the Aboriginal population of South Australia was 34,185 people, representing 2.0% of the state’s population of 1.7 million people (HPC 2019). In comparison, 1.2% of the SA Health workforce (headcount) identified as Aboriginal in 2018-19. The rate varies by local health network and divisions of SA Health—from 2.4% across the regional local health networks in aggregate, down to 0.1% recorded for SA Pathology.

**DATA GAP** The Council continues to encourage SA Health to more consistently and accurately record in its human resources systems where employees identify as an Aboriginal and/or Torres Strait Islander person.

Table 7: SA Health staff that identify as an Aboriginal or Torres Strait Islander person by local health network, 2008-09 to 2018-19



Source: SA Health Complete Human Resources Information System (CHRIS) customised extract

1. SA Health employees who have recorded on the SA Health payroll system that they self-identify as an Aboriginal and/or Torres Strait Islander person, as a proportion of headcount (see 2.) in 2018-19
2. The number of employee records per month for the 12 month period (based on employee commencement date and termination date), averaged across the 2018-19 financial year

\* Regional local health network data not available prior to 1 July 2019

Individual regional local health network data is not available prior to 1 July 2019. Table 7 presents Aboriginal workforce participation by regional local health network in the month of July 2019.

Table 8: SA Health staff that identify as an Aboriginal or Torres Strait Islander person by regional local health network, July 2019

Regional local health network	Aboriginal or Torres Strait Islander employees	Total headcount
Descending order by %	July 2019 (%)	July 2019 (no.)
1. Flinders and Upper North	3.8%	824
2. Eyre and Far North	2.5%	971
3. Barossa Hills Fleurieu	2.2%	2,094
3. Riverland Mallee Coorong	2.2%	1,468
5. Limestone Coast	2.1%	1,315
6. Yorke and Northern	2.0%	1,517
<b>REGIONAL TOTAL</b>	<b>2.3%</b>	<b>8,189</b>

Source: SA Health Complete Human Resources Information System (CHRIS) customised extract



## 2. Strategy goal 2: Targeted

*“South Australia’s health system, guided by evidence-based best practice, provides services and programs that meet population needs and disease prevalence, addressing service gaps and the variation in experience, and health outcomes” (SA Health 2020, p. 13)*

### SA Health’s supporting statement for the strategy’s goal

“To achieve excellence, health systems need to respond to emerging challenges, remain at the forefront of relevant science and evidence, and be aware of changes in the quality of patient outcomes and experiences. We must be able to respond quickly and appropriately to the needs of individuals and families, knowing where, when and how to support the most vulnerable in our community.” (SA Health 2020, p. 13)

### Why SA Health considers this strategy goal as important

“The ability to continuously incorporate new evidence into practice and adopt emerging technologies will allow the health system to improve the overall health and wellbeing of the population while addressing the very specific needs of those population groups who currently experience poorer than average health outcomes.” (SA Health 2020, p. 14)

### SA Health’s indicators for monitoring

The strategy does not present baseline quantitative measures for monitoring implementation of the targeted goal. It lists seven broad indicator groups to measure progress:

1. Access to services and treatment
2. Equity in service provision
3. Risk factors, healthy life expectancy and the prevalence of chronic disease
4. Hospital utilisation and potentially preventable hospitalisation
5. Quality and safety
6. Patient experience and outcomes
7. Timely availability of clinical information indicators.

### The Health Performance Council’s indicators for monitoring

The Health Performance Council proposes two *specific* baseline indicators—with time series data at the local health network level—for monitoring implementation of the strategy’s **targeted** goal:

1. Potentially preventable hospitalisations—by condition
2. Hospital acquired complications.

## 2.1 Potentially preventable hospitalisations

The Health Performance Council considers rates of potentially preventable hospitalisations a measure of how well health services are targeted. The Council reports on hotspots of potentially preventable hospitalisation in South Australia's public hospitals, available from our website at <https://www.hpcs.com.au/statistics>.

People can attend hospital for reasons that could have been avoided with preventative health care—by GPs, dentists or in other community health care settings—or with broader, public health interventions. In some cases, these hospitalisations (inpatient separations) should not have occurred at all (eg. vaccine-preventable conditions). In other cases, good primary care, community health care or public health can potentially reduce the rate of admissions for select acute or chronic conditions. A list of potentially preventable hospitalisations is provided in the definitions section of this report.

### All conditions

In 2018-19, around one out of every 11 (8.8%) of the 449,391 public hospital hospitalisations (inpatient separations) in South Australia were potentially preventable. The rate varies by population group—highest for persons aged 65 years and over. The rate also varies across the local health network (LHNs), from 10.8% in the Northern Adelaide LHN to 7.5% in the Central Adelaide LHN.

Table 9: Potentially preventable hospitalisation rates by local health network and population group, 2008-09 to 2018-19

LOCAL HEALTH NETWORK Descending order by all persons %	Northern Adelaide	Limestone Coast	Riverland Mallee Coorong	Eyre and Far North	Yorke and Northern	Women's and Children's	Barossa Hills Fleurieu	Flinders and Upper North	Southern Adelaide	Central Adelaide	TOTAL <sup>^</sup>
<b>TREND</b> x-axis: 2008-09 to 2018-19 y-axis: 0% to 15%											
<b>2018-19 potentially preventable hospitalisations (%)</b>											
<b>All persons</b>	<b>10.8%</b>	<b>10.6%</b>	<b>10.3%</b>	<b>10.2%</b>	<b>10.1%</b>	<b>9.5%</b>	<b>9.2%</b>	<b>8.0%</b>	<b>7.9%</b>	<b>7.5%</b>	<b>8.8%</b>
<b>Specific population group (sorted descending on total)</b>											
1. Persons aged 65+ years	13.2%	11.4%	11.2%	11.5%	10.5%	—	10.6%	8.7%	9.0%	9.1%	10.1%
2. Rural and remote residents	9.3%	10.6%	10.4%	10.1%	10.1%	9.3%	9.6%	7.8%	7.0%	7.0%	9.1%
3. Lowest SES residents	11.1%	10.6%	10.1%	15.9%	10.1%	11.5%	4.9%	7.8%	8.1%	6.8%	9.0%
4. Aboriginal persons	12.7%	6.3%	13.5%	8.9%	6.6%	10.1%	9.0%	5.6%	11.0%	6.4%	8.1%
5. CALD persons	9.0%	12.1%	11.6%	8.7%	8.5%	5.6%	8.2%	12.7%	5.9%	7.7%	7.6%
<b>2018-19 potentially preventable hospitalisations (no.)</b>	<b>7,148</b>	<b>1,689</b>	<b>2,051</b>	<b>1,026</b>	<b>1,939</b>	<b>3,204</b>	<b>2,801</b>	<b>1,512</b>	<b>7,730</b>	<b>10,273</b>	<b>39,385<sup>^</sup></b>

Source: SA Health Integrated South Australian Activity Collection (ISAAC) customised extract. Totals may not match exactly with nationally reported figures due to timing differences in extraction. x.x% Value is in top 10 of table cells

<sup>^</sup> South Australia total includes Southern Districts War Memorial Hospital.

Conditions for which hospitalisation is considered potentially preventable is divided across three broad categories:

Acute—Conditions that theoretically would not result in hospitalisation if adequate and timely care (usually non-hospital) was received.

Chronic—Conditions that theoretically would not result in hospitalisation through behaviour modification and lifestyle changes, or better out-of-hospital management.

Vaccine-preventable—Diseases that can be prevented by vaccination such as pneumonia and influenza and other vaccine-preventable conditions.

### Acute conditions

In 2018-19, 3.5% of public hospital hospitalisations (inpatient separations) in South Australia were the result of potentially preventable **acute** conditions (eg. cellulitis, ear nose throat infections, urinary tract infections). Aboriginal persons, persons who reside in the bottom 20% of socio-economic areas of South Australia and rural and remote residents are disproportionately impacted. These specific population groups are more likely to present at hospitals in the Women’s and Children’s Health Network, the Eyre and Far North Local Health Network and the Northern Adelaide Local Health Network for potentially preventable acute conditions.

Table 10: Potentially preventable hospitalisation rates by local health network and population group—**acute conditions**, 2018-19

Local health network	Persons aged 65+ years	Rural and remote residents	Lowest SES residents	Aboriginal persons	CALD persons	All persons
Descending order by all persons %						
1. Women’s and Children’s	–	6.4%	7.7%	6.5%	3.0%	<b>6.0%</b>
2. Eyre and Far North	3.6%	4.8%	6.2%	4.7%	2.7%	<b>4.8%</b>
3. Northern Adelaide	3.8%	3.8%	4.4%	5.9%	2.8%	<b>4.2%</b>
3. Yorke and Northern	3.6%	4.2%	4.4%	3.5%	2.3%	<b>4.2%</b>
5. Limestone Coast	2.9%	4.0%	3.7%	2.9%	4.1%	<b>4.1%</b>
6. Riverland Mallee Coorong	3.1%	4.0%	3.6%	3.8%	2.3%	<b>4.0%</b>
7. Barossa Hills Fleurieu	3.1%	3.6%	3.3%	5.0%	2.1%	<b>3.6%</b>
8. Southern Adelaide	2.6%	2.5%	3.3%	4.4%	1.6%	<b>3.2%</b>
9. Flinders and Upper North	2.2%	2.9%	2.8%	2.0%	3.6%	<b>3.0%</b>
10. Central Adelaide	2.5%	2.4%	2.1%	2.1%	2.2%	<b>2.7%</b>
TOTAL <sup>^</sup>	2.9%	3.6%	3.6%	3.4%	2.3%	<b>3.5%</b>

Source: SA Health Integrated South Australian Activity Collection (ISAAC) customised extract.

x.x% Value is in top 10 of table cells

<sup>^</sup> Total includes Southern Districts War Memorial Hospital.

### Chronic conditions

In 2018-19, 4.2% of public hospital hospitalisations (inpatient separations) in South Australia were the result of potentially preventable **chronic** conditions (eg. asthma, hypertension, rheumatic heart disease). The rate varies by population group—with persons aged 65 years or over disproportionately impacted. This specific population group is more likely to present at hospitals in the Limestone Coast, Riverland Mallee Coorong and Northern Adelaide for potentially preventable chronic conditions.

Table 11: Potentially preventable hospitalisation rates by local health network and population group—**chronic conditions**, 2018-19

Local health network	Persons aged 65+ years	Rural and remote residents	Lowest SES residents	Aboriginal persons	CALD persons	All persons
Descending order by all persons %						
1. Limestone Coast	7.9%	6.0%	6.3%	3.2%	6.0%	5.9%
2. Riverland Mallee Coorong	7.1%	5.5%	5.4%	8.7%	7.3%	5.4%
3. Northern Adelaide	7.8%	4.4%	5.3%	5.4%	4.1%	5.2%
4. Yorke and Northern	6.2%	5.1%	5.0%	2.8%	5.0%	5.1%
5. Barossa Hills Fleurieu	6.7%	5.3%	1.2%	3.5%	5.3%	4.9%
5. Eyre and Far North	7.4%	4.9%	8.7%	3.8%	5.8%	4.9%
7. Flinders and Upper North	5.7%	4.2%	4.3%	3.0%	7.7%	4.3%
8. Central Adelaide	5.5%	3.7%	3.8%	2.9%	4.1%	3.9%
9. Southern Adelaide	5.4%	3.7%	4.0%	4.9%	3.1%	3.7%
10. Women's and Children's	–	1.8%	2.7%	2.1%	0.6%	2.3%
TOTAL^	6.1%	4.7%	4.5%	3.6%	3.9%	4.2%

Source: SA Health Integrated South Australian Activity Collection (ISAAC) customised extract

x.x% Value is in top 10 of table cells

^ Total includes Southern Districts War Memorial Hospital.

### Vaccine-preventable conditions

In 2018-19, 1.1% of public hospital hospitalisations (inpatient separations) in South Australia were the result of potentially **vaccine-preventable** conditions (eg. influenza, tetanus, pertussis/whooping cough). The rate varies by population group—with culturally and linguistically diverse persons and Aboriginal persons disproportionately impacted. These specific population groups are more likely to present at hospitals in the Northern Adelaide, Women's and Children's and Central Adelaide Local Health Networks.

Table 12: Potentially preventable hospitalisation rates by local health network and population group—**vaccine-preventable conditions**, 2018-19

Local health network	Persons aged 65+ years	Rural and remote residents	Lowest SES residents	Aboriginal persons	CALD persons	All persons
Descending order by all persons %						
1. Northern Adelaide	1.9%	1.2%	1.6%	1.6%	2.2%	1.6%
2. Women's and Children's	–	1.2%	1.3%	1.6%	2.0%	1.3%
3. Central Adelaide	1.3%	1.1%	1.2%	1.7%	1.5%	1.1%
3. Southern Adelaide	1.2%	0.9%	0.9%	2.1%	1.2%	1.1%
5. Riverland Mallee Coorong	1.2%	1.0%	1.2%	1.2%	2.1%	1.0%
6. Flinders and Upper North	1.0%	0.8%	0.8%	0.7%	1.6%	0.9%
7. Barossa Hills Fleurieu	0.9%	0.8%	0.4%	n.p.	0.9%	0.8%
7. Yorke and Northern	0.8%	0.8%	0.8%	n.p.	1.5%	0.8%
9. Limestone Coast	0.8%	0.7%	0.6%	n.p.	2.2%	0.7%
10. Eyre and Far North	0.7%	0.6%	n.p.	0.5%	n.p.	0.6%
TOTAL^	1.3%	0.9%	1.1%	1.3%	1.6%	1.1%

Source: SA Health Integrated South Australian Activity Collection (ISAAC) customised extract

x.x% Value is in top 10 of table cells

^ Total includes Southern Districts War Memorial Hospital.

n.p. not published. Small cell data has been suppressed to protect privacy of individuals

## 2.2 Hospital acquired complications

The Health Performance Council considers rates of hospital acquired complications a measure of how well safety and quality in health services is targeted. In this section, the Council uses nationally-agreed definitions of hospital acquired complications, acknowledging that they do not incorporate all conditions that arise during the course of an admission.

A hospital-acquired complication (HAC) refers here to a complication for which clinical risk mitigation strategies may reduce (but not necessarily eliminate) the risk of that complication occurring. A nationally-agreed list of 16 high priority HACs was developed through a comprehensive process with clinicians, managers and others to work together to address and improve patient care (ACSQHC 2019). The list of 16 HACs applied in this section is provided in the definitions section of this report.

Overall, the rate of hospital acquired complications is relatively low. The rate varies across specific population groups, with persons aged 65 years or over and culturally and linguistically diverse (CALD) persons recording higher-than-average rates (2.3% and 1.8%, respectively). Rates for 2018-19 also vary across local health networks (LHNs), from 2.3% in the Central Adelaide LHN down to 0.3% in the Riverland Mallee Coorong LHN.

Table 13: Hospital acquired complication rates by local health network and population group, 2008-09 to 2018-19

LOCAL HEALTH NETWORK Descending order by all persons %	Central Adelaide	Southern Adelaide	Northern Adelaide	Limestone Coast	Women's and Children's	Barossa Hills Fleurieu	Flinders and Upper North	Yorke and Northern	Eyre and Far North	Riverland Mallee Coorong	TOTAL
TREND x-axis: 2008-09 to 2018-19 y-axis: 0% to 4%											
2018-19 hospital acquired complication rate (%)											
<b>All persons</b>	<b>2.3%</b>	<b>2.2%</b>	<b>1.4%</b>	<b>1.0%</b>	<b>0.9%</b>	<b>0.5%</b>	<b>0.4%</b>	<b>0.4%</b>	<b>0.3%</b>	<b>0.3%</b>	<b>1.6%</b>
Specific population group (sorted descending on total)											
1. Persons aged 65+ years	3.2%	3.1%	2.1%	1.5%	–	0.7%	n.p.	n.p.	n.p.	n.p.	2.3%
2. CALD persons	2.2%	2.1%	1.2%	n.p.	2.4%	n.p.	n.p.	n.p.	n.p.	n.p.	1.8%
3. Lowest SES residents	2.4%	1.9%	1.2%	n.p.	0.8%	n.p.	0.4%	n.p.	n.p.	n.p.	1.3%
4. Rural and remote residents	3.6%	3.7%	1.8%	1.0%	n.p.	0.5%	0.4%	0.4%	n.p.	0.3%	1.2%
5. Aboriginal persons	1.2%	3.1%	n.p.	–	n.p.	n.p.	n.p.	n.p.	n.p.	n.p.	0.8%
2018-19 hospitalisations with at least one of the 16 nationally-agreed hospital acquired complications (no.)	3,082	2,143	902	159	309	158	76	70	31	51	6,981

Source: SA Health Integrated South Australian Activity Collection (ISAAC) customised extract. Totals may not line up with nationally reported figures due to timing differences in extraction. x.x% Value is in top 10 of table cells  
n.p. Not published. Volume of data at the local health network level insufficient to support publishing meaningful results.

### 3. Strategy goal 3: Tailored

*“South Australia’s health workforce are informed by evidence and tailor the care, treatment, advice, guidance and support they offer in accordance with the expressed wishes of the individual, family and community with whom they are working.” (SA Health 2020, p. 15)*

#### SA Health’s supporting statement for the strategy’s goal

“Rapid uptake by the community of advances in digital technology across a range of service industries including banking and air travel has generated an appetite in consumers for greater flexibility, convenience and control over their interactions with service providers. Tapping into this preference offers many opportunities to drive improvements in the service provided and as a consequence, improvements in experience and outcomes for patients.” (SA Health 2020, p. 15)

#### Why SA Health considers this strategy goal as important

“For the health workforce, recognising health is an asset that helps people live good lives, while understanding the impact care and treatment can have on achieving that must be carefully weighed against the benefits. Side effects, treatment time and the implication for patient goals provide the lens through which these decisions can be considered.

“Patient experience and outcomes are improved when they can operate as equal and responsible partners in managing their health and wellbeing. Ensuring people are supported to do that is an important part of integrating informed, patient-led decision-making into the health system.” (SA Health 2020, p. 15)

#### SA Health’s indicators for monitoring

The strategy does not present baseline quantitative measures for monitoring implementation of the tailored goal. It lists four broad indicator groups to measure progress:

1. Indicators for access, equity, and patient experience
2. Outcomes for priority populations
3. Uptake of evidence-based technology within service models
4. Wait times for services.

#### The Health Performance Council’s indicators for monitoring

The Health Performance Council proposes three *specific* baseline indicators—with time series data at the local health network level—for monitoring implementation of the strategy’s **tailored** goal:

1. Consumers who were asked about their cultural or religious requirements during their hospital stay
2. Consumers who were involved, as much as they wanted to be, in decisions about their hospital care or treatment
3. Consumers who were kept informed as much as they wanted about their treatment and care.

### 3.1 Consumers who were asked about their cultural or religious requirements during their hospital stay

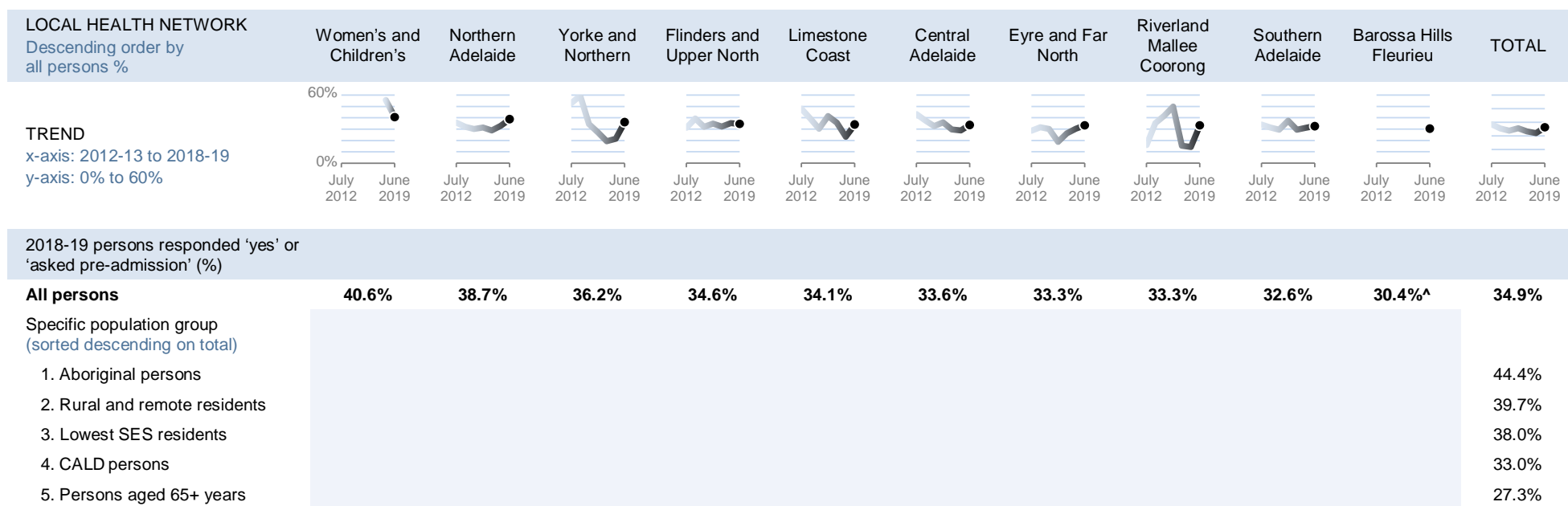
The Health Performance Council considers consumers being asked how their cultural or religious beliefs might affect their hospital treatment a measure of how perception of a “tailored” health system may be changing over time. For this measure, the Council has used results from the South Australian Consumer Experience Surveillance System (SACESS)—a survey administered by SA Health to monitor experiences of inpatients of the state’s public hospitals.

In 2018-19, 34.9% of SACESS survey respondents said they were asked whether they had any cultural or religious beliefs that might affect the way they were treated in hospital. The rate was highest in the Women’s and Children’s Health Network (40.6%) and lowest in the Barossa Hills Fleurieu Local Health Network (30.4%^). Overall, the state trend has remained relatively stable, fluctuating between a high of 38.2% in 2012-13 and a low of 29.4% in 2017-18.

Sample sizes are too small to support reporting this measure with statistical confidence for specific population groups by individual local health network. However, state results are available. The proportion of consumers asked whether they had any cultural or religious beliefs that might affect the way they were treated in hospital is highest for Aboriginal persons (44.4%) and lowest for persons aged 65 years or over (27.3%).

**DATA GAP** Sample sizes were not large enough to report data for specific populations by LHN. Specific population data is reported for South Australia overall for this indicator.

Table 14: Consumers were asked whether they had any cultural or religious beliefs that might affect the way they were treated in hospital, 2012-13 to 2018-19



Source: South Australian Consumer Experience Surveillance System (SACESS) customised extract. Complete times series not available for all local health networks.

Percentages exclude answers of ‘can’t remember’, ‘doesn’t apply’, ‘refused’

Percentages calculated from weighted data which can result in rounding discrepancies

^ Relative standard error is between 25% and 50%. Please treat the estimate with caution.



### 3.2 Consumers who were involved, as much as they wanted to be, in decisions about their hospital care or treatment

The Health Performance Council considers consumer involvement in their hospital care a measure of how perception of a “tailored” health system may be changing over time.

The South Australian Consumer Experience Surveillance System (SACESS) is a survey administered by SA Health to monitor experiences of inpatients of the state’s public hospitals. The SACESS survey was revised in 2018 and, due to changes in the questionnaire, time series monitoring for this measure is not available.

In 2018-19, 85.0% of SACESS survey respondents said they were ‘always or mostly’ involved, as much as they wanted, in making decisions about their treatment and care during their hospital stay. The rate was highest in the Women’s and Children’s Health Network (94.3%) and lowest in the Riverland and Mallee Coorong Local Health Network (83.3%).

Looking at SACESS survey respondents by specific population group in South Australia—the rate of consumer involvement in hospital care is highest amongst rural and remote residents (87.1%) and lowest for persons aged 65 years or over at 82.1%.

**DATA GAP** Due to changes in the SACESS survey, time series data is not available for this indicator. Sample sizes were not large enough to report data for specific population groups at the individual local health network level. Specific population data is reported for South Australia overall for this indicator.

Table 15: Consumers were involved, as much as they wanted, in making decisions about their treatment and care, 2018-19

Local health network	Persons who responded ‘always’ or ‘mostly’ involved
Descending order by %	2018-19
1. Women’s and Children’s	94.3%
2. Eyre and Far North	93.1%
3. Flinders and Upper North	87.2%
4. Limestone Coast	86.1%
5. Barossa Hills Fleurieu	85.7%
6. Central Adelaide	85.0%
7. Yorke and Northern	84.5%
8. Southern Adelaide	83.7%
9. Northern Adelaide	83.5%
10. Riverland Mallee Coorong	83.3%
<b>SOUTH AUSTRALIA</b>	<b>85.0%</b>

Source: South Australian Consumer Experience Surveillance System (SACESS) customised extract  
 Percentages exclude answers of ‘can’t remember’, ‘doesn’t apply’, ‘refused’  
 Percentages calculated from weighted data which can result in rounding discrepancies

Table 16: Consumers were involved, as much as they wanted, in making decisions about their treatment and care—by specific population group, 2018-19

Specific population group	Persons who responded ‘always’ or ‘mostly’ involved
Descending order by %	South Australia, 2018-19
1. Rural and remote residents	87.1%
2. Aboriginal persons	86.3%
3. CALD persons	86.0%
4. Lowest SES residents	84.5%
5. Persons aged 65+ years	82.1%
<b>ALL PERSONS</b>	<b>85.0%</b>

Source: South Australian Consumer Experience Surveillance System (SACESS) customised extract  
 Percentages exclude answers of ‘can’t remember’, ‘doesn’t apply’, ‘refused’  
 Percentages calculated from weighted data which can result in rounding discrepancies



### 3.3 Consumers who were kept informed as much as they wanted about their treatment and care

The Health Performance Council considers consumers being kept informed about their hospital care a measure of how perception of a “tailored” health system may be changing over time.

The South Australian Consumer Experience Surveillance System (SACESS) is a survey administered by SA Health to monitor experiences of inpatients of the state’s public hospitals. The SACESS survey was revised in 2018 and, due to changes in the questionnaire, time series monitoring for this measure is not available.

In 2018-19, 84.9% of SACESS survey respondents said they were ‘always or mostly’ kept informed, as much as they wanted, about their treatment and care during their hospital stay. The rate was highest in the Eyre and Far North Local Health Network (91.7%) and lowest in the Riverland and Mallee Coorong Local Health Network (81.8%).

Looking at SACESS survey respondents by specific population group in South Australia—the rate of consumers kept informed about their hospital care is highest amongst culturally and linguistically diverse (CALD) persons (87.6%) and lowest for persons aged 65 years or over at 84.6%.

**DATA GAP** Due to changes in the SACESS survey, time series data is not available for this indicator. Sample sizes were not large enough to report data for specific population groups at the individual local health network level. Specific population data is reported for South Australia overall for this indicator.

Table 17: Consumers were kept informed, as much as they wanted, about their treatment and care, 2018-19

Local health network	Persons who responded ‘always’ or ‘mostly’ informed
Descending order by %	2018-19
1. Eyre and Far North	91.7%
2. Women’s and Children’s Health	91.4%
3. Limestone Coast	88.8%
4. Flinders and Upper North	86.7%
5. Yorke and Northern	86.1%
6. Barossa Hills Fleurieu	85.7%
7. Central Adelaide	84.5%
8. Northern Adelaide	84.0%
9. Southern Adelaide	83.8%
10. Riverland Mallee Coorong	81.8%
<b>SOUTH AUSTRALIA</b>	<b>84.9%</b>

Source: South Australian Consumer Experience Surveillance System (SACESS) customised extract  
 Percentages exclude answers of ‘can’t remember’, ‘doesn’t apply’, ‘refused’  
 Percentages calculated from weighted data which can result in rounding discrepancies

Table 18: Consumers were kept informed, as much as they wanted, about their treatment and care—by specific population group, 2018-19

Specific population group	Persons who responded ‘always’ or ‘mostly’ informed
Descending order by %	South Australia, 2018-19
1. CALD persons	87.6%
1. Rural and remote residents	87.6%
3. Aboriginal persons	85.3%
4. Lowest SES residents	85.1%
5. Persons aged 65+ years	84.6%
<b>ALL PERSONS</b>	<b>84.9%</b>

Source: South Australian Consumer Experience Surveillance System (SACESS) customised extract  
 Percentages exclude answers of ‘can’t remember’, ‘doesn’t apply’, ‘refused’  
 Percentages calculated from weighted data which can result in rounding discrepancies

#### 4. Strategy goal 4: Timely

*“Everyone working in the South Australian health system recognises that people’s time is valuable and seeks to minimise waiting in all interactions for all members of the community.” (SA Health 2020, p. 16)*

##### SA Health’s supporting statement for the strategy’s goal

“Waiting for access to services, assessment of need, decisions about care or transfer between components of the system is frustrating, can adversely affect outcomes and is costly to the system.” (SA Health 2020, p. 16)

##### Why SA Health considers this strategy goal as important

“Reduction in waiting at all points of care improves outcomes for patients, reduces cost releasing funds which can then be allocated for other uses either in health or for other government priorities.” (SA Health 2020, p. 16)

##### SA Health’s indicators for monitoring

The strategy does not present baseline quantitative measures for monitoring implementation of the timely goal. It lists four broad indicator groups to measure progress:

1. Wait times for services
2. Time spent in hospital
3. Ambulance ramping indicators
4. Patient experience and outcomes indicators.

##### The Health Performance Council’s indicators for monitoring

The Health Performance Council proposes four *specific* baseline indicators—with time series data at the local health network level—for monitoring implementation of the strategy’s **timely** goal:

1. Emergency department wait times/presentations seen “on-time”
2. Elective surgery wait times
3. Ambulance response times—including ambulance ‘ramping’
4. Outpatient wait times.

## 4.1 Emergency department wait times

The Health Performance Council considers waiting times for emergency department (ED) care a measure of how health consumer experience of health system timeliness may be changing over time.

'Seen on time' is a nationally reported (RoGS 2019a) performance indicator of timely hospital-related care. It is reported as percentage of presentations to major South Australian public hospital EDs where waiting time to commencement of clinical care was within nationally recognised benchmarks for triage category. The 'seen on time' performance indicator excludes people who left the ED before being seen by a clinician.

Seen-on-time rates vary across the local health networks (LHNs), from 99.9% at Riverland Mallee Coorong LHN (Riverland hospital ED) to 45.0% in the Women's and Children's Hospital. Seen-on-time rates are lowest for culturally and linguistically diverse persons in the Central Adelaide, Northern Adelaide and Women's and Children's Local Health Networks.

Table 19: Emergency department 'seen on time' rates by local health network, 2008-09 to 2018-19

LOCAL HEALTH NETWORK Descending order by all persons %	Riverland Mallee Coorong	Barossa Hills Fleurieu	Eyre and Far North	Flinders and Upper North	Yorke and Northern	Limestone Coast	Southern Adelaide	Central Adelaide	Northern Adelaide	Women's and Children's	TOTAL
TREND x-axis: 2008-09 to 2018-19 y-axis: 0% to 100%											
2018-19 ED seen on time <sup>1</sup> (%)											
<b>All persons</b>	<b>99.9%</b>	<b>97.4%</b>	<b>97.0%</b>	<b>89.6%</b>	<b>87.0%</b>	<b>81.2%</b>	<b>58.2%</b>	<b>50.5%</b>	<b>46.1%</b>	<b>45.0%</b>	<b>58.4%</b>
Specific population group (sorted descending on total)											
1. Rural and remote residents	99.9%	97.3%	97.1%	89.7%	87.0%	81.2%	60.0%	50.3%	50.4%	50.3%	79.0%
2. Aboriginal persons	100.0%	96.6%	97.0%	87.1%	85.7%	80.5%	59.6%	49.4%	52.1%	48.7%	66.7%
3. Lowest SES residents	99.9%	97.5%	97.5%	89.8%	86.9%	82.5%	57.1%	52.1%	47.4%	45.3%	63.8%
4. Persons aged 65+ years	99.9%	97.0%	98.0%	92.6%	89.7%	84.2%	50.6%	49.0%	41.9%	—	55.1%
5. CALD persons	n.p.	n.p.	n.p.	n.p.	n.p.	n.p.	54.7%	48.9%	41.1%	44.3%	48.0%
ED presentations	10,907	15,570	7,281	27,568	11,964	20,953	131,428	128,364	118,952	46,609	519,596

Source: SA Health Emergency Department Data Collection (EDDC) customised extract

x.x% Value is in bottom 10 of table cells

n.p. Not published. Volume of data at the local health network level insufficient to support publishing meaningful results.

Limited volume of data only supports reporting partial time series for some regional local health networks.

1. Seen on time thresholds are: Triage category 1—seen within seconds (calculated as less than or equal to 2 minutes); Triage category 2—seen within 10 minutes; Triage category 3—seen within 30 minutes; Triage category 4—seen within 60 minutes; Triage category 5—seen within 120 minutes. Excludes people who left the emergency department before being seen by a clinician

## 4.2 Elective surgery wait times

The Health Performance Council considers elective surgery waiting times a measure of how consumer experience of health system timeliness may be changing over time.

Elective surgery is planned surgery that can be booked in advance following a specialist clinical assessment. It does not refer to emergency surgery or treatment. Public hospital elective surgery waiting list information is collected and maintained centrally by SA Health on its Booking List Information System (BLIS) and reported on SA Health's business information Table, the Quality, Information and Performance (QIP) Hub.

The waiting times data presented in this report represent the time elapsed (in days) for a patient on the elective surgery waiting list from the date they were added to the waiting list for the procedure to the date they were removed from the waiting list. The number of days waited does not include days when the patient was not ready for care or the time waited for the initial appointment with the specialist after referral by the patient's general practitioner.

Median wait times for elective surgery are trending up, from 36 days in 2008-09 to 41 days in 2018-19. There is variation between the local health networks, from a median of 70 days waiting for elective surgery at booking list hospitals in the Northern Adelaide Local Health Network, down to 14 days in the Limestone Coast Local Health Network.

Table 20: Hospital elective surgery wait times by local health network, 2008-09 to 2018-19

LOCAL HEALTH NETWORK Descending order by median days	Northern Adelaide	Women's and Children's	Southern Adelaide	Riverland Mallee Coorong	Central Adelaide	Barossa Hills Fleurieu	Yorke and Northern	Flinders and Upper North	Eyre and Far North	Limestone Coast	TOTAL
TREND x-axis: 2008-09 to 2018-19 y-axis: 0 to 80 days				time series not available		time series not available	time series not available	time series not available	time series not available	time series not available	
<b>2018-19 wait time for elective surgery (median)</b>	<b>70 days</b>	<b>54 days</b>	<b>42 days</b>	<b>40 days</b>	<b>37 days</b>	<b>32 days</b>	<b>30 days</b>	<b>28 days</b>	<b>23 days</b>	<b>14 days</b>	<b>41 days</b>
2018-19 elective surgery admissions (no.)	8,966	5,250	13,882	2,354	14,895	4,727	2,584	2,308	1,339	2,530	58,835

Source: SA Health Booking List Information System (BLIS) customised extracts (2008-09 to 2017-18 data) and Quality, Information and Performance (QIP) Hub customised extract (2018-19 data)

Includes admissions for which the surgical specialty was not reported

There is also variation in wait times for elective surgery between specific population groups, from a median of 45 days waiting for elective surgery at booking list hospitals for persons who reside in geographical areas in the lowest quintile (lowest 20%) socio-economic status (SES) areas of South Australia, down to 36 days among Country SA residents.

**DATA GAP** SA Health advises that elective surgery wait time data for culturally and linguistically diverse (CALD) persons is not available.

Table 21: Hospital elective surgery wait times by specific population group, 2018-19

Specific population group	2018-19 wait time for elective surgery (median)
Descending order by median days	
South Australia, 2018-19	
1. Lowest SES residents	45 days
2. Aboriginal persons	39 days
3. Persons aged 65+	37 days
4. Rural and remote residents	36 days
5. CALD persons	n.a.
<b>ALL PERSONS</b>	<b>41 days</b>

n.a. not available

Source: SA Health customised extract

### 4.3 Ambulance response times

The Health Performance Council considers trends in ambulance response times a measure of how health consumer experience of health system timeliness may be changing over time. In this report, the Council considers two ambulance response time metrics—Code 1 dispatch-to-arrival times and ‘ramping’ (percentage of patients seen within 30 minutes of arrival of ambulance to hospital, and average time ambulance crew/patients spend on ‘ramp’ when delayed more than 30 minutes for handover)

#### Ambulance ‘code 1’ dispatch-to-arrival times

Time from a ‘code 1’ dispatch to arrival at life-threatening or time-critical incidents is a nationally reported (RoGS 2019b) performance indicator of timely ambulance response. A dispatch of ‘code 1’ represents the most urgent dispatches, commonly referred to as ‘lights and sirens’.

In 2018-19 the median ambulance response time in South Australia for a code 1 dispatch to life-threatening or time-critical incident was 10.1 minutes. The trend has been relatively stable over the period 2011-12 to 2018-19. There is variation between the local health networks, from a median of 10.7 minutes in the Northern Adelaide Local Health Network down to 7.3 minutes in the Yorke and Northern Local Health Network. Note that the South Australian Ambulance Service only provides response times in regional areas for urban centres with a population of 10,000 people or more, not for the entire regional area. See the data sources notes of this report for more information.

**DATA GAP** Data for specific population groups at the individual local health network level is not available for this indicator.

Table 22: Ambulance ‘code 1’ dispatch-to-arrival times by local health network, 2011-12 to 2018-19

LOCAL HEALTH NETWORK Descending order by median minutes	Northern Adelaide	Southern Adelaide	Barossa Hills Fleurieu	Central Adelaide*	Flinders and Upper North	Riverland Mallee Coorong	Eyre and Far North	Limestone Coast	Yorke and Northern	TOTAL
TREND x-axis: 2011-12 to 2018-19 y-axis: 0 to 15 minutes										
2018-19 ambulance code 1 <sup>1</sup> dispatch-to-arrival times (median)	10.7 mins	10.6 mins	10.1 mins	10.0 mins	8.9 mins	8.3 mins	7.7 mins	7.4 mins	7.3 mins	10.1 mins

Source: South Australian Ambulance Services (SAAS) customised extract

\* Central Adelaide Local Health Network includes Women’s and Children’s Health Network data

1. ‘Code 1’ represents the most urgent ambulance dispatches (commonly referred to as ‘lights and sirens’) to life-threatening or time-critical incidents

### Ambulance ‘ramping’—handover within 30 minutes

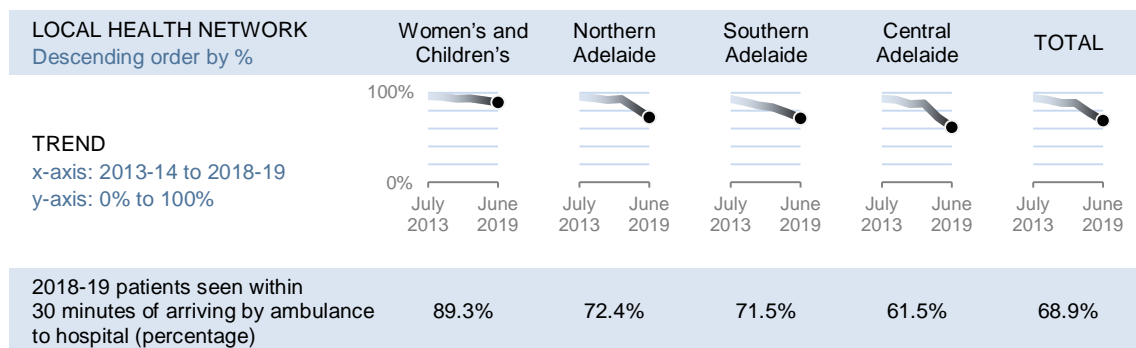
SA Health local health networks have a key performance target of 30 minutes between ambulance patients’ arrival and handover to the hospital, 90% of the time. This key performance target is effective from July 2019 – prior to that the transfer of care time was 25 minutes or less. Data in table 21 reflects the new target.

**DATA GAP** The South Australian Ambulance Service records the time it takes between arrival at the hospital and handover of care to hospital staff in metropolitan hospitals only. Data for regional hospitals is not available.

In 2018-19, no metropolitan Adelaide local health network was reaching the 30 minute transfer of care target 90% of the time. In that financial year, 68.9% of patients arriving by ambulance at metropolitan Adelaide public hospitals were transferred to the facility within 30 minutes of arrival. The percentage is highest for the Women’s and Children’s Hospital (89.3%) and lowest in the Central Adelaide Local Health Network (61.5%). Trends have been down across all metropolitan Adelaide local health networks over the time series.

**DATA GAP** Data for specific population groups at the individual local health network level is not available for this indicator.

Table 23: Ambulance ‘ramping’ —transferred to hospital within 30 minutes of arrival by ambulance—by local health network, 2013-14 to 2018-19



Source: South Australian Ambulance Services (SAAS) customised extract

## Ambulance 'ramping'—lost hours

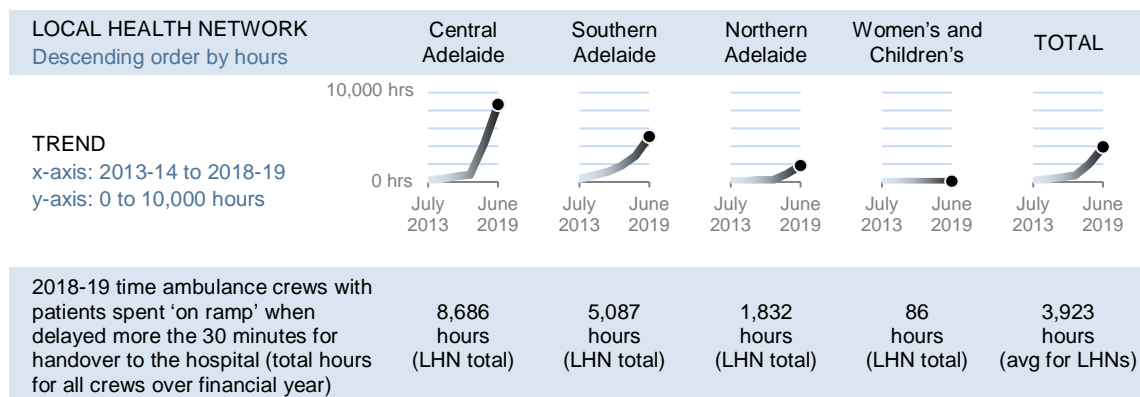
The South Australian Ambulance Service also records the number of 'lost hours' associated with ramping. This is the total time that ambulance crews and patients spend 'on ramp' when they are delayed more than 30 minutes for handover to the hospital.

**DATA GAP** The South Australian Ambulance Service records transfer of care (patient handover) timestamps for public metropolitan hospitals only. Data for regional hospitals is not available.

In 2018-19, all ambulance crews with patients spent an aggregate 15,690 hours (an average of 3,923 hours across the four local health networks that report data) 'on ramp' at metropolitan Adelaide public hospitals after being delayed more than 30 minutes for handover to the facility. Total number of 'lost hours' was highest in the Central Adelaide Local Health Network (8,686 total hours) and lowest at the Women's and Children's Hospital (86 total hours). Trends have increased in recent years.

**DATA GAP** Data for specific population groups at the individual local health network level is not available for this indicator.

Table 24: Ambulance 'ramping' —total lost hours—by local health network, 2013-14 to 2018-19



Source: South Australian Ambulance Services (SAAS) customised extract



#### 4.4 Outpatient wait times

The Health Performance Council considers trends in outpatient wait times a measure of how consumer experience of health system timeliness may be changing over time.

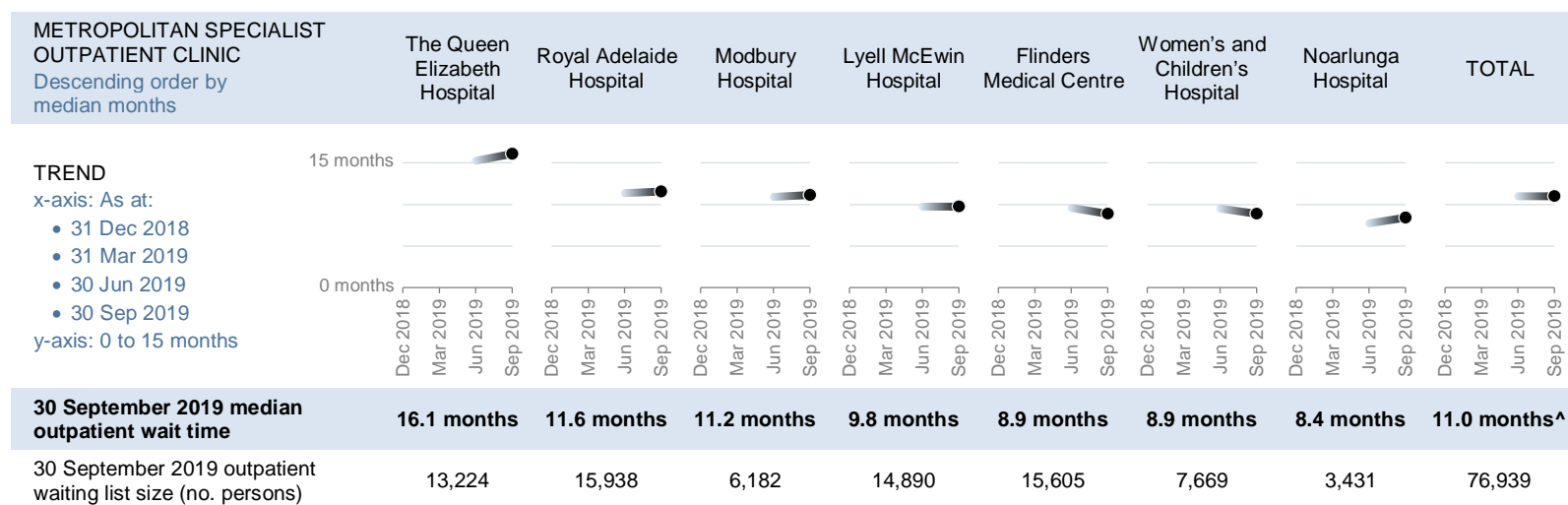
SA Health publishes on its website Specialist Outpatient Waiting Time Reports (SA Health 2019a). These reports detail metropolitan Adelaide specialist outpatient waiting times for clinician-assessed routine and non-urgent patients. Reported waiting times do not apply to urgent referrals that may need to be seen by a clinician within 30 days. SA Health produces its outpatient waiting time reports from local health network patient administrative and waiting list management systems with caveats, recognising that “the quality, accuracy and consistency of outpatient data is a significant challenge” (SA Health 2019b).

SA Health arranges outpatient waiting times in its reports by: Outpatient speciality, hospital, median waiting time (months) and maximum waiting time (months). However, waiting time summary information by local health network is not published. Due to this data gap the Health Performance Council (HPC) has sourced a customised extract from SA Health with data for the most recent two outpatient census periods (30 June 2019 and 30 September 2019). HPC encourages SA Health to include summaries of outpatient waiting times data at the local health network level in its published results.

**DATA GAP** The Health Performance Council also requested outpatient wait times data by specific population group for this report. SA Health advises that this would require significant manual resourcing and so for timeliness reasons has not been included here. The Health Performance Council notes the unavailability of outpatient wait times information by specific population groups is a significant data gap in SA Health’s published material.

**DATA GAP** The Council has no information on the cumulative total wait that a person might experience—that is, the time they wait for an outpatient consultation *plus* surgery. Median wait time varies between metropolitan specialist outpatient clinics, from 16.1 months at The Queen Elizabeth Hospital to 8.4 months at Noarlunga Hospital (public).

Table 25: Hospital outpatient wait times by metropolitan specialist outpatient clinics and discreet reporting period



Source: SA Health Specialist Outpatient Clinic Waiting Time Reports' data, customised extract

<sup>^</sup> Weighted average of the metropolitan specialist outpatient clinic median wait times

## Background information

### SA Health's patient electronic medical record

SA Health is implementing a patient electronic medical record system to provide a consistent and complete clinical and administrative medical record for patients across the state's public hospitals and health services.

The electronic medical record system used by SA Health in South Australia is called the *Sunrise* Electronic Medical Record (EMR) and Patient Administration System (PAS). It is a state-based electronic medical record that replaces the need for paper-based documentation.

#### History

In 2011, South Australia commenced implementation of an integrated Electronic Medical Record (EMR) and Patient Administration System (PAS). The system (EPAS) was developed to replace obsolete patient administration systems across all Adelaide metropolitan public hospitals, SA Health GP Plus clinics, and two country hospitals.

In April 2018, the Government ceased activations of EPAS at sites and sought an independent review of the program. The final EPAS Independent Review report and response to the recommendations were released on 29 January 2019<sup>1</sup>.

#### Future

The review identified a number of issues around the implementation and governance of the program and made 36 recommendations for improvement, all of which have been fully accepted or accepted in principle.

In April 2019, a proposed scope of works to implement review recommendations was approved by the reconstituted EMR Project Board. The proposed scope of works included a staged activation of Sunrise EMR and PAS into two exemplar sites—the Royal Adelaide Hospital (RAH) and the Mount Gambier and Districts Health Service (MGDHS).

The EMR rollout / activation plan for MGDHS has been successfully completed. Three of the four stages for the activation at the RAH have also been completed. The final RAH Stage 4 —implementing remaining functionality, including Medication Management—is scoped to Go-Live in March 2020.

Implementation of Sunrise EMR and PAS beyond these two hospitals is subject to user acceptance of these implementations and to a new business case detailing options for the future of electronic medical records for SA Health beyond March 2020.

1. [www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/reviews+and+consultation/epas+independent+review](http://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/reviews+and+consultation/epas+independent+review)

## Data sources

### BLIS

The Booking List Information System (BLIS) is SA Health's central data repository of South Australian public hospital elective surgery waiting list information. Elective surgery is planned surgery that can be booked in advance following a specialist clinical assessment. It does not refer to emergency surgery or treatment. Patients' waiting times for elective surgery are categorised according to clinical urgency determined by their treating medical practitioner. SA Health makes every effort to treat patients within the clinically indicated time. However, sometimes other factors can affect the timely treatment of all patients, including the need for public hospitals to give priority to emergency patients who need a hospital bed.

The Health Performance Council excludes people admitted from the booking list as emergency patients to ensure consistency with standard BLIS business counting rules.

### CHRIS

The Complete Human Resources Information System (CHRIS) is SA Health's human resources management and payroll database system.

For the purpose of calculating active employee records, the following records have been excluded from the analysis: Non-Employees; Sessional; Boards & Committees; Contract employees with no right to ongoing employment (where identified); RN0101 employees considered Graduate Nurses; and employees on secondment to another agency.

Headcount is the average headcount: The number of employee records per month for the 12 month period (based on the employee commencement date and termination date), averaged across the financial year.

### EDDC

The Emergency Department Data Collection (EDDC) details presentations for emergency departments (EDs) in public hospitals across South Australia.

A key aspect of measuring and understanding what is happening within an emergency department is use of triage categories. These categorise the urgency of the patient's need for medical and nursing care as set by the Australian College of Emergency Medicine:

- Triage 1 (resuscitation): Patient must be seen within 2 minutes of presentation time
- Triage 2 (emergency): Patient must be seen within 10 minutes of presentation time
- Triage 3 (urgent): Patient must be seen within 30 minutes of presentation time
- Triage 4 (semi-urgent): Patient must be seen within 60 minutes of presentation time
- Triage 5 (non-urgent): Patient must be seen within 120 minutes of presentation time

To ensure consistency, the Health Performance Council applies pre-defined EDDC business counting rules and limits reporting ED activity to the following major South Australian public hospitals: The Lyell McEwin Hospital, Modbury Hospital, Royal Adelaide Hospital, The Queen Elizabeth Hospital, Flinders Medical Centre, Noarlunga Hospital, Gawler Health Service, Port Lincoln Health Service, Port Augusta Hospital and Regional Health Service, Whyalla Hospital and Health Service, Mount Gambier and Districts Health Service, Riverland General Hospital (Berri), Port Pirie Regional Health Service, and the Women's and Children's Hospital.

### ISAAC

The Integrated South Australian Activity Collection (ISAAC) covers all public and private hospitals in South Australia. It records details of inpatient "episodes of care" commencing with admission to hospital and concluding with a "separation" (discharge, transfer or death). ISAAC is the means by which admitted patient activity can be monitored, funded, evaluated, planned for, researched and reviewed to ensure that SA Health continues to deliver efficient and equitable health services.

To ensure consistency, the Health Performance Council applies pre-defined ISAAC business counting rules to the hospital activity data before extraction and further analysis. Standard business counting rules include grouping, or “bundling”, episodes that experience multiple care type changes during a hospital stay into a single record. Bundling provides a more accurate picture of the number of patients actually discharged from a hospital. Standard business counting rules also excludes sameday endoscopy and chemotherapy activity.

From 1 July 2017, SA Health adopted new state-wide business counting rules to hospital admitted activity data and this may affect time series reported in this document. Hospitalisation (inpatient separation) totals presented in this report may not match exactly with nationally reported figures due to timing differences in the extraction of data and subsequent updates to the data warehouse.

Identification of culturally and linguistically diverse (CALD) persons in this report is based only on their country of birth. New CALD data elements—preferred language, religious affiliation and interpreter required—have been piloted in ISAAC from 1 July 2017 (a Health Performance Council initiative). However, these new data elements are not currently supplied to ISAAC consistently by the hospitals at a suitable quality for reporting.

### Outpatient wait times

Outpatient wait time data is summarised in Specialist Outpatient Waiting Time Reports, published by SA Health quarterly since 2018 on its website (SA Health 2019a). These reports detail metropolitan Adelaide specialist outpatient waiting times for clinician-assessed routine and non-urgent (category 2 and category 3) patients. Reported wait times do not apply to urgent referrals that may need to be seen by a clinician within 30 days.

SA Health produces its outpatient waiting time reports from local health network patient administrative and waiting list management systems with several important caveats. In summary, SA Health’s own data quality statement

recognises that “the quality, accuracy and consistency of outpatient data is a significant challenge” and that it “has dedicated resources to improve the accuracy of waiting list information” (SA Health, SA Health 2019b).

The SA Health reports arrange outpatient wait times by: Outpatient speciality, hospital, median waiting time (months) and maximum waiting time (months) (see extract). Waiting time medians for the hospital or local health network overall are not published. Data for specific population groups is also not published.

Extract from an SA Health *Specialist Outpatient Waiting Time Report*

Outpatient Speciality	Hospital	Median Waiting Time (Months)	Maximum Waiting Time (Months)
Breast	RAH	<1	3
	TQEH	<1	3.8
	LMH	0	0
	MH	0	0
Cardiology	RAH	8.3	93.6
	TQEH	19.7	57.5
	LMH	5.6	36.7
	FMC	0	0
	NHS	3	7
Cardiothoracic	WCH	2.5	23.1
	RAH	<1	3
Craniofacial	WCH	0	0
	RAH	3.6	21.8

### SAAS

Ambulance response times data by local health network was provided to the Health Performance Council by the South Australian Ambulance Service (SAAS).

For 2017-18 and 2018-19 data, SAAS only provides response times in regional areas for urban centres with a population of 10,000 persons or more, not for the entire regional area. SAAS data provided for these two financial years this report uses an urban centre to local health network (LHN) mapping:

#### Local health network

Barossa Hills Fleurieu  
 Eyre and Far North  
 Flinders and Upper North  
 Limestone Coast  
 Riverland Mallee and Coorong  
 Yorke and Northern

#### Urban centres

Crafers-Bridgewater; Gawler; Mount Barker; Victor Harbor  
 Port Lincoln  
 Port Augusta; Whyalla  
 Mount Gambier  
 Murray Bridge  
 Port Pirie

Response times data prior to 2017-18 is limited to urban centres with a population of 13,000 persons or more, and based on a suburb mapping within an urban centre boundary (so does not exactly match the geographic boundary of the urban centre). Urban centre to local health network mappings for data prior to 2017-18 are the same as the table above, other than Barossa Hills Fleurieu, which previously did not contain the urban centres of Mount Barker or Victor Harbor.

SAAS does not have metropolitan boundaries that map exactly to SA Health local health networks. For this report, SAAS has provided an approximation based on the following:

<b>Local health network</b>	<b>SAAS metropolitan Adelaide regions</b>
Northern Adelaide	Metro North
Central Adelaide	Metro East; Metro West
Southern Adelaide	Metro South

Central Adelaide Local Health Network SAAS data used in this report includes Women’s and Children’s Health Network.

Ambulance Code 1 response time reported in the Productivity Commission’s Report on Government Services maps to SAAS Priority 1 and Priority 2 cases.

The SAAS computer aided dispatch system (CAD) went live in 2011. Response time data by local health network prior to that time is not available.

## **SACESS**

The South Australian Consumer Experience Surveillance System (SACESS) is an epidemiological survey system administered by SA Health’s Safety and Quality Unit to improve the quality of public health services for South Australians. SACESS continuously monitors experiences of consumers regarding their health care, providing high quality data from a representative sample of South Australian adult inpatients of the state’s public hospitals. The SACESS survey was revised in 2018, adopting a new national questionnaire known as the Australian Hospital Patient Experience Question Set (AHPEQS)—a set of 12 questions endorsed by the Australian Health Ministers’ Advisory Council (AHMAC).

The sample is comprised of South Australian adults aged 16 years and over who spent at least one night in a selected public hospital. Eligibility criteria include:

- Hospitalised for between one and no more than 35 days in the preceding month
- Not admitted for psychiatric, mental health, substance abuse, chemotherapy or renal dialysis of care
- Valid address and phone number
- Excludes residents of residential care, nursing homes, prison/correctional facilities.

SA Health has published the aggregate results from SACESS but not published the survey method. The Council does not know if, or to what extent, interpreters or translators are available for this survey, or to what extent non-English speakers may be excluded from the survey results.

For more information about SACESS, including how the survey is conducted and how survey results are processed, please contact the SA Health Safety and Quality Unit directly on Email: [HealthSafetyQualityFeedback@sa.gov.au](mailto:HealthSafetyQualityFeedback@sa.gov.au) or telephone: 8226 6539.

## **SLS**

The Safety Learning System (SLS) is a reporting tool administered by SA Health’s Safety and Quality Unit enabling all SA Health services to record, manage, investigate and analyse patient and worker incidents; information about security services; and formal notifications such as those for coronial matters or medical malpractice. Consumer feedback is also recorded in SLS to drive improvement in the quality, responsiveness and timeliness of health care services provided, and enable the identification of trends and risk.

The Health Performance Council includes “Approved” and “Unapproved” SLS consumer feedback categories but excludes SLS consumer feedback classified as “Rejected” from the data reported in this document to ensure consistency with SA Health business counting rules.

## Data quality

This report sources data from internal government enterprise datasets provided with the approval of their custodians. Where the Health Performance Council extracted data itself from enterprise systems, it applies standardised business counting rules where applicable. Data sources, definitions and other technical information is provided so that results can be replicated.

It is standard Council practice to validate its reports prior to publication with data custodians, relevant experts and key stakeholders to sense-check findings, and confirm robustness of method, accuracy of findings and clarity of presentation.

### Missing data and under-reporting

Despite the quality assurances of data providers and others, the Health Performance Council recognises that there is data missing, under-reported and misreported in administrative datasets that can and do impact the analysis in this report. The Council can only report self-identified data as-is.

### Identification of Aboriginal people

For example, the Council recognises that not all Aboriginal people are correctly identified in the data and acknowledges that not all Aboriginal people choose to identify themselves or their loved ones every time they interact with government services. Aboriginal leaders have told the Council that many Aboriginal health consumers do not identify as Aboriginal for fear of discrimination. Aboriginal leaders have also told the Council that health service providers frequently fail to ask about the Aboriginal status of health consumers, even where collection of this status field is mandatory. The Council will work to report on systemic racism in the health system as part of its forward review program.

The issue of integrity, variability and quality of self-reported data in administrative datasets applies to other specific population groups as well—often for fear of discrimination—such as culturally and linguistically diverse people and aged persons.

### Identification of culturally and linguistically diverse (CALD) persons

Identification of culturally and linguistically diverse (CALD) persons in this report is based only on their country of birth. CALD identification would be improved if preferred language, religious affiliation and interpreter required were also available. These new CALD data elements have been piloted in SA Health's central hospital inpatient activity data warehouse (ISAAC) from 1 July 2017 (a Council initiative). However, new data elements are not supplied to ISAAC consistently by the hospitals at a suitable quality. Until there is greater compliance by the hospitals, ISAAC's collection manager won't make the new CALD elements available for extraction by analysts via the data portal (HIP).

### Reliability of outpatient wait times

Outpatient wait times are derived from SA Health's published Specialist Outpatient Waiting Time Reports. SA Health produces these reports with caveats, recognising that "the quality, accuracy and consistency of outpatient data is a significant challenge". SA Health continues to work with clinicians and administrative staff to improve the accuracy of the waiting lists and develop an outpatient reporting system that will provide timely and consistent information about outpatient waiting times.

## Definitions

### **Aboriginal persons**

The Health Performance Council (HPC) respectfully uses the term 'Aboriginal', rather than 'Indigenous', to refer to people who self-identify as Aboriginal, Torres Strait Islander, or both. HPC recognises Aboriginal and Torres Strait Islander people as two separate groups. However, this document refers to Aboriginal persons in recognition that Aboriginal people are the original inhabitants of South Australia. We also acknowledge the complexity and diversity of the Aboriginal communities of South Australia, recognising each has its own beliefs and practice.

### **Aged persons**

Inpatients whose age at admission was 65 years or older.

### **Average**

A central value of a set of numbers, calculated by adding the numbers together and dividing by how many numbers there are.

### **Confidence interval**

An interval computed from the observed data that might contain the true value of an unknown parameter. Most commonly, a 95% confidence level is used. That is, the researcher is 95% confident that the true value of the parameter is within approximately plus or minus two standard errors of the estimate.

### **Culturally and linguistically diverse (CALD) persons**

Defined by the Health Performance Council as persons born in non-main English speaking countries. These are countries other than Australia, Canada, Ireland, New Zealand, South Africa, the United Kingdom, and the United States of America.

### **Hospital acquired complication**

The national list of 16 hospital acquired complications (HACs) are (ACSQHC 2019):

Cardiac complications; Delirium; Falls resulting in fracture or intracranial injury; Gastrointestinal bleeding; Healthcare-associated infection; Malnutrition; Medication complications; Neonatal birth trauma; Persistent incontinence; Pressure injury; Renal failure; Respiratory complications; Surgical complications requiring unplanned return to theatre; Third and fourth degree perineal laceration during delivery; Unplanned intensive care unit admission; Venous thromboembolism.

### **Hospitalisation (inpatient separation)**

A hospital inpatient 'separation' is a completed episode of care of an admitted patient, generally concluding with their discharge from hospital (mostly to home), transfer to another healthcare facility or in-hospital death. It can also include other types of separation, such as 'administrative separation' applied for hospital activity payment purposes.

### **Lowest socio-economic status (SES) residents**

The Health Performance Council defines lowest socio-economic status residents as people who reside in the lowest quintile (lowest 20%) socio-economic status geographic areas of South Australia, identified using the Australian Bureau of Statistics' (ABS) Socio-economic Index for Areas (SEIFA), Index of Relative Socio-economic Disadvantage (IRSD) (ABS 2018).

ABS Statistical Areas-Level 2 (SA2s) in the lowest quintile SES areas of South Australia are:

Anangu Pitjantjatjara Yankunytjatjara (APY) Lands, Berri, Christie Downs, Christies Beach, Coober Pedy, Davoren Park, Elizabeth East, Elizabeth, Enfield – Blair Athol, Hackham West – Huntfield Heights, Mannum, Millicent, Morphett Vale – West, Mount Gambier – West, Murray Bridge, Outback, Parafield Gardens, Paralowie, Peterborough – Mount Remarkable, Pooraka – Cavan, Port Adelaide, Port Augusta, Port Pirie, Quorn – Lake Gilles, Renmark, Salisbury North, Salisbury, Smithfield – Elizabeth North, The Parks, Virginia – Waterloo Corner, Wallaroo, Whyalla.

### **Median**

The middlemost point in a sorted set of data. In a sequence of numbers arranged from lowest to highest, half (50%) of the numbers will be below the median and half above.

### **Potentially preventable hospitalisation**

Diseases for which hospitalisation is considered potentially preventable are grouped across three categories (AIHW 2019):

#### **Acute conditions**

Cellulitis; convulsions and epilepsy; dental conditions; ear, nose and throat infections; eclampsia; gangrene; pelvic inflammatory disease; perforated/bleeding ulcer; pneumonia (not vaccine-preventable); urinary tract infections (including kidney infections).

#### **Chronic conditions**

Angina; asthma; bronchiectasis; chronic obstructive pulmonary disease (COPD); congestive cardiac failure; diabetes complications; hypertension; iron deficiency anaemia; nutritional deficiencies; rheumatic heart diseases.

#### **Vaccine-preventable conditions**

Chicken pox (varicella); diphtheria; German measles (rubella); haemophilus meningitis; hepatitis B; influenza; measles; mumps; pneumonia (vaccine-preventable); polio; rotavirus; tetanus; whooping cough (pertussis).

### **Rural and remote residents**

Defined by the Health Performance Council as persons who reside within SA Health's regional local health network boundaries. That is, residents of the Flinders and Upper North, Eyre and Far North, Barossa Hills Fleurieu, Riverland Mallee Coorong, Limestone Coast or Yorke and Northern Local Health Networks.



## Acronyms

BLIS	Booking List Information System (refer to data sources section)
CALD	Culturally and linguistically diverse
CHRIS	Complete Human Resources Information System (refer to data sources section)
ED	Emergency department
EDDC	Emergency Department Data Collection (refer to data sources section)
HAC	Hospital acquired complication
HIP	Health Information Portal
HPC	Health Performance Council
ISAAC	Integrated South Australian Activity Collection (refer to data sources section)
LHN	Local Health Network
PPH	Potentially preventable hospitalisation
QIP	Quality, Information and Performance (Hub)
SA	South Australia
SACCESS	South Australian Consumer Experience Surveillance System (refer to data sources section)
SES	Socio-economic status
SLS	Safety Learning System (refer to data sources section)

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