

Development of a Performance Reporting System for Indigenous Primary Health Care

**Report of a project by the Cooperative Research Centre for
the Primary Health Care Access Program Working Group**



PO Box 41096
Casuarina, NT 0811

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Abbreviations

ABS	Australian Bureau of Statistics
ACDHS	Australian Child Dental Health Survey
ACHS	Australian Council of Healthcare Standards
AIHW	Australian Institute of Health and Welfare
BSM	Birth Suite Module
CareSys	Hospital Morbidity Data System
CARPA	Central Australian Rural Practitioners Association
CCIS	Community Care Information System
CIN	Cervical Intraepithelial Neoplasia
DC	Disease Control
DEET	Department of Employment, Education and Training
DHCS	Department of Health and Community Services
DoHA	Department of Health and Aging
EPC	Enhanced Primary Care
FIS	Financial Information System
GAA	Growth Assessment and Action
HIC	Health Insurance Commission
IHANT	Indigenous Housing Association of the Northern Territory
IMMDC	Immunisation - Disease Control
MIS	Medical Information System
NHPA	National Health Priority areas
NHPC	National Health Performance Committee (National Report on Health Sector Performance Indicators)
NPIATSIH	National Performance Indicators for Aboriginal and Torres Strait Islander Health
NPSU	National Perinatal Statistics Unit
PCA	Productivity Commission Australia - Review of Government Services
PCIS	Primary Care Information System
PHC	Primary Health Care
SAR	Service Activity Report

Executive Summary

The aim of this project was to develop a NTAHF-endorsed interim performance reporting process, which could be used by Commonwealth/NT co-funded fundholders / service providers until such time as more exhaustive studies and collaboration achieve a more excellent performance reporting system.

The primary impetus for initiating the development of a performance reporting process was the imminent emergence of a number of Health Zones under PHCAP in Central Australia. However, the potential application of this performance reporting process was thought to be broader than just for services funded by PHCAP and relevant to all Indigenous primary health care services in the Northern Territory.

This project has identified a range of performance measures recommended for use by Indigenous Primary Health Care Services in the Northern Territory. The data provided through this process will assist performance monitoring and can be used for comparisons with previous trend data available or with other zones. In the latter situation there will be a need for contextual data such as employment and education statistics and quality of housing and other services to allow interpretation and meaningful comparisons.

The proposed performance measures are presented in Appendix B mapped to the Health Information Framework. This framework also includes some contextual measures that assist in the interpretation of the performance reporting process but not intended to be reported by Health Boards. A supplementary list of data items that may be used by Health Board for decision making and priority setting is included as Appendix D. This document also identifies the source of the information.

An additional document "Technical Instructions" presents each performance measure with details regarding the rationale for use of the measure, a description of the measure or method of analysis, source of data and frequency of reporting. Previously reports were required 6 monthly, however, many indicators of health system performance require a longer timeframe than 6 months to indicate change. Many of the measures of health status were changed to annual reporting.

1. Introduction

Background

Over the next few years it is envisaged that the delivery of most Primary Health Care (PHC) services in remote areas of the Northern Territory (NT) will be based around geographically defined areas called Health Zones and delivered under the management of Health Boards. The expectation is that these services will be jointly funded by the NT Department of Health and Community Services (DHCS) and the Commonwealth Office of Aboriginal & Torres Strait Islander Health (OATSIH) through the Primary Health Care Access Program (PHCAP).

The planning and implementation of PHCAP in the Northern Territory is being coordinated by the NT Aboriginal Health Forum (NTAHF) through one of its Standing Committees; the Primary Health Care Standing Committee. The membership of this Standing Committee includes the Aboriginal and Torres Strait Islander Commission (ATSIC), the Aboriginal Medical Services Alliance NT (AMSANT), OATSIH and NTDHCS.

During the last decade there has been a growing awareness among both funding bodies and service providers of the importance of developing processes to measure the performance of health services. Although much of the work previously undertaken has been involved in developing performance monitoring processes that have targeted the acute care sector more recent efforts have investigated indicators that will measure the effectiveness of health care services in the other areas of health.

At present performance reporting processes for primary health care are not well established with different requirements be required by different funding bodies. Processes are not consistent within organisation with internal and external providers providing different information to their funders. Reporting processes have been developed in isolation by individual program areas without any coordination. As well as inconsistencies in the indicators used for different reporting requirements there is also a lack of standardisation of data definitions. This results in duplication of effort, poor interpretation of the available information and unnecessary costs.

The PHC Standing Committee has recognised the need for robust performance reporting processes that will measure the effectiveness of primary health care service provision under the PHCAP model and has sought collaboration in a range of projects aimed at increasing knowledge in this area.

Planning for longitudinal studies into issues related to governance and effective models of service delivery have been encapsulated in the broader projects discussed in the Cooperative Research Centre for Aboriginal and Tropical Health (CRCATH) workshop of 14/8/01, and documented in the *Longitudinal Evaluation of Primary Health Care Services*. The scope of the proposed CRCATH series of studies is broad and will take a number of years to complete. However, there is a more urgent need to establish an interim set of performance reporting requirements for the emerging and existing health zones and Coordinated Care Trials, as well as other providers of primary health care in the Northern Territory. The CRCATH has been engaged to manage the necessary research and consultations required to establish an appropriate reporting process.

Aims and Objectives

To develop NTAHF-endorsed interim performance reporting, including performance measures, which can be used by Commonwealth/NT co-funded fundholders/ service providers until such time as more exhaustive studies and collaboration achieve a more excellent performance reporting system.

Performance reporting must meet the accountability requirements of both governments, and be acceptable to fundholders and providers. It must be implementable and to, as great an extent as is practical, contribute to the streamlining of accountability mechanisms.

The aim was further refined throughout the project at Steering Group meetings and workshops.

2. Method

The Project Team consisted of four personnel listed below. Expert advice and leadership was provided throughout the project as required by Dr Ross Bailie and Professor Tony Barnes. The general organisation, coordination and execution of consultation meetings and workshops for the project was undertaken by the Project Manager who work part-time on the project. A project office was employed for three weeks in the early stages of the project to conduct early interviews and preliminary research. Throughout the project various people with skills/expertise on Performance Reporting and provision of health services were consulted.

Project Team

Project Advisor Prof Tony Barnes
CRC Program Leader Dr Ross Bailie
Project Manager Pam Gollow
Project Officer (casual) Dr George Latham

Steering Committee

The Primary Health Care Standing Committee (formerly the PHCAP Working Group) was identified as the Steering Committee for the project. This Standing Committee has representatives from the four partners of the Aboriginal Health Form, including the NT Department of Health and Community Services (NTDHCS), the Office for Aboriginal and Torres Strait Islander Health (OATSIH), the Aboriginal and Torres Strait Islander Commission (ATSIC) and the Aboriginal Medical Services Alliance of the Northern Territory (AMSANT).

This Committee is a high level group of senior officers from both the non-Government and the Government sectors with responsibilities that cover many areas associated with the implementation of Indigenous primary health care. For this reason full meetings to deal with specific issues related to this project had to be arranged out of session of their routine meetings. Due to the considerable commitments of all members of this group meetings were often difficult to organise requiring several weeks notice and with some last minute cancellations.

There were also acknowledged differences within the group in expectations and requirement of a performance reporting process for primary health care. This was reflected in the different perspective of the organisations that were represented. In addition, during the course of the project some of the organisation had staffing changes that resulted in the replacement of members of the steering group. Some of these changes in membership introduced alternative views on the purpose and requirements of a performance reporting process.

Review of existing indicators & related projects

A comprehensive literature review was undertaken using the library database, Winspurs. The topics under consideration were: performance monitoring systems, conceptual frameworks for evaluation of health systems, indicator development, evaluation of chronic disease management. The keywords used as search terms were: “performance indicator”, “health indicator”, “performance measurement”, “performance monitoring”, “performance management”, “conceptual framework”, “framework and health”, “primary health care”. The literature review of journal articles relevant to this area revealed that much of the research into performance measurement is encapsulated in studies completed in the last ten years. This area is a relatively new and rapidly changing science and the more recent publications provided the more valuable and up to date information.

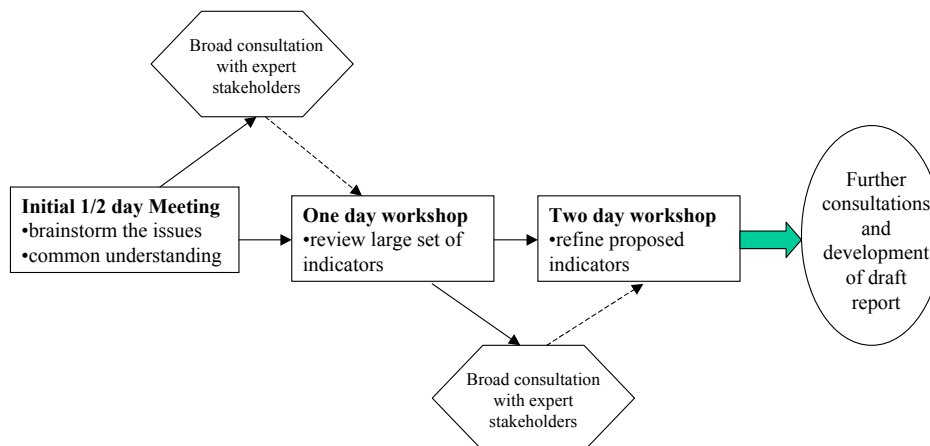
An extensive search of the ‘world wide web’ was also conducted, however, the most productive source of information was to search the websites of state, national and international health departments, organisations linked to these websites and other national organisations involved in performance measurement. A number of current projects and reports have been scrutinised, including a range of recent reports from NHPC, to ensure coordination with national indicator sets and to gain evidence/justification for the inclusion of the indicator.

A review of existing indicator sets for performance measurement in the health sector provided baseline information. A range of indicators have already been collated as part of refinement processes for other indicator sets ie the refinement of the National Performance Indicators for Aboriginal and Torres Strait Islander Health, and were used to inform this process. Other Commonwealth and State/Territory government departments or organisations involved in the development of performance indicators for health were also consulted to provide additional information on any relevant new initiatives that have been in progress over recent months. In addition, experiences gained through the process of monitoring the Coordinated Care Trials in the NT informed the development of an appropriate set of indicators.

Workshops and Consultations

A number of workshops and consultations were planned at various stages of the project (see Figure 1 below).

Figure 1: Flowchart of Workshop and Consultation Process



An initial half-day planning meeting was held in the early stages of the project and included the members of the steering committee and most of the project team. This meeting had several purposes:

- To endorse a plan to progress the project.
- To establish an agreed understanding of the purpose of a performance reporting system and the components that should be included in the reporting process
- To discuss the level of reporting required of the Health Boards.
- To develop a framework to guide the development of the performance reporting system

Consultations with a range of key stakeholders and identified experts were held throughout the project. Experts from a range of the areas were consulted; included Indigenous health service providers and managers, health specialists, information technology experts, finance officers, epidemiologists and demographers. A list of consultees is included in Appendix A. The purpose of the initial consultations were:-

- to inform the project about the perspectives and needs of the various stakeholders, and
- to seek advice from relevant individuals with expertise in the development of performance indicators
- to seek clarification regarding the relevance of specific indicator in the PHC setting.

Information gathered from all sources was documented and a list of proposed performance measures was produced for discussion at a workshop. The workshop provided an opportunity to discuss and debate the suitability of the selected measures and to propose additional areas requiring further investigation. Each partner from the Steering Group nominated a list of individuals to be invited to participate in the first workshop. These individuals included representatives of the partner organisations of the AHF as well as representatives from Aboriginal Medical Services, the existing Health Boards and identified experts in indicator development or health service management or delivery.

The list of proposed performance measures were compiled from existing sets of performance indicators identified by the literature review and those that had been recommended during consultations with a range of stakeholders and experts. The identified measures were arranged under the headings of the framework that had been identified at the Planning Workshop to guide indicator development. This list was intentionally large and was used as the basis for discussion and debate. The list of indicators were divided into three sets:

- The main list of proposed indicators for reporting to the funding bodies by Health Boards
- Health information that Health Boards might use for decision making and priority setting – this information is generally available from various Government Departments.
- Contextual or explanatory indicators – these indicators were not reportable by Health Boards but would provided background information to allow better interpretation of the performance reports ie education status, housing, employment etc.

The workshop identified a list of criteria that an indicator should meet in order to be acceptable for inclusion in the Performance Reporting process.

These criteria were:

- Is the measure useful from the service provision point of view
- Is the measure useful from the funding point of view
- How frequently should the measure be reported
- Can the data be collected / reported
- Is data available / are there any quality issues
- Other comments

The workshop participants assessed the 'set of indicators for reporting to the funding bodies by Health Boards' against the above criteria and those measures not meeting these criteria were removed from the list. In some cases additional indicators were proposed for inclusion or investigation.

The reduced set of indicators was then taken to a more targeted range of identified experts for further discussion and refinement.

This set of indicators was used as the basis for discussion for the second major workshop. A table including the rationale and justification for the choice of the indicators, the recommended frequency of reporting and potential sources of data was used to provide evidence for inclusion. Further refinement of the indicators resulted from the discussion and debate generated at the second workshop.

At this workshop it was agreed that a separate group should meet to discuss the reporting requirement for financial acquittal. This group would be coordinated by Roger Brailsford and include representatives from both funding bodies, the existing Health Boards and AMSANT. (NOTE: this group has subsequently met and a paper has been presented to PHC Standing Committee for their consideration.)

Broader Consultations

During the course of this project a parallel process was taking place with the DHCS concerned with the development of performance measures for primary health care. Relevant DHCS representatives were regularly consulted throughout this project as well as being invited to participate in the project workshops. This ensured a consistent approach to indicator development as well as allowing an alternative process for consultation with and feedback from Indigenous controlled community health services.

Several opportunities were also taken to meet with visiting representatives from the Canberra office of the Department of Health and Ageing to discuss the project and related projects in performance reporting for health services.

Related Projects

The consultations identified a number of projects at various stages of development, both nationally and within the Northern Territory, that were related to the establishment or refinement of performance reporting processes. Project officers in each project was consulted to gain a clearer knowledge of current best practice evidence as well as the stage of development of a range of performance indicator sets in health. Another major consideration was to avoid duplication of effort. Some of the major initiatives relevant to this project are listed below. These initiatives are grouped as National, NT Government or other initiatives.

National Initiatives in the development of performance measures

- Service Activity Report (SAR) through Department of Health and Ageing
- Development of Performance Indicators for the Primary Health and Community Care Sector
- Public Health Performance Project

Territory Government Reporting Requirements

- Refinement of accountability processes for internal and external (NGOs) health service providers by the Department of Health and Community Services.

Other Northern Territory initiatives related to the development of performance measures

There are a range of projects and other research initiatives being undertaken in the Northern Territory in relation to PHC services delivery and factors that influence health status which will be very relevant to the development of performance measures. These initiatives are listed below with a diagram that indicates how each is related to the Health Zones.

Audit of Best Practice of Chronic Diseases Project (ABCD Project)

The project will investigate the nature, use and impact of systems and activities within remote health centres in the Top End of the Northern Territory directed at the prevention and management of chronic disease. This

project will introduce a process of continuous quality improvement of organisational systems for chronic disease care.

Socio-economic and Environmental Determinants of Health in Indigenous Communities in the Northern Territory (SEEDH Project)

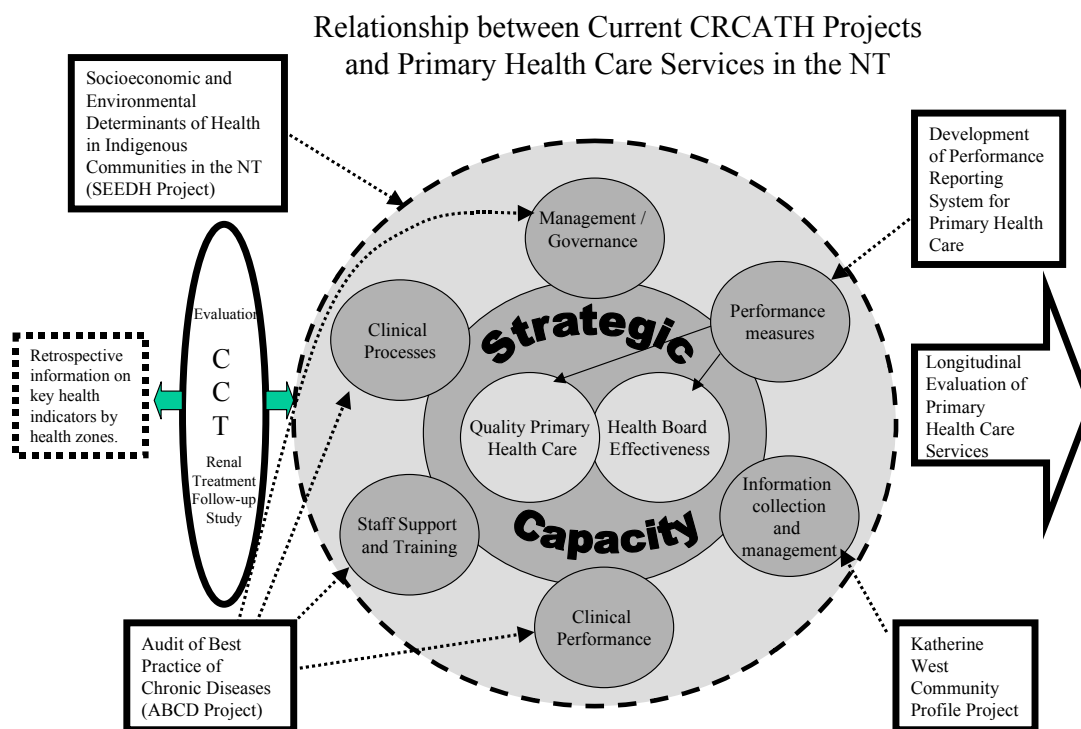
This project has three overall aims:

1. Assess quality of routinely reported data relevant to socio-economic and environmental determinant of health.
2. To provide an improved understanding of the relationship between socio-economic and environmental factors, health care access and utilisation, and health outcomes in Indigenous communities in the Northern Territory.
3. To determine the relative need of communities, Indigenous areas and/or location (ABS Indigenous geographic classification), and health zones in relation to socio-economic and environmental factors, health care access, and the health status of Indigenous people living in these areas.

Review of CH Definitions & Performance Indicators
Katherine West Community Profiles

Longitudinal Evaluation of Primary Health Care

Figure 2: Relationship between Current CRCATH Projects and Primary Health Care Services in the NT



The attached document presents the outcomes of all consultations in the form of a list of indicators with technical instructions for each indicator. Also attached is a sample reporting template that may be used as a performance reporting tool.

During both workshops and the individual consultations many issues have been raised regarding performance reporting for Health Boards. These issues has recorded and are included in this document for future consideration.

Presentation of Finding

The workshop participants agreed that a technical document for PHC Performance Reporting should include:

- Clear descriptions and definitions for each performance measures
- Data definitions
- Rationale for collection
- Instructions for analysis and reporting.

3. Literature Review of Performance Reporting

Recent Developments in Performance Reporting

During the last few decades there has been a worldwide trend towards the definition and use of indicators as a way of monitoring and reporting on performance in health (Chrvala and Bulger, 1999; Gakidou et al, 1999; Murray and Frenk, 1999). Performance indicators have been developed to evaluate activities undertaken by or on behalf of health organisations with the overall aim of improving the health of the population for whom the service is provided. This process recognises the importance of incorporating relevant information and evidence-based medicine into decision-making and policy development (Collopy, 1998).

Durch et al (1997, p4) defined the terms ‘performance monitoring’ as a:

“process of selecting indicators that can be used to measure the process and outcomes of an intervention strategy for health improvement, collecting and analysing data on those indicators, and making the results available to the community to inform assessments of the effectiveness of an intervention and the contributions of accountable entities. Performance monitoring should promote health in a context of shared responsibility and individual accountability for achieving desired outcomes.”

Since its introduction the focus of performance measurement in the health sector has changed significantly. Prior to the mid-1980s performance monitoring was mainly driven by concerns for efficiency and cost containment. The rising cost of health care was having a huge economic impact on health services and in turn funding bodies demanded that health services become more accountable in the way they provided health care and allocated funding. The performance monitoring systems that were established during this period reported on the cost of health care and measured the volume of services provided (Plantz et al, 1999).

Towards the end of the 1980’s quality issues related to the provision of health care started to receive increased attention from governments, providers and consumers. Health care costs were continuing to rise and justification for the use of more expensive methods of treatment was needed. However, it was generally accepted that economies in health care would not necessarily lead to better outcomes. Providing the best quality health care, even though initial costs may be more expensive, will generally produce better long-term outcomes and therefore is more cost effective. To promote good quality care, health care policy makers and providers needed relevant information to provide the evidence for effective decision making about the provision of health care (Collopy, 1998).

Around this period the general public also began insisting that they have a greater say in the way health services were provided. Consumers were demanding to know whether the increased levels of funding for health services were actually producing better health outcomes and raised issues such as consumer acceptability of health services. The demands for greater public accountability and transparency in the actions of health departments led to many changes in the focus of performance measurement and resulted in the introduction of the requirement for all health services to measure participant satisfaction.

In the last decade a more proactive approach towards better health outcomes has resulted in quality issues becoming “an impetus for change rather than a mere afterthought to change” (Barnsley et al, 1996, p 5). The realisation that meeting acceptable standards of efficiency alone would not guarantee high quality health care, resulted in a shift from the dependence on only measures of process and structure to include the use of outcome measures (Barnsley et al, 1996).

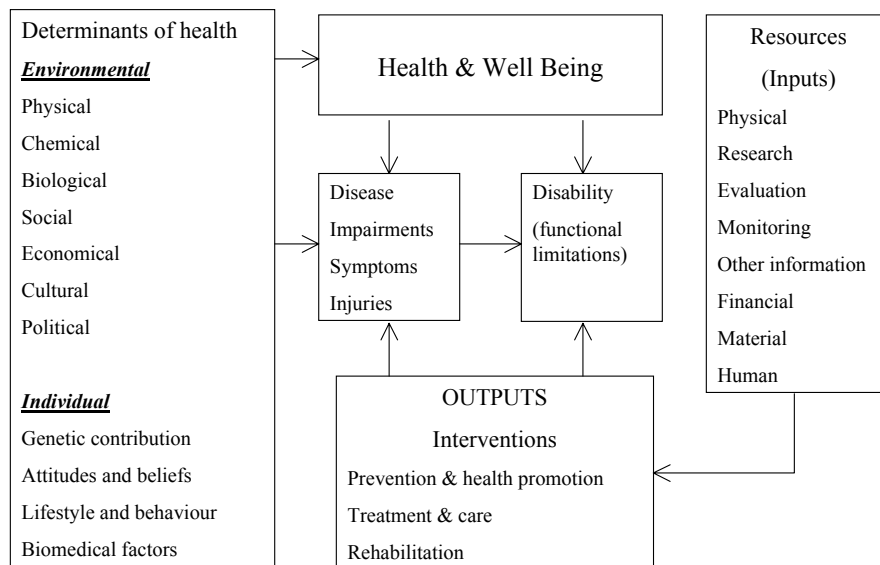
The focus on quality of care was accompanied by more innovative approaches to the measurement of provider performance and management of health services. In addition to the need to measure effectiveness, the importance of including the measurement of appropriateness of health care was also receiving attention. A treatment or program might be judged effective if it was performed correctly but if it wasn’t the best method of treatment for that condition it would not produce the most desirable outcome. For example, a below knee amputation for a ‘diabetic foot’ may be performed effectively, however, the most desirable outcome would be to prevent the infection from reaching that stage by more appropriate preventative measures such as education about foot care and optimal control of blood glucose levels.

Advances in diagnostic methods and therapeutic treatments were also placing increased demands on health systems. New treatments and better technologies were often more expensive, however, they also had an impact on the cost of health care by increasing the demand for health services. Furthermore, these technologies were improving survival rates and health outcomes and the aging population with their deteriorating health were also increasing the usage of health services and the types of health services required. The increasing longevity resulted

in a relative rise in chronic diseases and a need for more community based care and different models of disease management. (NHPC, 2000)

Information on changes in the health of populations was recognised as a valuable tool to assist planning of health care and to inform policy development and decision-making. However, there has also been a growing international recognition of the influence of social determinants on health status. Social and economic factors affect health throughout life and play a major role in health outcomes. Social determinants such as social class, stress, social exclusion, unemployment, poor social support, nutrition, environment, also need to be measured to allow a comprehensive and holistic approach to health policy. (NHPC, 2000) One model that has been developed to demonstrate the relationship between the factors influencing health is shown below (AIHW, 2000).

Figure 3: A Conceptual Framework for Health



In general, effective performance monitoring systems attempted to:-

- Promote a holistic view of health and its determinants;
- Promote of systematic development of appropriate indicators;
- Identify the level of development of existing indicators;
- Identify areas where indicators are lacking (gaps);
- Identify priority issues affecting health;
- Inform decision making and policy development;
- Support identification and definition of outcomes;
- Promote comparability and consistency of indicators developed for services provided by internal departmental providers and external providers (ie. NGOs);
- Inform data collection and data quality requirement.

To promote a more holistic view of health and incorporate the range of factors influencing health into a performance monitoring system a systematic and organised approach is required. The elements of this system include:-

- Identification of the desired outcomes of the health service;
- Establishment of a conceptual framework for health performance monitoring;
- Development of indicators that provide information.

Review of Existing Indicators

The consultation process and the scan of literature identified a number of completed and current initiatives occurring at a national and international level. Evidence available from these initiatives informed the development and refinement of many of the proposed measures. These initiatives included:

- The NHPC Report on Performance Indicators for primary health and community care
- The Victorian Ambulatory Care Sensitive Conditions Study: Preliminary Analysis

Draft Framework for Reporting on Indigenous Disadvantage

The refinement of the National Performance Indicators for Aboriginal and Torres Strait Islander Health
the development of national public health indicators being undertaken under the auspices of the National Public Health Partnership

The establishment of a National Funding Program for Cervical screening and State cervical smear registers.

The establishment of Aboriginal and Torres Strait Islander health framework agreements in each State and Territory.

The research from these projects has produced some nationally accepted definitions of National Performance Indicators for Aboriginal and Torres Strait Islander Health, standard calculation methods, standard definitions for source data and agreed minimum data sets.

4. The Development of a Framework for Performance Reporting

Principles of a Performance Reporting Process

A performance reporting process requires the interpretation of information from a range of sources that combine to form a picture of how effectively a services is achieving the required outcome for which it is being funded. It includes the following steps:

- Clearly defined outcomes and priorities of the health service
- Appropriate processes to collect information to report against performance measures
- The collation of performance reports within appropriate timeframes
- Analysis and interpretation of information by funding organisation
- Feedback and further planning and decision making

Agreed Purpose of the performance monitoring system for Indigenous PHC

The primary impetus for initiating the development of a performance reporting process was the imminent emergence of a number of Health Zones under PHCAP in Central Australia. However, the potential use of this process was seen to be relevant for all Indigenous primary health care services in the Northern Territory. This would broaden the use of the performance reporting process to include both urban and remote health services with many differences in their structure, their client populations and the service demands placed on them.

The principal use of this performance reporting process will be to measure the quality of primary health care services and the effectiveness of clinical and corporate governance practices of the Health Board. Many of the proposed measures can also be used by the Health Boards to assist decision-making, management and prioritisation in service provision. However, their primary purpose is to establish accountability processes between the funded organisation and the funding bodies.

During the planning meeting it was identified that there was a range of diverse expectations and requirements demanded of a performance monitoring system for Indigenous primary health care. Substantial discussion identified the following points in relation to the requirements of a performance reporting process. It should be able to:

- monitor primary health care services in terms of availability, accessibility, appropriateness etc of the health services
- monitor the health outcomes of the population within the Health Zone
- monitor the performance of the Health Boards
- monitor accountability for resource allocation
- monitor reforms in health service delivery
- monitor progress towards community control
- provide contextual information against which performance could be interpreted.

Expected Outcomes of Community Controlled Health Services

The Steering Group also acknowledged that the primary health services funded under the PHCAP are only one aspect of the total health system available to remote Indigenous people. There are a number of other factor influencing health outcomes, ranging from access to hospital care and specialist services to environmental and social disadvantage. A performance monitoring system will need to measure a range of information that will effectively monitor how well the health zones are performing. The measurement of population health outcomes provides data on the overall health of the population serviced within each zone. The interpretation, however, of indicators of health outcomes must consider that they measure other influences on health outside the control of Health Boards and are not necessarily an accurate reflection of the effectiveness of the Health Board in managing the primary health care service. For example, the inability to access tertiary health service may produce unfavourable health outcomes or a deterioration in determinants of health such as housing, education or employment could also produce poor health outcomes. In other words the performance of the health zones would be diluting within the measurement.

The expected outcomes for Community Controlled primary health care services funded under the PHCAP were used to guide the development of the performance reporting process. These outcomes are documented in the background information PHCAP: Guide for communities in the NT, (DHCS unpublished). The expected outcomes are to optimise the health of Indigenous people, particularly in remote areas, by improving the quality and appropriateness of health care services. This is achieved through the allocation of additional funding and the establishment of processes to assist the management of the services. It is anticipated that Indigenous PHC will:

- increase the availability of appropriate primary health care services where there are currently inadequate services;

reform the health system to better meet the needs of Aboriginal and Torres Strait Islander people; and assist individuals and community to take greater responsibility for their health.

National Health Performance Framework

In Australia, the need for performance monitoring of the health sector to be more coordinated as well as more comprehensive was generally acknowledged. A system was needed that would support indicator development in areas such as public health, community health and allied health, in addition to the acute care setting. To further the existing body of work the Australian Health Ministers' Conference established the National Health Performance Committee (NHPC, 2000). Their goal was to establish a framework against which the government could comprehensively report on the performance of the whole of Australia's health system.

The committee undertook a review of frameworks for monitoring health performance that had been established through effort within Australia as well as internationally. More recently, efforts have attempted to take a more holistic view of performance measurement of the health system by expanding the focus to include areas such as public health, community health and allied health. Subsequently, the National Public Health Partnership in conjunction with the NHPC, AIHW and representatives from the various jurisdictions began work on the development of a national health system framework that would (NHPC, 2000, p.21):

“provide a structure against which government can comprehensively and clearly report on the Australian health system's performance so that consumers, service providers and government can assess progress towards national health policy goals”.

During 2000 a number of national and international frameworks were reviewed for monitoring the performance of the health sector in Australia. From the range of frameworks reviewed an amended version of a model developed by the Canadian Institute for Health Information (CIHI, 2000) was recommended by the National Public Health Partnership Workshop for use in performance monitoring of the Australian health care system. One of the strengths of this framework is that it incorporates many familiar dimension of the frameworks previously developed in Australia eg Public Health Framework and the Framework for Acute Care. Features that were incorporated into the framework from international models were amended to suit Australian health priorities and to meet the needs of the Australian health system. The resulting framework is referred to as the National Health Performance Framework (NHIMG, 2001). It consists of three tiers:

Health status and outcomes: How healthy are Australians?

Determinants of health: Are the factors determining health changing for the better?

Health system performance: How well is the health system performing in delivery quality health actions to improve the health of all Australians?

The tiers are not represented in any order or hierarchy. They reflect the range of factors that influence the health of Australians and the performance of the health system. The tiers are further divided into dimensions. The “Health Status and Outcomes” tier has four dimensions: health conditions, health function, life expectancy and wellbeing, and deaths. The “Health Determinants” tier has five dimensions: environmental factors, socio-economic factors, community capacity, health behaviours, and person-related factors. The last tier, “Health System Performance”, is divided into nine dimensions: effective, appropriate, efficient, responsive, accessible, safe, continuous, capable, and sustainable. At each tier and dimension questions are posed to help focus attention on the relationship between the tiers and the dimension.

Equity and quality are integral parts of the framework. Equity can be applied across all dimensions of the framework using the question – ‘Is it the same for everyone?’ Differentials in equity can be presented by reporting by age, sex, rurality, ethnicity, socio-economic status etc.

Quality is also an integral part of the framework and measures are reflected in the dimensions of the health system performance tier. However, quality cannot be assessed through a single dimension such as cost effectiveness and must be viewed in light of the effectiveness of the delivery of interventions. (NHPC, 2000)

The NT DHCS has also endorsed this framework for used in development of performance reporting process with minor amendments to suit local needs (see Appendix B).

A Structure for PHC

To guide the development of the performance reporting process for PHC two related structures were used to inform the development of a framework. One is the ‘Definition of the core functions of Aboriginal Comprehensive Primary Health Care and the other is the ‘Roles and Responsibility of the Health Boards’. There is significant overlap between these two structures, therefore a combination of these two structures has been proposed. The two structures are documented below.

Definition Of The Core Functions Of Aboriginal Comprehensive Primary Health Care

The systematic documentation of the various elements of a service helps identify priority issues of the health system and enables clarity of the links between decision making and policy development. In addition, the process promotes comparability and consistency of indicator development for comparable services within the departments and across the health sector.

The agreed functions include:

1. Clinical Services

- a) Primary clinical care such as treatment of illness using standard treatment protocols, 24 hour emergency care, provision of essential drugs and management of chronic illness.
- b) Population health / preventative care such as immunisation, antenatal care appropriate screening, and early intervention, STD and other communicable diseases control.
- c) Clinical support systems such as pharmaceutical supply system and a comprehensive health information system.

2. Support Services

- a) Internal to the health services
 - Staff training and support such as AHW training, cross-cultural orientation, continuing education.
 - Management systems that are adequately resourced, financially accountable and include effective recruitment and termination practices.
 - Adequate infrastructure at the community level such as staff housing and clinic facilities, functional transport facilities.
- b) External to the health service
 - appropriate visiting specialists and allied health professionals
 - medical evacuation or ambulance services
 - access to hospital facilities
 - costs of transport and accommodation to access specialist and ancillary care
 - tertiary education and training

3. Special Programs

Resources should be made available for community initiated activities dealing with the underlying causes of ill health and population health programs which seek to promote good health and prevent poor health. Communities should determine their own priorities. These programs require community action or agency to have any chance of success.

They should include areas such as:

- substance misuse
- nutrition
- emotional and social well being
- environmental health
- oral health
- special services aimed at particular targets groups such as youth, frail aged and disabled people, mens health and womens health, young mothers, school children etc.

4. Advocacy and Policy Development

Advocacy and policy development activities provide opportunities for communities and organisations to advocate for their health needs and contribute to the development of policy that affects their health care.

Roles and Responsibilities of the Health Boards

The measurement of progress towards reform of the health system is assisted by a performance reporting process that is specifically relevant to the agreed roles and responsibilities of the Health Boards. Accountability and quality improvements in health service delivery can be included in the development of a framework using the concepts of corporate and clinical governance. These are defined as:

Corporate governance is a system through which an organisation is accountable for standards and performance in the delivery and aspects of business, including the quality of service provision (ie an effective Health Board).

Clinical governance is a system through which an organisation is accountable for continuously improving the quality of the health service and ensuring high standards of care by creating an environment to promote excellence in clinical care.

The roles and responsibilities of the Health Boards and, therefore, their accountability to the funding bodies will be determined through negotiations between the individual Health Boards and the PHC Standing Committee with the assistance of the consultants selected by each Health Board. The timing of this will depend on the individual readiness of each Health Board to take on these roles.

This project assumed that the Health Boards were fund holders with full responsibility for the provision of all primary health care services to the population of the Health Zone. The level of reporting required by Health Boards in a performance reporting process was agreed by the Steering Group to be as fundholders and purchasers of the health service.

The roles and responsibilities have been defined under four broad headings which include:-

1. Resource management

- Financial
- Human
- Physical

2. Compliance

3. Service Delivery

- Quality of service
- Range of programs etc

4. Innovation

- Initiative/leadership
- Creativity

The Agreed Structure for PHC Performance Reporting

These two concepts have been merged into one framework to avoid duplication and to more effectively guide the development of performance measures. The proposed combined framework includes two main headings (see Appendix C):-

- Quality of health service delivery
- Clinical and Corporate Governance of the Health Board

Quality of health service delivery is further divided into the three sub-headings; Clinical Services, Support Services and Special Programs.

Clinical and corporate governance of the Health Board is divided into four sub-headings; Strategic Capacity, Resource Management, Processes and Innovation.

The proposed set of performance measures for PHC that had been developed using the adapted Primary Health Care Framework (see Appendix C) were then mapped to the Health Information Framework (see Appendix B). This assisted consistency of indicators across national indicator sets and allowed the assessment of the coverage of the major areas impacting on health.

5. Discussion

Application of the Performance Reporting System

The primary impetus for initiating the development of a performance reporting process was the imminent emergence of a number of Health Zones under PHCAP in Central Australia. At the time of this report none of the emerging Health Boards in Central Australia under the PHCAP funding were available for consultation. The community controlled primary health care services that were available for consultation were two Health Boards established under the Coordinated Care Trial program (one of the Health Boards had recently signed an agreement under PHCAP) and an urban Indigenous health service. It was assumed that many of the lessons learned through the implementation of the Coordinated Care Trial program would assist the PHCAP process and that many of the issues associated with performance reporting and accountability were common between the two processes.

However, the potential application of this performance reporting process was thought to be broader than for services funded by PHCAP but that it could be relevant to all Indigenous primary health care services in the Northern Territory. This broader context was considered in the development of the performance reporting process with potential indicators being assessed for both urban and remote health services with many differences in their structure, their client populations and the service demands placed on them.

The principal use of this performance reporting process will be to measure both the quality of primary health care services and the effectiveness of clinical and corporate governance practices of the Health Board. The performance indicators included in the proposed set describe the health status of the community within the Health Zone. They reflect the incidence and prevalence of selected illnesses, social and economic well-being, factors pertaining to the organisation and delivery of health services, and social factors which affect the health of the communities.

Indicator Selection

The proposed performance indicators signal sentinel health-related information that draws attention to some of the major issues impacting on the health of Aboriginal and Torres Strait Islander people in Health Zones in the Northern Territory. As such they do not represent a complete list of all health-related problems or provide the information required identify the cause or to solve the problems. This can only be achieved by examining more detailed content-specific indicators or the use of other information.

In many cases the statistical information can be compared with NT data to indicate the differential between Indigenous and non-Indigenous health and assist in the interpretation of health priorities. Some indicators are proxies for other health issues where information is not readily available.

The majority of indicators are reported by gender and the differential will identify the priority health areas for males and females. A small number of indicators are gender specific such as indicators related to maternal health and screening for cervical cancer. Most of the indicators are also reported in age groups.

Many of the proposed measures can also be used by the Health Boards to assist decision-making, management and prioritisation in service provision. Collectively the indicators provide an overview of the health of Aboriginal and Torres Strait Islander peoples in each Health Zone as well statistical or descriptive information of health-related issues. They provide information about the clinical and corporate governance activities of Health Boards, and about the outcomes of actions taken. However, their primary purpose is to establish accountability processes between the funded organisation and the funding bodies.

To be considered for inclusion in the Performance Reporting process it was essential that the measures were useful for both the Health Board and the funding bodies. To enhance the validity and accuracy of the data collected by the Health Zones the information must be of interest and of relevance to the Zones. A major issue for reportability of data is the availability of effective information systems. Appropriate systems must be in place and able to be used by the local workforce. This will require significant training and support.

6. Conclusion

This project has identified a range of performance measures recommended for use by Indigenous Primary Health Care Services in the Northern Territory, primarily the Health Zones funded under PHCAP. The data provided through the performance monitoring process can be compared with previous trend data available or there may be comparison with other zones. In the latter situation there will be a need for contextual data such as employment and education statistics and quality of housing and other services to allow interpretation and meaningful comparisons.

The proposed performance measures are presented in Appendix B mapped to the Health Information Framework. This framework also includes some contextual measures that assist in the interpretation of the performance reporting process but not intended to be reported by Health Boards. These are identified in bold text. Several indicators measure progress in more than one domain within the Framework. This is demonstrated by including indicators in each relevant domain of the framework, and identifying the duplicates in italics. A supplementary list of data items that may be used by Health Board for decision making and priority setting is included as Appendix D. This document also identifies the source of the information.

An additional document "Technical Instructions" presents each performance measure with details regarding the rationale for use of the measure, a description of the measure or method of analysis, source of data and frequency of reporting. Previously reports were required 6 monthly, however, many indicators of health system performance require a longer timeframe than 6 months to indicate change. Many of the measures of health status were changed to annual reporting.

During the consultation process a number of domains of health were identified for which measures were not recommended for reporting. There were several reasons for this including:

- emerging capacity of Health Board / Health Service
- limitations in information systems
- indicator not well developed.

Some of the indicators or health domains considered but either not recommended for inclusion, or requiring further development, are listed below:

- Suicide rate
- Sexual assaults
- Injury rate
- Health Board capacity
- Prevalence of hazardous levels of alcohol / other drug intake
- Prevalence of tobacco use

Issues requiring further consideration

The issues raised during the two workshops and the consultations have been grouped into several themes and documented below.

Information Systems

The information system implemented by each Health Zone will need to be capable of providing the information required by the funding bodies as well as the local users and management. Additional considerations need to be made with regard to the consistency and comparability of the information provided. It is preferable that a common system is used by all health boards to enhance the consistency and comparability of data.

Common/Compatible Systems

There are a range of systems for managing medical information that are available to the Health Zones. In this project the capability of PCIS in providing the necessary data for the proposed indicator was reviewed. The use of PCIS provides an opportunity to reduce the risk of duplication of client records through the use of the unique identifier used by DHCS. This is particularly relevant for individuals who move between communities within a zone but can also identify individuals who are accessing services from more than one health zone. The PCIS also provides the potential to access a range of health information relevant to residents of the Zone that is held by the DHCS.

Technical support

Technical support for information systems in remote areas is a major issue for the existing Health Boards. Long periods of down time will result in a failure to electronically capture service episodes and poor quality or incomplete data. Consideration needs to be given to the development of IT services for remote areas sites.

Staff Training

Staff training is a major concern in all remote areas and is especially critical with information systems. High staff turnover and workload demands make ongoing training essential. Consideration needs to be given to the IT training needs of PHCAP sites especially those in remote areas.

Data management issues

Data management issues for consideration include:

- Geographical coding – ideally should be geographical coordinates to enable zone boundary changes to be readily accommodated and for analysis by different geographies to occur (ie remoteness).

- Identification of Indigenous status, resident / visitor status, etc

- Data definitions

- Completeness of electronic record

- Data replication process to prevent duplicate records for health zones with multiple sites

Preparation of Reports

Most Health Boards will require some assistance from Governments with analysis of data, preparation of performance reports and access to external data sources. Health Boards that are well established may have expertise in analysing and reporting on the data collected within their service. However, much of the information required for priority setting and decision-making may be difficult for Health Boards to obtain. A process is needed to ensure that relevant data from external agencies is made available.

Emerging Health Boards may require more assistance in the early stages. They may require assistance with all aspects of reporting including use of data collection systems, analysis of data and report preparation.

Communication/Feedback with Health Boards

There needs to be a capacity within the funding bodies to collate and analyse reports for purposes of comparison, benchmarking and responding to the reports with timely feedback of relevant evaluation to Health Boards. This will promote quality improvements as well as ensuring the opportunity for the two-way exchange of information.

Workshop participants stressed the need for procedures and schedules for routine communication with Health Boards. This should include feedback on performance/financial reports and a process for regular communication. This communication should assist continuous quality improvement, not just when things were go wrong. Although the need for processes to be in place to ensure a rapid response to support Health Boards who were faltering was strongly supported.

The workshop participants also emphasised the need for funding bodies to acquire expertise in understanding and appropriately responding to individual performance reports. This would include the collation of information across Health Zones in order to assist benchmarking.

Alternative Providers

In zones with more than one potential provider of health services the reporting of information may be complicated ie lack of clarity with regard to denominators etc.

Duplication of Reporting

Some of the proposed PHC indicators are also included in the SAR. This will require duplicate reporting. A process to reduce duplication of effort by facilitating the sharing of information might be considered.

Quality Assurance Systems

The workshop participants stressed the requirement for Health Boards to establish an infrastructure to support quality data collection systems. This included the need to develop quality assurance systems for areas such as:

- Accreditation

- Clinical audits

- File audits

- Staff feedback

Client Populations

In remote areas it is most likely that there will only be one provider of primary health care services, compared with urban areas where there are generally several alternative providers of primary health care services. It was assumed that for indicators measuring coverage of population health services the target population was the whole 'resident population' of the geographical area or Health Zone. For other indicator the population was defined as the 'serviced population', which may be different from the estimated resident population. A number of different population definitions are included in Appendix E.

7. Recommendations

The development of the proposed performance reporting process has been developed with much consultation, however, there has been limited input from emerging Health Boards. Although established Health Boards and Indigenous Health Services have demonstrated that they are able to report on these measures the ability of new Health Board to provide similar information may be affected by immature information systems and limited experience. There may also be a time lag between the establishment of the Health Board and its ability to adequately report on their performance.

The proposed indicators should be considered a starting point for further refinement and research into development of the most effective measures to for performance reporting and the infrastructure required to support this process. Some specific recommendations include:

Further Refinement

A process for ongoing assessment, review and refinement of the performance reporting process should accompany the implementation of this performance reporting process. This should test the appropriateness and suitability of the proposed indicators as well as their reportability and usefulness. Further refinement could be undertaken as a Participatory Action Research project that would allow greater consultation with a broader range of Indigenous community members and health care providers.

Development of Procedures, Protocols and Review Audits

Significant effort has gone into the development of operating procedure manuals, protocols and review audit tools for quality assurance. To prevent duplication of effort generic manuals and audit tools could be provided to emerging Health Boards.

Information Systems

Establishment of guidelines for information system that will meet the needs of the health service in terms of client management, financial management and performance reporting.

Feedback on Reports

Establishment of a process for timely review, analysis and feedback on performance reports to the Health Boards.

Benchmarking

Development of targets and benchmarks for performance measures to assist Health Boards in quality assurance and improvement processes.

MoU for Provision of Information

Much of the information necessary for Health Board to make informed decision about health service management and health priorities is not readily available to Health Boards. A process to assist Health Boards in obtaining this information would assist their capacity for clinical and corporate governance.

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8. Appendix A: List of Consultations

Jenny Cleary (DHCS)
Noelene Swanson (DHCS)
Roger Brailsford (DHCS)
James Baban (DHCS)
Leonie Young (DoHA)
Janice Barr (DoHA)
Sharon Clark (OATSIH)
Jenny Norris (OATSIH)
Peter Pearse (OATSIH)
Christine Edwards (OATSIH)
Andrew Benson (OATSIH)
Frances McCann (ATSIC)
Stephanie Bell (AMSANT)
Dr John Boffa (CAAC)
Donna Ah Chee (CAAC)
Kez Hall (Danila Dilba)
Irene Fischer (Sunrise HB)
Sanchia Shibasaki (CAAC)
Peter D'Abbs (MSHR)
Gary Robinson (NTU)
Terry Dunbar (Research Advisory Working Group)
Kirk Whelan (KWHB)
Dr Andrew Bell (KWHB)
Libby Lawler (KWHB)
Bill Barclay (THB)
Dave Morris (THB)
Brett Kirkwood (DHCS)
Dr John Condon (MSHR)
Dr Joan Cunningham (MSHR)
Dr David Ashbridge (DHCS)
Dr Vicki Krause (DHCS)
Dr Christine Selvey (DHCS)
Dr Jan Savage (DHCS)
Mary-Anne Measey (DHCS)
Tamie Devine (DHCS)
Cynthia Croft (DHCS)
Rebecca Orr (DHCS)
Sandy Spears (DHCS)
Margo MacGregor (DHCS)
Richard Inglis (DHCS)
Gloria Bailey (DHCS)
John Paice (ABS)
Allison Stewart (MSHR)
Matthew Stevens (MSHR)
Judy Barnes (OATSIH)
Nada Pavlak (OATSIH)
Kylie Jonasson (DoHA)

9. Appendix B: Primary Health Care Performance Measures mapped to the Health Information Framework

Health Status and Outcomes			
How healthy are Territorians: Where is the opportunity for improvement?			
Health Conditions	Human Functions	Life Expectancy and Well-being	Deaths
<i>Prevalence of disease, disorder, injury or trauma or other health-related states.</i>	<i>Alterations to body, structure or function (impairment), activities (activity limitation) and participation (restrictions in participation)</i>	<i>Measures of physical, mental and social well-being.</i>	
Prevalence of preventable chronic diseases in resident clients aged 15 years and over, by age and gender	Disability rates Presentations to emergency for injury/trauma Amputations resulting from poor diabetic control	Number and proportion of screened children less than 2 years of age who are underweight Proportion of children less than 5 years of age who are anaemic.	Mortality rate in Health Zone
Determinants of Health			
Are we trending towards or away from health?			
Environmental Factors	Socio-economic Factors	Person-related Factors	
<i>Physical, chemical and biological factors such as water, food and soil quality</i>	<i>Such as education, employment, per capita expenditure on health and average weekly earnings, income distributions</i>	<i>Genetic related susceptibility to disease and other factors</i>	
Frequency of refuse removal Sealed roads Food supply, store turnover and store opening hours House occupancy rate Number and proportion of Indigenous people who reside in dwellings with adequate water, electricity and sewerage	Proportion of adults aged 20-64 who are employed full-time, employed part-time, unemployed, on CDEP and not in the labour force, by indigenous status Number of adults aged 20-24 who have completed secondary school (or equivalent level of education) by gender and indigenous status Number completing Year 12 by region School attendance at each primary school in Health Zone Average income	Number and proportion of liveborn infants born to resident clients in selected birthweight range. Mean birthweight of liveborn infants born to resident clients	
Community Capacity		Health Behaviours	
<i>Characteristics of the community such as population, age structure, health literacy, education, community support services, housing and transport</i>		<i>Aspects of personal behaviour and risk factors that influence health status, including behaviours, meanings and knowledge</i>	
Number of resident clients serviced by Health Zone by age, sex and Indigenous status. Local training opportunities and proportion of workforce filled by local Indigenous people.		Store sales of cigarettes expressed as number of cigarettes per resident population Qualitative report on initiatives targeted at reducing use of hazardous substances eg alcohol, tobacco and kava. Number and proportion of resident clients aged 15 years and over with BMI in the overweight and obese range, by age group and gender	

indicators in italics appear in more than one section

indicators listed in bold are contextual indicators are not required to be reported on

Health System Performance

How well is the THS health system performing in delivering actions to improve the health of Territorians?

Effective	Coordinated, Appropriate and Safe
<p><i>Care, intervention or action achieves desired outcome</i></p>	<p><i>Care/intervention/action is coordinated and relevant to the client's need and based on established standards. Potential risks of an intervention or environment are identified and avoided or minimised</i></p>
<p>Proportion of clients with preventable chronic diseases managed on care plans (by disease).</p> <p>Proportion of resident clients with diabetes who have had a HbA1c test in the last 12 months.</p> <p>Proportion of resident clients with diabetes with a HbA1c less than 7% and less than 9.5% in the last 12 months</p> <p>Mean HbA1c level for resident diabetic clients in the last 12 months</p> <p>Proportion of resident children fully immunised at 1 year and 2 years and 6 years of age</p> <p>Proportion of resident clients aged 50 years and over who were immunised for influenza in the previous 12 months, by gender</p> <p>Number and proportion of resident clients who have been seen by a dentist or dental therapist in the previous twelve months.</p> <p>Proportion of resident clients aged 5 and 10 years who have participated in a school screening program in the previous 12 months, by gender. Also provide details on:</p> <p>Number and proportion of 4-5 year olds who had ear examinations (otoscopy) and number and proportion who needed followup.</p> <p>Number and proportion of 4-5 year olds who were screened for hearing and number and proportion who needed followup.</p> <p>Number and proportion of 10 year olds who had urinalysis for proteinuria and number and proportion who needed followup.</p> <p>Number and proportion of 10 year olds who had a heart examinations (for rheumatic heart disease) and number and proportion who needed followup</p> <p>Number and proportion of 10 year olds who had a Mantoux test.</p> <p>Proportion of resident clients aged 15 years and over who were screened for chronic diseases in the past year, by age group and gender. Also report on:</p> <p>Number and proportion of population who have been tested for chlamydia, gonorrhoea, syphilis and HIV/AIDS in the last 12 months, by age group and gender</p> <p>Number and proportion of screened population who reported use of tobacco.</p> <p>Number and proportion of screened population who report use of harmful or hazardous levels of alcohol consumption</p> <p>Number and proportion of population who were screened for hypertension</p> <p>Proportion of resident female clients having pap tests for cervical cancer in the previous 24 months period for the target group (15 – 69 years)</p>	<p>Report on normal health centre hours and after hour's service if provided.</p> <p>If after hours service provided, report on proportion of consultation after hours</p> <p>If after hours service provided, report on procedures implemented for staff safety on after hours call outs</p> <p>Proportion of resident clients who have an abnormal pap smear in the previous 12 months who have had appropriate followup</p> <p>Report on procedures in place to follow up on abnormal laboratory tests.</p>

indicators in italics appear in more than one section

Accessible and Responsive	
<i>Ability of the community to obtain care or service at the right place and right time, with access to appropriate technology and accommodation</i>	
<p>Mean number of consultations per estimated zone resident, per year, by service provider type, health centre, age group, gender and indigenous status</p> <p>Ratio of full time equivalent staff to estimated zone population, by profession</p> <p>Proportion of pregnant resident clients attending their first antenatal visit at or before 13 and 20 weeks gestation</p> <p><i>Proportion of resident clients with diabetes who have had a HbA1c test in the last 12 months</i></p> <p><i>Number and proportion of resident clients who have been seen by a dentist or dental therapist in the previous twelve months.</i></p> <p><i>Proportion of resident clients aged 5 and 10 years who have been screened according to the guidelines for Healthy School Aged Kids in the previous 12 months, by gender.</i></p> <p><i>Proportion of resident clients aged 15 years and over who were screened for chronic diseases in the past year, by age group and gender</i></p> <p><i>Proportion of population who have been tested for chlamydia, gonorrhoea, syphilis and HIV/AIDS in the last 12 months, by age group and gender</i></p> <p><i>Proportion of resident female clients having pap tests for cervical cancer in the previous 24 months period for the target group (15 – 69 years)</i></p>	
Efficient	Capable and Sustainable
<i>Achieving desired results with the most cost effective use of resources</i>	<i>System or capacity to provide a health service and infrastructure such as workforce, facilities and equipment, and to be innovative and respond to emerging needs (research, monitoring)</i>
<p>Provide evidence of risk management strategies and discuss their implementation</p> <p>Proportion of total funding managed by Health Board that was sourced from funding bodies other than PHCAP</p> <p>NB: Financial measures listed in separate document</p>	<p>Average number of filled board places in the previous 12 months per meeting</p> <p>Number of meetings of the board and proportion of board members in attendance</p> <p>Report on turnover of Health Board members and any issues related to recruitment of Board members</p> <p>Proportion of board members undertaking governance training by type of training undertaken ie financial, management, computing etc. in the previous 12 months</p> <p>Report on actions taken to ensure compliance with formalised policies and guidelines for clinical management</p> <p>Is the health service accredited. Report of processes in place to assess client satisfaction</p> <p>Provide evidence of formal guidelines for staff recruitment and termination including report on current EBA and identify issues related to completion and/or implementation of EBA</p> <p>Number of visitor clients who have presented to the health centre at least once during the last 12 months, by age, gender and Indigenous status</p> <p>Provide details of training and development opportunities by professional group and type of training undertaken</p> <p>Proportion of new staff who have been employed for at least 6 months who have attended an orientation program</p> <p>Report of processes in place to ensure cultural awareness of staff</p> <p>Report on quality assurance processes including development of procedures manual and systems for audit and review of health services</p> <p>Report on strategies and practices for community involvement in health planning</p>

indicators in italics appear in more than one section

10. Appendix C: Proposed Framework for Indigenous PHC

Quality of health service delivery

1. Clinical Services

Primary clinical care such as treatment of illness using standard treatment protocols, 24 hour emergency care, provision of essential drugs and management of chronic illness.

Population health / preventative care such as immunisation, antenatal care appropriate screening, and early intervention, STD and other communicable diseases control.

Clinical support systems such as pharmaceutical supply system.

2. Support Services

External to the health service

appropriate external health services

medical evacuation or ambulance services

access to hospital facilities

3. Special Programs

Resources should be made available for community initiated activities dealing with the underlying causes of ill health and population health programs which seek to promote good health and prevent poor health. Communities should determine their own priorities. These programs require community action or agency to have any chance of success.

They should include areas such as:

substance misuse

nutrition

emotional and social well being

environmental health

oral health

special services aimed at particular targets groups such as youth, frail aged and disabled people, mens health and womens health, young mothers, school children etc.

Clinical and Corporate Governance of Health Board

1. Strategic Capacity

Patient focus (advocacy)

Leadership

Direction and planning (policy development)

2. Resource Management

Financial accountability

Human

Staff recruitment and termination practices

Staff training

Staffing levels/mix

Physical

Adequate infrastructure at the community level such as staff housing and clinic facilities, functional transport facilities.

3. Processes

Patient and public involvement

Clinical audit

Effective risk management

Clinical effectiveness programmes

Health information system

4. Innovation

Initiative/leadership

Creativity

11. Appendix D: Additional Information for use by Health Boards

	Suggested Measures for use by Health Boards	Data Source
Health Status and Outcomes	Health Conditions	
	Number of patients per year by diagnostic category eg Accident/injury, infections etc	MIS
	Notification for sexually transmitted diseases by major health location/service	DHCS-CCIS
	Hospitalisation rates for mental health conditions	DHCS-CareSys
	Hospital presentations for suicide / attempted suicide.	DHCS-CareSys
	Presentations to emergency for injury/trauma	DHCS-CareSys
	Point prevalence of scabies	MIS
	Human Functions	
	Disability rates	DHCS / MIS
	Births & deaths	
	Birth rate by zone	MIS
	Mortality rate by zone	MIS
Determinants of Health	Environmental Factors	
	Food supply, store turnover and store opening hours	DHCS-MBS / Internal reports
	Socio-economic Factors	
	Proportion of adults aged 20-64 who are employed full-time, employed part-time, unemployed, on CDEP and not in the labour force, by indigenous status	ABS
	Number of adults aged 20-24 who have completed secondary school (or equivalent level of education) by gender and indigenous status	DEET / ABS
	Number completing Year 12 by region	DEET
	School attendance at each primary school in Health Zone	DEET
	House occupancy rate	Housing survey/ IHANT
	Number and proportion of Indigenous people who reside in dwellings with adequate water, electricity and sewerage	IHANT
	Average income	ABS
	Person-related Factors	
	Number of brief interventions for substance use (by substance type)	MIS
	Ratio of staff to population by profession for each health centre	Internal Report
	Proportion of population participating in physical activity	Survey
	Level of Gambling	Survey
	Recreational facilities, sporting clubs and programs	Survey
Health System Performance	Effective	
	Proportion of patients who have a care plan by gender and indigenous status	MIS
	Proportion of children seen in the health centre in the previous month who have immunisations due that are given the relevant immunisation	MIS
	Proportion of adults seen in the health centre in the previous month who have immunisations due that were given the relevant immunisation	MIS
	Costs of transport and accommodation to access specialist and ancillary care	Internal report

Health System Performance	Coordinated, Appropriate and Safe	Data Source
	Availability of interpreter services	Internal report
	Health Care facility adequacy for number of clients and activities required.	Internal report
	Proportion of vehicles functional for transport purposes.	Internal report
	Report on results of clinical audit ie including quality of clinical records, the extent to which clinical management follows clinical protocols, the documentation relating to management plans and referrals.	Internal report
	Implementation of Service standards	Internal report
	Accessible and Responsive	
	Number of clinic presentation by diagnosis	MIS
	Proportion of females screened through the BreastScreen Australia program in the target age group (50-69 years).	BreastScreen Australia
	Number of visits by external health professional by profession type	Internal report / DHCS
	Number of emergency medical air evacuation by disease category	Internal report / DHCS
	Number of ambulance services by disease category	Internal report / DHCS
	Number of hospital admissions by age group and diagnosis	DHCS
	Number of targeted education sessions, by substance and target group	Internal report
	Waiting lists for general and denture clients per quarter by number and time	MIS
	List of health promotion programs by targeted group	Internal report
	Number of consultation regarding health care carried out during the year with residents of the health zones.	MIS
	Proportion of residents satisfied with the service	Internal report
	Number of complaints and type	Internal report
	Efficient	
	Number of out of hours call outs by staff and reason for call out	MIS
	Capable and Sustainable	
	Proportion of staff undertaking performance management	Internal report
	Staff turnover	Internal report
	Report on progress in implementation of health information systems.	Internal report
	Functionality of other systems to support delivery of health care ie. pharmaceutical system	Internal report
	Proportion of resident clients aged 55 years or over who have had a EPC item claimed for a health assessment in the previous 12 months, by gender.	HIC
	Report on development of innovative models of service delivery to suit the unique needs of the population.	Internal report

12. Appendix E: Population Estimates

Within the proposed set of performance measures for Primary Health Care there is a need to define a number of different population for use as denominators. These populations include:

Estimated resident population (Indigenous / non Indigenous). *Used as denominator for evaluation of success of population health programs.*

Serviced (client) population (Indigenous / non Indigenous). *Used to evaluate effectiveness of health care to residents who access the PHC services.*

Service population subgroups ie clients diagnosed with diabetes

A range of definitions are required to promote consistency and comparability across Zones. Some proposed definitions are included below.

Estimated resident population

Estimated resident population includes those who usually live in the health zone and who are eligible to receive primary health care services during the reporting period. These initial estimates will be replaced with revised estimates based on subsequent service enrolments and service delivery levels. Services will be required to enrol their total service population in Medicare.

Serviced (client) population

Serviced population includes those who were provided with one or more episodes of health care by the health service during the reporting period. This population assesses the extent of penetration by the health service into the resident population.

Resident

A resident is an individual who is identified as 'belonging' in the Zone, who usually resides in the Zone and has been present in the Zone for at least 6 months of the reference period.

Visitor

Visitors are those who usually reside outside the health zone but were provided with one or more episodes of health care by the health service during the reporting period.

Condition Specific Population

Condition specific population includes those who are diagnosed with a particular condition according to the established criteria (ie CARPA Standard Treatment Manual), who usually live in the health zone and who are eligible to receive primary health care services during the reporting period.

13. Performance Reporting Template

3. Health Condition

1. Prevalence of preventable chronic diseases in resident clients aged 15 years and over, by age group and gender

Males										
	Diabetes		Hypertension		Heart Disease		Respiratory Disease		Renal Disease	
Age (yrs)	No.	% of Pop	No.	% of Pop	No.	% of Pop	No.	% of Pop	No.	% of Pop
15-24										
25-44										
45-64										
65+										

Females										
	Diabetes		Hypertension		Heart Disease		Respiratory Disease		Renal Disease	
Age (yrs)	No.	% of Pop	No.	% of Pop	No.	% of Pop	No.	% of Pop	No.	% of Pop
15-24										
25-44										
45-64										
65+										

Life Expectancy and Well-being

2. Number and proportion of screened children less than 2 years of age who are underweight

	No. of children	Proportion of screened children (%)
Underweight Children		

3. Number and proportion of screened children less than 5 years of age who are anaemic.

	No. of children	Proportion of screened children (%)
Children with anaemia		

4. Person-related Factors

4. Number and proportion of liveborn infants born to resident clients in selected birthweight range.

	No. low birthweight	Proportion of liveborn infants (%)
>1000g		
1000-1499g		
1500-2499g		
2500 – 3999g		
4000g and over		

5. Mean birthweight of liveborn infants born to resident clients

12. Proportion of resident clients with diabetes who have had a HbA1c test in the last 12 months.

Total no. of patients with diabetes	No. having HbA1c test	Proportion (%)

13. Proportion of resident clients with diabetes with a HbA1c less than 7% and less than 9.5% in the last 12 months

	No. having HbA1c test result	Proportion of residents with diabetes
Less than 7%		
Less than 9.5%		

14. Mean HbA1c level for resident diabetic clients in the last 12 months.

Sum of most recent HbA1c for each clients tested	No. of clients tested	Mean HbA1c

15. Proportion of resident children fully immunised at 1 year and 2 years and 6 years of age

Age Group	No. of children	Proportion (%)
12-15 months		
24-27 months		
60-63 months		

16. Proportion of resident clients aged 50 years and over who were immunised for influenza in the previous 12 months, by gender.

	No. of clients ages 50 yrs & over	No. of clients 50yrs & over immunised for influenza	Proportion (%)
Males			
Females			

17. **Number and proportion of resident clients who have been seen by a dentist or dental therapist in the previous twelve months**

Total no. of resident clients	No. seen by dentist / dental therapist	Proportion (%)

18. **Proportion of resident clients aged 5 and 10 years who have participated in school screened Kids in the previous 12 months, by gender.**

Age	No. of children		No. of children screened		Proportion (%)	
	Males	Females	Males	Females	Males	Females
5 year old						
10 year old						

18 (Cont.)

Also provide details on:

Number and proportion of 4-5 year olds who had ear examinations (otoscopy) and number and proportion who needed followup.

Number and proportion of 4-5 year olds who were screened for hearing and number and proportion who needed followup.

Number and proportion of 10 year olds who had urinalysis for proteinuria and number and proportion who needed followup.

Number and proportion of 10 year olds who had a heart examinations (for rheumatic heart disease) and number and proportion who needed followup

Number and proportion of 10 year olds who had a Mantoux test.

Screening test	No. of children tested	No. requiring follow-up	Proportion requiring follow-up (%)
Otoscopy (4-5 yrs)			
Hearing (4-5 yrs)			
Urinalysis (10 yrs)			
Heart examination (10 yrs)			
Mantoux test (10 yrs)			

19. **Proportion of resident clients aged 15 years and over who were screened for chronic diseases (eg using the CARPA Standard Treatment Manual guidelines for 'Well Person' screening) in the past year, by age group and gender.**

Age	Screening for Chronic Diseases			
	Males		Females	
	Total No. screened	Proportion of population %	Total No. screened	Proportion of population %
15-24				
25-44				
45-64				

65+				
Total				

Also provide details on:

Number and proportion of population who have been tested for chlamydia, gonorrhoea, syphilis and HIV/AIDS in the last 12 months, by age group and gender

Number and proportion of screened population who reported use of tobacco.

Number and proportion of screened population who report use of harmful or hazardous levels of alcohol consumption

Number and proportion of population who were screened for hypertension.

Males									
Age (yrs)	Total Pop	Screened for Chlamydia		Screened for Gonorrhoea		Screened for Syphilis		Screened for HIV/AIDS	
		No.	% screened	No.	% screened	No.	% screened	No.	% screened
15-24									
25-44									
45-64									
65+									

Females									
Age (yrs)	Total Pop	Screened for Chlamydia		Screened for Gonorrhoea		Screened for Syphilis		Screened for HIV/AIDS	
		No.	% screened	No.	% screened	No.	% screened	No.	% screened
15-24									
25-44									
45-64									
65+									

Males							
Age (yrs)	Total Pop	Reported use of tobacco		Reported harmful alcohol use		Screened for Hypertension	
		No.	% screened	No.	% screened	No.	% screened
15-24							
25-44							
45-64							
65+							

Females							
Age (yrs)	Total Pop	Reported use of tobacco		Reported harmful alcohol use		Screened for Hypertension	
		No.	% screened	No.	% screened	No.	% screened
15-24							
25-44							
45-64							
65+							

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9. Accessible and Responsive

26. **Mean number of consultations per estimated zone resident, per year by service provider type, health centre or major locality, age group, gender and client Indigenous status**

Consultations with Doctors								
Age Groups	Indigenous Males		Non-Indigenous Males		Indigenous Females		Non-Indigenous Females	
	No of consultations	Mean	No of consultations	Mean	No of consultations	Mean	No of consultations	Mean
15-24								
25-44								
45-64								
65+								
Total								

Consultations with Nurses								
Age Groups	Indigenous Males		Non-Indigenous Males		Indigenous Females		Non-Indigenous Females	
	No of consultations	Mean	No of consultations	Mean	No of consultations	Mean	No of consultations	Mean
15-24								
25-44								
45-64								
65+								
Total								

Consultations with Health Workers								
Age Groups	Indigenous Males		Non-Indigenous Males		Indigenous Females		Non-Indigenous Females	
	No of consultations	Mean	No of consultations	Mean	No of consultations	Mean	No of consultations	Mean
15-24								
25-44								
45-64								
65+								
Total								

27. **Ratio of full time equivalent staff to estimated zone population, by profession**

Profession	No. of FTE	Est. Population	Ratio FTE:Population
Doctors			
Nurses			
Aboriginal Health Workers			
Allied Health Professionals			
Etc			

PRIMARY HEALTH CARE PERFORMANCE MEASURES

TECHNICAL INSTRUCTIONS



PO Box 41096
Casuarina, NT 0811

June 2003

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42.	Report on quality assurance processes including development of procedures manual and systems for audit and review of health services.....	70
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15.

ABBREVIATIONS

ACIR	Australian Childhood Immunisation Register
AIHW	Australian Institute of Health and Welfare
BMI	Body Mass Index
CARPA	Central Australian Rural Practitioners Association
CCIS	Community Care Information System
CIN	Cervical Intraepithelial Neoplasia
DHCS	Department of Health and Community Services
DoHA	Department of Health and Aging
FTE	
GAA	Growth Assessment and Action
HbA1c	Glycated Haemoglobin
NHPC	National Health Performance Committee (National Report on Health Sector Performance Indicators)
NHS HA	National Health Service – Hospital Authority
NIDDM	Non insulin dependent diabetes mellitus
NPIATSIH	National Performance Indicators for Aboriginal and Torres Strait Islander Health
PHCAP	Primary Health Care Access Program
STIs	Sexually Transmitted Diseases

16. TECHNICAL INSTRUCTION FOR ANALYSIS AND PRESENTATION

ITEM	DESCRIPTION
Indicator	<i>Prevalence of preventable chronic diseases in resident clients aged 15 years and over, by age and gender</i>
What the indicator tell us	This indicator measures changes in the identification of client with the 5 Preventable Chronic Diseases over time. Increases in prevalence may be the result of increased screening so this measure should be interpreted in the context of the history of screening programs that have been conducted.
Numerator	The number of people aged 15 years and over with the 5 Preventable Chronic Diseases in the following age categories: 15-24, 25-44, 45-64, 65 and over, by gender.
Denominator	Estimated resident population for the same time period by the same age and sex categories.
Source of data	Internal Medical Information System
Method of calculation of indicator	Divide numerator by denominator then multiply by 100 for expression as percentage.
Frequency of reporting	Annually
Evidence base justifying inclusion of indicator	Similar indicators are in use in other countries (ie UK, USA) and are being proposed as developmental indicators by NHPC.

ITEM	DESCRIPTION
Indicator	<i>Number and proportion of screened children less than 2 years of age who are underweight</i>
What the indicator tell us	The measurement of growth of children under 2 years is a sensitive indicator of the nutritional status of children.
Numerator	Number of children who were less than the two standard deviations away from the mean weight for age
Denominator	Number of children under two years of age who were screened for weight in the specified time period.
Source of data	DHCS – GAA or Internal Medical Information System
Method of calculation of indicator	Divide numerator by denominator then multiply by 100 for expression as percentage.
Frequency of reporting	Annually
Evidence base justifying inclusion of indicator	Weight for age is a sensitive measure of growth in children. The calculation does not require height so coverage is generally better weight for height.

ITEM	DESCRIPTION
Indicator	<i>Proportion of children less than 5 years of age who are anaemic.</i>
What the indicator tell us	This indicator reflects effectiveness of program to reduce anaemia in children.
Numerator	Number of children with a haemoglobin level less than 11.0mmol/L in the reporting period.
Denominator	Number of children under five years of age who were screened for anaemia in the specified time period.
Source of data	DHCS – GAA or Internal Medical Information System
Method of calculation of indicator	Divide numerator by denominator then multiply by 100 for expression as percentage.
Frequency of publication	Annually
Evidence base justifying inclusion of indicator	Anaemia in children can result in delayed growth and development. Education and treatment programs have produced significant improvements in Hb levels and educational outcomes.

ITEM	DESCRIPTION
Indicator	<i>Number and proportion of liveborn infants born to resident clients in selected birthweight range.</i>
What the indicator tell us	Reflects the health of pregnant Aboriginal and Torres Strait Islander women, their access to and utilisation of antenatal care, and the quality of antenatal care. Also is an indicator of future health and development of infants.
Numerator	Number of liveborn infants born to women who are usual residents of the Health Zone in each weight range in a specified time period.
Denominator	Total number of liveborn infants born to women who usually reside in the Health Zone in the same time period.
Source of data	Department of Health and Community Services – Perinatal Statistics
Method of calculation of indicator	Divide each numerator by the denominator then multiply by 100 for expression as percentage.
Frequency of reporting	Annually
Evidence base justifying inclusion of indicator	The definition of low birth weight is considered to be those less than 2,500g. Improvement in maternal nutritional status may gradually shift the whole population or change the normal distribution of birthweights. The inclusion of a number of weight ranges below 2,500g will allow a change to be more readily observed. Inclusion of the weight range 4000g and over will allow the proportion of large babies to be monitored.

ITEM	DESCRIPTION
Indicator	<i>Mean birthweight of liveborn infants born to resident clients</i>
What the indicator tell us	This indicator provides additional information on changes in birth weight of all newborns
Numerator	Sum of all birthweights of liveborn infants to resident clients.
Denominator	Number of liveborn infants to resident clients
Source of data	DHCS – Perinatal Statistics
Method of calculation of indicator	Divide the numerator by the denominator.
Frequency of reporting	Annually

Evidence base justifying inclusion of indicator	Allows changes in the distribution of the birthweight of the whole population to be observed.
-------------------------------------------------	-----------------------------------------------------------------------------------------------

ITEM	DESCRIPTION
Indicator	<i>Number of resident clients serviced by Health Zone by age, sex and Indigenous status.</i>
What the indicator tell us	Demographic information. Health Zones will vary according to the number of residents accessing the service.
Description	Report on number of resident clients serviced by Health Zone by age, sex and Indigenous status. See Appendix 1 for definition of client population.
Source of data	Internal Medical Information System
Frequency of reporting	Annually
Evidence base justifying inclusion of indicator	Useful data for planning and resource allocation.

ITEM	DESCRIPTION
Indicator	<i>Local training opportunities and proportion of workforce filled by local Indigenous people.</i>
What the indicator tell us	This indicator reports on development and uptake of local people into the health workforce.
Description	Report on types of training programs provided or made available to local Indigenous people to improve their access to employment in the local health service. Provide details of the number of people accessing the training activities and the proportion of the workforce filled by people who normally reside in the Health Zone
Source of data	Internal report / staff records.
Frequency of reporting	Annually
Evidence base justifying inclusion of indicator	The involvement and employment of local people will enhance the appropriateness and the acceptability of the health service. Improved employment opportunities has also been linked with improvements in health status.

ITEM	DESCRIPTION
Indicator	<i>Store sales of cigarettes expressed as number of cigarettes per resident population</i>
What the indicator tell us	This indicator reflects changes in the consumption of tobacco by residents of the Health Zone
Numerator	Number of cigarettes sold at retail outlets in the Health Zone in the specified period.
Denominator	Estimated resident population for the Health Zone in the specified period.
Source of data	Local retail outlets
Method of calculation of indicator	Divide the numerator by the denominator.
Frequency of reporting	Annually
Evidence base justifying inclusion of indicator	Tobacco use is a major preventable health problem for Indigenous Australians. This indicator reflects the impact of targeted health promotion programs to reduce smoking.

ITEM	DESCRIPTION
Indicator	Qualitative report on initiatives targeted at reducing use of hazardous substances eg alcohol, tobacco and kava.
What the indicator tell us	This indicator provides a record of the types of initiatives targeted at reducing use of
Description	Qualitative report on types of program used to reduce hazardous substance use. Information on numbers of people involved in programs and description of types of activities should be documented.
Source of data	Internal report
Frequency of reporting	Annually
Evidence base justifying inclusion of indicator	Hazardous intakes of alcohol and kava, and use of tobacco are associated with a number of health conditions as well as leading to high rates of injury and violence. This indicator reflects the impact of targeted health promotion programs to reduce hazardous substance use.

ITEM	DESCRIPTION
Indicator	Number and proportion of resident clients aged 15 years and over with BMI in the overweight and obese range, by age group and gender
What the indicator tell us	This indicator reports on the prevalence of risk factors for chronic diseases.
Numerator	Measured weight, in kilograms, for residents aged 15 years and over
Denominator	Measured height, in metres, squared in residents aged 15 years and over.
Source of data	Internal Medical Information System
Method of calculation of indicator	Calculate BMI = weight (kg) / height (metres) ² and then categorise: Not overweight or obese: BMI < 25.00 Overweight: BMI > or = 25.00 to <30.00 Obesity: BMI > or = 30.00 Do not round the body mass index prior to categorising Calculate the weight categories as percentages of the population who were measured, for each sex.
Frequency of reporting	Annually
Evidence base justifying inclusion of indicator	Overweight and obesity is a major risk factor for preventable chronic diseases. This indicator has been adopted by NHPC National Report on Health Sector Performance Indicators and NPIATSIH.

SPECIAL INSTRUCTIONS

1. See National Health Data Dictionary for a description of the method for measuring height and weight.

ITEM	DESCRIPTION
Indicator	Proportion of clients with preventable chronic diseases managed on care plans (by disease).
What the indicator tell us	This indicator reflects the quality of management of preventable chronic diseases.
Numerator	Number of clients with diabetes, hypertension, renal disease, heart disease and chronic airways disease managed on care plans (by disease) in the previous 12 months.
Denominator	Total number of clients with diabetes, hypertension, renal disease, heart disease and chronic airways disease in the specified time period
Source of data	Internal Medical Information System

Method of calculation of indicator	Divide each numerator by the denominator then multiply by 100 for expression as percentage.
Frequency of reporting	Annually
Evidence base justifying inclusion of indicator	Preventable chronic diseases if poorly controlled increase the cost of health care. Care plans are the foundation for providing appropriate long term care.

ITEM	DESCRIPTION
Indicator	<i>Proportion of resident clients with diabetes who have had a HbA1c test in the last 12 months.</i>
What the indicator tell us	This indicator reflects the quality of primary care management offered to clients with diabetes.
Numerator	Number of resident clients with diabetes in the Health Zone who have had a HbA1c test in the last 12 months.
Denominator	Number of resident clients with diabetes in the Health Zone in the specified time period.
Source of data	Internal Medical Information System / Pathology Services
Method of calculation of indicator	Divide the numerator by the denominator then multiply by 100 for expression as percentage.
Frequency of reporting	Annually
Evidence base justifying inclusion of indicator	The US Diabetes Control and Complications Trial and the UK Prospective Diabetes Study have established that the risk of diabetic complications is strongly associated with previous hyperglycaemia and that any reduction in HbA1c is likely to reduce the risk of complications.

ITEM	DESCRIPTION
Indicator	<i>Proportion of resident clients with diabetes with a HbA1c less than 7% and less than 9.5% in the last 12 months</i>
What the indicator tell us	This indicator reflects effectiveness of primary care management of diabetes.
Numerator	Number of resident clients with diabetes in the Health Zone who have had a HbA1c test >7% and >9.5% in the last 12 months.
Denominator	Number of resident clients with diabetes in the Health Zone who had a HbA1c test in the last 12 months.
Source of data	Internal Medical Information System / Pathology Service
Method of calculation of indicator	Divide each numerator by the denominator then multiply by 100 for expression as percentage.
Frequency of reporting	Annually
Evidence base justifying inclusion of indicator	The lowest risk of diabetic complications being in those with HbA1c values in the normal range and the CARPA manual uses the target level of <7% and recommends assessment 6 monthly for NIDDM. Recent NT reviews have suggested that measurement of <9.5% may show early improvement of control in the target population.

ITEM	DESCRIPTION
Indicator	<i>Mean HbA1c level for resident diabetic clients in the last 12 months</i>
What the indicator tell us	The US Diabetes Control and Complications Trial and the UK Prospective Diabetes Study have established that the risk of diabetic complications is strongly associated with previous hyperglycaemia and that any reduction in HbA1c is likely to reduce the risk of complications
Numerator	Sum of the most recent HbA1c of resident clients with diabetes .
Denominator	Number of resident clients with diabetes in the Health Zone who had a HbA1c test in the last 12 months.
Source of data	Internal Medical Information System / Pathology Service
Method of calculation of indicator	Divide the numerator by the denominator.
Frequency of publication	Annually
Evidence base justifying inclusion of indicator	Allows changes in the distribution of the birthweight of the whole population to be observed.

ITEM	DESCRIPTION
Indicator	<i>Proportion of resident children fully immunised at 1 year and 2 years and 6 years of age</i>
What the indicator tells us	Reflects the prevalence of full age-appropriate immunisation of children. Reflects access to and utilisation of immunisation services.
Numerator	Number of children aged 12-15 months, 24-27months and 60-63 months who have received all the immunisations at the designated milestone times as per the Australian Childhood Immunisation Schedule.
Denominator	Total number of children in the age cohort 12-15 months, 24-27months and 60-63 months at the specified time period.
Source of data	DHCS – CCIS / ACIR
Method of calculation of indicator	For each of the 3 age cohorts, divide the numerator by the appropriate denominator then multiply by 100 for expression as a percentage.
Frequency of publication	Annual
Evidence base justifying inclusion of indicator	This indicator reflects the quality of the childhood immunisation program and has been adopted for NHPC National Report on Health Sector Performance, the Review of Government Services and other national reporting mechanisms. Similar indicators have been adopted in other countries although the immunisation schedules may vary. Data is available from ACIR.

ITEM	DESCRIPTION
Indicator	<i>Proportion of resident clients aged 50 years and over who were immunised for influenza in the previous 12 months, by gender</i>
What the indicator tell us	In addition to measuring the immunisation status of clients aged 50 years and over this indicator is a proxy for measuring delivery of quality healthcare to the older population.
Numerator	Number of resident clients aged 50 years and over who have received the influenza immunisation in the previous 12 months.
Denominator	Total number of resident clients aged 50 years and over in the Health Zone in the specified time period.
Source of data	Internal Medical Information System
Method of calculation of indicator	Divide the numerator by the denominator then multiply by 100 for expression as a percentage
Frequency of reporting	Annually
Evidence base justifying inclusion of indicator	This indicator is reported by NHS HA for age group 65 years. It has also been adopted in a number of other countries (UK, NZ and US). In addition to immunisation it is a proxy for measuring delivery of quality healthcare to the older population.

ITEM	DESCRIPTION
Indicator	<i>Number and proportion of resident clients who have been seen by a dentist or dental therapist in the previous twelve months.</i>
What the indicator tell us	This indicator demonstrates the quality of dental services in the Health Zones.
Numerator	Number of resident clients who have been seen by a dentist or dental therapist in the previous 12 months.
Denominator	Total number of resident clients in the Health Zone in the specified time period.
Source of data	Internal Medical Information System
Method of calculation of indicator	Divide the numerator by the denominator then multiply by 100 for expression as a percentage
Frequency of reporting	Annually
Evidence base justifying inclusion of indicator	Measures of DMFT for specific age groups are accepted by the WHO as indicators of oral health outcomes, however, there are issues about the quality and availability of NT data from the Australian Child Dental Health Survey. In remote areas where there are limited dental services measuring improvements in access will indicate improved dental outcomes.

ITEM	DESCRIPTION
Indicator	<i>Proportion of resident clients aged 5 and 10 years who have been screened according to the guidelines for Healthy School Aged Kids in the previous 12 months, by gender.</i>
What the indicator tell us	This indicator reflects access to child health monitoring / screening programs
Numerator	Number of resident clients aged 5 and 10 years who have been screened according to the guidelines for Healthy School Aged Kids (HSAK) in the previous 12 months, by gender.
Denominator	Total number of resident clients 5 and 10 years in the Health Zone in the specified time period.
Source of data	Internal Medical Information System
Method of calculation of indicator	Divide the numerator by the denominator then multiply by 100 for expression as a percentage
Frequency of reporting	Annually
Evidence base justifying inclusion of indicator	Compliance with recommended school screening protocols (HSAK) will allow comparison across NT

ITEM	DESCRIPTION
Indicator	<p>12. Proportion of resident clients aged 5 and 10 years who have been screened according to the guidelines for Healthy School Aged Kids in the previous 12 months, by gender. (18. Cont)</p> <p>Also report on:</p> <p>Number and proportion of 4-5 year olds who had ear examinations (otoscopy) and number and proportion who needed followup.</p> <p>Number and proportion of 4-5 year olds who were screened for hearing and number and proportion who needed followup.</p> <p>Number and proportion of 10 year olds who urinalysis for proteinuria and number and proportion who needed followup.</p> <p>Number and proportion of 10 year olds who had a heart examinations (for rheumatic heart disease) and number and proportion who needed followup</p> <p>Number and proportion of 10 year olds who had a Mantoux test.</p>
What the indicator tell us	This indicator reflects the quality of preventative health care for a range of program including growth, hearing, TB programs etc.
Numerator	Number of resident children at relevant age who have had the test in the previous 12 months.
Denominator	Total number of resident clients at relevant age in the Health Zone in the specified time period.
Source of data	DHCS – CCIS / Internal Medical Information System
Method of calculation of indicator	Divide the numerator by the denominator then multiply by 100 for expression as a percentage
Frequency of reporting	Annually
Evidence base justifying inclusion of indicator	<p>These measures are targeted at specific health issues that are relevant to the Indigenous population of the NT.</p> <p>Mantoux testing of 10 year olds is mandatory for Indigenous people living in remote areas. This indicator reflects the quality of preventative health care programs for TB program.</p>

ITEM	DESCRIPTION
Indicator	<i>Proportion of resident clients aged 15 years and over who were screened for chronic diseases in the past year, by age group and gender</i>
What the indicator tell us	Indicates quality of primary care management of chronic diseases.
Numerator	Number of resident clients aged 15 years and over who were screened for chronic diseases as per the CARPA 'Well Person' screening guidelines, in the following age categories: 15-24, 25-44, 45-64, 65 and over, by gender in the previous 12 months
Denominator	Estimated resident population for the same time period by the same age and sex categories.
Source of data	Internal Medical Information System
Method of calculation of indicator	Divide the numerator by the denominator then multiply by 100 for expression as a percentage
Frequency of reporting	Annually
Evidence base justifying inclusion of indicator	Reports on compliance with CARPA standard Treatment Manual has been extensively reviewed and provides guidelines for best practice in the management of the chronic diseases identified in the Preventable Chronic Disease Strategy.

ITEM	DESCRIPTION
Indicator	<p>13. Proportion of resident clients aged 15 years and over who were screened for chronic diseases in the past year, by age group and gender (19 Cont.)</p> <p>Also provide details on:</p> <p>Number and proportion of population who have been tested for chlamydia, gonorrhoea, syphilis and HIV/AIDS in the last 12 months, by age group and gender</p> <p>Number and proportion of screened population who reported use of tobacco.</p> <p>Number and proportion of screened population who report use of harmful or hazardous levels of alcohol consumption</p> <p>Number and proportion of population who were screened for hypertension</p>
What the indicator tell us	Indicates quality of primary care management of chronic diseases.
Numerator	Number of resident clients aged 15 years and over who were screened for in each category (above) as per the CARPA 'Well Person' screening guidelines, in the following age categories: 15-24, 25-44, 45-64, 65 and over, by gender in the previous 12 months
Denominator	Estimated resident population for the same time period by the same age and sex categories.
Source of data	Internal Medical Information System
Method of calculation of indicator	Divide the numerator by the denominator then multiply by 100 for expression as a percentage
Frequency of reporting	Annually
Evidence base justifying inclusion of indicator	Reports on compliance with CARPA standard Treatment Manual has been extensively reviewed and provides guidelines for best practice in the management of the chronic diseases identified in the Preventable Chronic Disease Strategy.

ITEM	DESCRIPTION
Indicator definition	<i>Proportion of resident female clients having pap tests for cervical cancer in the previous 24 months period for the target group (15 – 69 years)</i>
What the indicator tell us	This indicator measures the effectiveness of women's health programs for cervical cancer screening.
Numerator	Number of resident clients aged 15-69 years who have had a pap tests for cervical cancer in the previous 24 months period in 5 year age groups.
Denominator	Estimated resident population for the same time period by the same age and sex categories.
Source of data	Internal Medical Information System / Pap Smear Register
Method of calculation of indicator	Divide the numerator by the denominator then multiply by 100 for expression as a percentage
Frequency of publication	Annually
Evidence base justifying inclusion of indicator	This indicator has been adopted from the national cervical screening monitoring indicators (Cervical screening Australia 1998-1999 AIHW & DoHA Canberra 2002 (Cancer Series No. 16)). As per discussion with Breast Screening staff the age range has been expanded from 20-69 to 15-69 to reflect the earlier sexual activity of the target group. This is also a common indicator in other indicator sets (NHPC) and for other countries ie US, NZ and UK

SPECIAL INSTRUCTIONS

Target 70%

ITEM	DESCRIPTION
Indicator	<i>Report on normal health centre hours and after hour's service if provided.</i>
What the indicator tell us	This indicator provides details of access to services by resident of the Health Zone
Description	Provide details of after hour's service including details of staffing levels. Definition of after hour's service includes services provided after the normal clinic hours of 8.00am – 4.00pm.
Source of data	Internal report
Frequency of publication	Annually

ITEM	DESCRIPTION
Indicator	<i>If after hours service provided, report on proportion of consultation after hours</i>
What the indicator tell us	This indicator provides details of health centre workload.
Numerator	Number of after hour's consultations
Denominator	Total number of consultations
Source of data	Internal report
Method of calculation of indicator	Divide the numerator by the denominator then multiply by 100 for expression as a percentage
Frequency of publication	Annually
Evidence base justifying inclusion of indicator	Over usage of after hour's services reduces the capacity for staffing of the normal hour's health service. If excessive use of after hour's service is identified then strategies are needed to manage this more effectively.

ITEM	DESCRIPTION
Indicator	<i>If after hours service provided, report on procedures implemented for staff safety on after hours call outs</i>
What the indicator tell us	Initiatives in place to ensure workplace safety for staff working after normal clinic hours
Description	Qualitative report on workplace practices and procedures implemented for staff safety on after hours call outs
Source of data	Internal report
Frequency of publication	Workplace safety is required for accreditation processes and is consistent with measures in the Australian Health and Community Services Standards.

ITEM	DESCRIPTION
Indicator	<i>Proportion of resident clients who have an abnormal pap smear in the previous 12 months who have had appropriate followup</i>
What the indicator tell us	This indicator reflects the quality and appropriateness of follow up for the Women's Cervical Screening program.
Numerator	Number of clients with an abnormal pap smear (CIN 1,2 or 3) in the previous 12 months who had a followup pap smear according to national guidelines.
Denominator	Number of clients with an abnormal pap smear (CIN 1,2 or 3) in the previous 12 months.
Source of data	Internal Medical Information Systems
Method of calculation of indicator	Divide the numerator by the denominator then multiply by 100 for expression as a percentage
Frequency of publication	Annually
Evidence base justifying inclusion of indicator	Evidence of best practice management of cervical cancer according the standard treatment guidelines.

ITEM	DESCRIPTION
Indicator	<i>Report on procedures in place to follow up on abnormal laboratory tests.</i>
What the indicator tell us	This indicator reports on the presence of comprehensive procedures and protocol for health service practice.
Description	Qualitative report on procedures and protocols including evidence of implementation and review.
Source of data	Internal report
Frequency of publication	Annually
Evidence base justifying inclusion of indicator	Evidence of existence of comprehensive procedures and protocol for health service practice improves the consistency, appropriateness and safety of health care.

ITEM	DESCRIPTION
Indicator	<i>Mean number of consultations per estimated zone resident, per year, by service provider type, health centre, age group and gender</i>
What the indicator tell us	This indicator measures the uptake of the service as well as equity in access to health services between health centres within a zone
Numerator	Total number of consultations by service providers (including doctors, nurses, Aboriginal Health Workers) by health centre or major locality, gender and Indigenous status in the following age groups: 0-14, 15-24, 25-44, 45-64, 65 and over
Denominator	Estimated resident population for the same time period by the same age and sex categories.
Source of data	Internal Medical Information System
Method of calculation of indicator	Divide numerator by denominator.
Frequency of publication	Annually

ITEM	DESCRIPTION
Indicator	<i>Ratio of full time equivalent staff to estimated zone population, by profession</i>
What the indicator tell us	This indicator reflects capability and capacity of health service, as well as the appropriateness and accessibility of the service to the population. Current National Drug Strategic Framework indicator.
Numerator	Number of FTE staff in each provider type (including doctors, nurses, Aboriginal Health Workers) in the Health Zone.
Denominator	Estimated resident population for the same time period.
Source of data	Internal Medical Information System
Method of calculation of indicator	Divide numerator by denominator.
Frequency of publication	Annually

ITEM	DESCRIPTION
Indicator	<i>Proportion of pregnant resident clients attending their first antenatal visit at or before 13 and 20 weeks gestation</i>
What the indicator tell us	A range of studies show a relationship between antenatal care and reductions in low birth weight with infant mortality.
Numerator	Number of pregnant resident clients in the Health Zone who attended their first antenatal visit at or before 13 and 20 weeks gestation
Denominator	Number of pregnant resident clients in the Health Zone
Source of data	Internal Medical Information System / DHCS Perinatal Statistics
Method of calculation of indicator	Divide each numerator by the denominator then multiply by 100 for expression as percentage.
Frequency of publication	Annually
Evidence base justifying inclusion of indicator	Best practice evidence recommends the first antenatal visit should ideally be <13 weeks gestation but changes in the short term for this time period are considered unrealistic for the NT remote indigenous population. Reporting at both <13 and <20 weeks is more likely to show early signs of change. Reported annually by NPIATSIH.

ITEM	DESCRIPTION
Indicator	<i>Provide evidence of risk management strategies and discuss their implementation</i>
What the indicator tell us	This indicator reflects the accountability of the board as a governing body. It is consistent with measures in the Australian Health and Community Services Standards.
Description	A qualitative report on evidence of risk management strategies and their implementation including clinical compliance, financial management, staff management, legal compliance, natural disaster
Source of data	Internal report
Frequency of publication	Annually
Evidence base justifying inclusion of indicator	This is required in accreditation processes and is consistent with measures in the Australian Health and Community Services Standards.

ITEM	DESCRIPTION
Indicator	<i>Proportion of total funding managed by Health Board that was sourced from funding bodies other than PHCAP</i>
What the indicator tell us	This indicator reflects the innovation of the health board in obtaining alternative funding.
Numerator	Amount of funding managed by Health Board that was sourced from funding bodies other than PHCAP
Denominator	Total amount of funding managed by Health Board
Source of data	Internal report
Method of calculation of indicator	Divide each numerator by the denominator then multiply by 100 for expression as percentage.
Frequency of publication	Annually

ITEM	DESCRIPTION
Indicator	<i>Average number of filled board places in the previous 12 months per meeting</i>
What the indicator tell us	This indicator measures the capacity/functionality of the board in terms of having filled positions.
Numerator	Number of FTE board members employed at the time of each meeting in the previous 12 months
Denominator	Number of board meetings in the previous 12 months
Source of data	Internal Medical Information System / DHCS Perinatal Statistics
Method of calculation of indicator	Divide each numerator by the denominator
Frequency of publication	Annually

ITEM	DESCRIPTION
Indicator	<i>Proportion of FTE board members in attendance at each meeting</i>
What the indicator tell us	This indicator measures the effectiveness of the board as a governing body.
Numerator	Number of FTE board members in attendance at each meeting in the previous 12 months
Denominator	Number of board meetings in the previous 12 months
Source of data	Internal Medical Information System / DHCS Perinatal Statistics
Method of calculation of indicator	Divide each numerator by the denominator
Frequency of publication	Annually
Evidence base justifying inclusion of indicator	This is required in accreditation processes and is consistent with measures in the Australian Health and Community Services Standards.

ITEM	DESCRIPTION
Indicator	<i>Report on turnover of Health Board members and any issues related to recruitment of Board members</i>
What the indicator tell us	This indicator reflects the maturity of the Health Board in terms of governance.
Description	Qualitative report on the turnover of Health Board members and any issues related to recruitment of Board members
Source of data	Internal report
Frequency of publication	Annually

ITEM	DESCRIPTION
Indicator	<i>Proportion of FTE board members undertaking governance training by type of training undertaken ie financial, management, computing etc. in the previous 12 months</i>
What the indicator tell us	This indicator reflects the capacity of the board as a governing body.
Numerator	Number of FTE board members undertaking governance training by type of training undertaken ie financial, management, computing etc. in the previous 12 months
Denominator	Total number of FTE board members in the previous 12 months
Source of data	Internal Medical Information System / DHCS Perinatal Statistics
Method of calculation of indicator	Divide each numerator by the denominator then multiply by 100 for expression as percentage.
Frequency of publication	Annually
Evidence base justifying inclusion of indicator	This is required in accreditation processes and is consistent with measures in the Australian Health and Community Services Standards.

ITEM	DESCRIPTION
Indicator	<i>Report on actions taken to ensure compliance with formalised policies and guidelines for clinical management</i>
What the indicator tell us	This indicator reflects the accountability of the board as a governing body.
Description	Qualitative report on actions taken to ensure compliance with formalised policies and guidelines for clinical management eg CARPA Standard Treatment Manual, care plans
Source of data	Internal report
Frequency of publication	Annually
Evidence base justifying inclusion of indicator	This indicator reflects the progress of the Health Board towards best practice standards for a quality health service.

ITEM	DESCRIPTION
Indicator	<i>Is the health service accredited. Report of processes in place to assess client satisfaction</i>
What the indicator tell us	This indicator is part of quality assurance processes.
Description	Qualitative report on mechanisms in place for measuring client satisfaction and dealing with consumer complaints
Source of data	Internal report
Frequency of publication	Annually
Evidence base justifying inclusion of indicator	This indicator reflects the progress of the Health Board towards best practice standards for a quality health service.

ITEM	DESCRIPTION
Indicator	<i>Provide evidence of formal guidelines for staff recruitment and termination including report on current EBA and identify issues related to completion and/or implementation of EBA</i>
What the indicator tell us	This indicator measures the efficiency of the board's administrative systems.
Description	Qualitative report on implementation of formal guidelines for staff recruitment and termination including report on current EBA and identify issues related to completion and/or implementation of EBA
Source of data	Internal report
Frequency of publication	Annually
Evidence base justifying inclusion of indicator	This is required in accreditation processes and is consistent with measures in the Australian Health and Community Services Standards.

ITEM	DESCRIPTION
Indicator	<i>Number of visitor clients who have presented to the health centre at least once during the last 12 months, by age, gender and Indigenous status</i>
What the indicator tell us	Demographic information. Indicates fluctuations in workload when expressed as total per quarter.
Description	Total number of visitor clients who have presented to the health centre at least once during the last 12 months, by age, gender and Indigenous status
Source of data	Internal report
Frequency of publication	Annually
Evidence base justifying inclusion of indicator	The high mobility of the population presents major implications for service delivery. Capturing the extent of mobility will provide useful information for planning

ITEM	DESCRIPTION
Indicator	<i>Provide details of training and development opportunities by professional group and type of training undertaken</i>
What the indicator tell us	This indicator measures the board's commitment to providing a high quality service through training and development opportunities for staff.
Description	Qualitative report on training and development opportunities, providing details of the type of training undertaken and the type of health professional receiving the training.
Source of data	Internal report
Frequency of publication	Annually
Evidence base justifying inclusion of indicator	This is required in accreditation processes and is consistent with measures in the Australian Health and Community Services Standards.

ITEM	DESCRIPTION
Indicator	<i>Proportion of new staff who have been employed for at least 6 months who have attended an orientation program</i>
What the indicator tell us	This indicator measures the board's commitment to providing a high quality service that reflects the needs of the residents of the Health Zone.
Numerator	Number of new staff members over the last 12 months who have been employed for at least 6 months who have attended an orientation program
Denominator	Number of new staff employed in the previous 12 months who have been employed for at least 6 months.
Source of data	Internal report
Method of calculation of indicator	Divide each numerator by the denominator then multiply by 100 for expression as percentage.
Frequency of publication	Annually
Evidence base justifying inclusion of indicator	This is required in accreditation processes and is consistent with measures in the Australian Health and Community Services Standards.

ITEM	DESCRIPTION
Indicator	<i>Report of processes in place to ensure cultural awareness of staff</i>
What the indicator tell us	This indicator measures the board's commitment to providing a culturally appropriate health service that meets the needs of the residents of the Health Zone.
Description	Provide qualitative report on processes in place to ensure cultural awareness of staff
Source of data	Internal report
Frequency of publication	Annually
Evidence base justifying inclusion of indicator	This is required in accreditation processes and is consistent with measures in the Australian Health and Community Services Standards.

ITEM	DESCRIPTION
Indicator	<i>Report on quality assurance processes including development of procedures manual and systems for audit and review of health services</i>
What the indicator tell us	This indicator measures the quality of the board's clinical and administrative systems.
Description	Provide qualitative report on quality assurance processes including development of procedures manual and systems for audit and review of health services
Source of data	Internal report
Frequency of publication	Annually
Evidence base justifying inclusion of indicator	This is required in accreditation processes and is consistent with measures in the Australian Health and Community Services Standards.

ITEM	DESCRIPTION
Indicator	<i>Report on strategies and practices for community involvement in health planning</i>
What the indicator tell us	This indicator reflects the board support for community participation in service planning and decision making.
Description	Provide qualitative report on strategies and practices for community involvement in health planning
Source of data	Internal report
Frequency of publication	Annually
Evidence base justifying inclusion of indicator	This is required in accreditation processes and is consistent with measures in the Australian Health and Community Services Standards.