



Mental Health Information Strategy Subcommittee

Developing Systems for Public Reporting:

Recommendations from the MHISS Working Group

Final Report

May 2011



Foreword

Since the implementation of the National Mental Health Strategy, Australia's mental health sector has been a world leader in developing information and reporting on indicators that demonstrate the ongoing reforms that have been taking place across the mental health system. While a great deal of information has been made available, it has been recognised that more needs to be done to ensure timeliness and relevance of this information for all stakeholders - consumers, clinicians, service managers and policy makers.

To this end, the 4th National Mental Health Plan has identified "Accountability – measuring and reporting progress" as one of five key priority areas. The aim is to establish processes that provide greater accountability and reporting on reforms to the general public and which also ensure that services routinely monitor the quality of their performance and make this information available to mental health consumers, allowing comparisons against national benchmarks. It is anticipated that these reporting initiatives will encourage a continuous cycle of quality improvement, leading to better outcomes for all mental health consumers.

It is hoped that the recommendations provided in this document will inform deliberations about the public reporting of information relevant to the mental health sector.

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Introduction

The 4th National Mental Health Plan¹ (the Plan) commits governments to improved accountability and transparency in mental health reform and service delivery. Priority Area 5 of the Plan ('Accountability - measuring and reporting progress') sets the national agenda and outlines a new framework that foreshadows action across both the policy and the service delivery levels, recognising that each level of the mental health system has a unique contribution to make in establishing public confidence in the mental health system.

To strengthen accountability and transparency at the service delivery level, the Plan commits to building "... a service delivery system that monitors its performance on service quality indicators and makes this information available to consumers and other stakeholders". This commitment charts new territory for public mental health services in Australia. Although the commitment to public reporting represents a logical extension of information-driven developments progressed over recent years (e.g., national key performance indicators, benchmarking, seclusion reduction project), there have not been precedents or established ground rules within the Australian mental health sector to guide the introduction of the new commitments.

This report recognises that discussion of public reporting in the 4th Plan occurs within the context of broader health reform agenda. Up to now, much public reporting on health services at national and state/territory level has been of highly aggregated data. Current national health reforms include a number of initiatives aimed at increasing the transparency of the system through performance reporting at a more detailed service level.

Public reporting has been established in mental health service systems overseas, and more locally, is being implemented in other human services in Australia. These examples highlight that there are clear risks and opportunities awaiting the mental health sector as it undertakes the new commitment to public reporting.

Aims and parameters for public reporting as set by the 4th National Mental Health Plan

The 4th Plan sets the broad aims and parameters for public reporting by mental health services. The Plan states:

"The aim [of public reporting] will be to stimulate the development of informed mental health service delivery organisations that value positive results, strive for quality and are transparent to those they serve."

The Plan recognises that different stakeholders have different interests in public reporting but within these, the interests of consumers are paramount.

"At the service delivery level, very little information is readily available to consumers and other stakeholders on the performance of their local mental health services ... Consumers are the central group. They need the health organisations responsible for their care to make information available that allows them to understand treatment options, make informed decisions and participate actively in their care. This should include information about how the organisation performs in comparison



to its peers on a range of health quality indicators, presented in a way that will assist the person to understand what they can expect as a consumer of the organisation.

Mental health service providers also need information about how the treatments they provide compare with similar organisations so that they can establish evidence based treatment systems. Service managers need information about the performance of services for which they are responsible (and other similar services), in order to make operational decisions that will affect the efficiency and effectiveness of the service. Mental health policy makers and planners need a wide range of information about how the mental health system is performing to enable them to determine priorities for resource allocation, plan and pay for services, and monitor the achievement of outcomes.”

Finally, the Plan recognises that support and incentives rather than coercion are needed to build a culture of public reporting:

“Steps to build stronger accountability at this level involve providing tools and incentives to support service managers and clinical leaders establish a culture of continuous quality improvement ...

Introduction of these new arrangements will be achieved through incentives and supports to organisations seeking to participate in the new developments. This will include providing access to national benchmarking data, forums for interaction between peer organisations to share performance data and learn from each other and other leadership development opportunities. Internet based systems of reporting and benchmarking will be developed to better inform consumers, carers and the general community about local service performance.”

In the Australian health sector, in its recent report on performance indicators to the Australian Safety and Quality Commission, the AIHW presented a useful summary of the evidence on public reporting on health services.³ The Institute observed that

“... the appropriateness and usefulness of public reporting of indicators in the health area remains a contentious issue in Australia. High level national reporting of data on health care safety and quality has been undertaken to a limited extent by the National Health Performance Committee and in publications such as in the AIHW’s Australia’s health. However, Australia has yet to follow the lead of countries such as the United States of America and United Kingdom which have adopted detailed regular public reporting at the provider level.”



The Public Reporting Working Group

Within the Australian Health Ministers Advisory Council (AHMAC) governance arrangements, the Mental Health Information Strategy Subcommittee (MHISS) is the lead committee to develop proposals for moving forward the priority actions described in the 4th National Mental Health Plan's Priority Area 5 – Transparency and Accountability.

At the MHISS meeting of 19-20 November 2009, it was agreed that a working group would be established to develop a draft implementation strategy for the introduction of public reporting on performance indicators by state and territory mental health services. The terms of reference for the Public Reporting Working Group (PRWG) are to be found in Appendix 1.

The announcement that public reporting initiatives will be part of the government's health reform agenda has implications for the commitment to transparency and accountability as described in the 4th National Mental Health Plan. MHISS and the PRWG strongly endorsed the view that it should continue with its deliberations and develop a set of recommendations relevant to the mental health sector across Australia. These recommendations might then be readily utilised as part of the government's reform agenda when considering options for a model for public reporting of health performance information.

The PRWG met face-to-face and via teleconference and developed a number of recommendations in relation to several key areas:

- a. *Scope* – i.e. which service streams and provider groups within the specialised mental health sector should be expected to participate in public performance reporting?
- b. *Governance*– who should be responsible for the reporting process and what structural arrangements are needed to manage the various interests of stakeholders?
- c. *Content and structure* – what aspects of mental health service performance should be reported, and how should services be grouped to facilitate fair, 'like with like' comparisons?
- d. *Methods for reporting* – what options should be pursued for how information on mental health service performance should be made available to the public?
- e. *Relative Commonwealth and State/Territory roles* – what roles need to be played by each level of government in introducing public reporting by mental health services, and is there a place for collaborative or centrally-led national activity?
- f. *Resources, supports, incentives and infrastructure* - what is required to introduce public reporting in the Australian mental health sector?
- g. *Communication and consultation strategy* – how do these need to be planned both within the mental health sector and more broadly?
- h. *Timeframe* – what is a feasible timeframe for implementing public reporting by Australian mental health services, with reference to short term, medium term and long term goals?



The discussion of these issues was informed by a review of the evidence for public reporting both in Australia and internationally found in Appendix 3.



Review of the Evidence

To inform the work of the PRWG, MHISS also agreed that there was logic in commissioning a review of the evidence and experience in public reporting - both within the mental health industry and more broadly. This review covered both published and grey literature and was undertaken by the Australian Mental Health Outcomes and Classification Network (AMHOCN). A copy of the report on the literature review can be found in Appendix 3.

The key findings from the literature review note that in Australia, public reporting is relatively unexplored territory in the mental health sector, although there are some examples of public reporting in the general health sector which include one or two indicators that are relevant to mental health. There are a number of international examples of public reporting systems that pertain to the performance of mental health systems, and these may have lessons for the Australian context:

- In the United States, the New York State Office of Mental Health (<http://www.omh.state.ny.us/>) provides a quarterly, web-based report of the performance of public sector organisations against critical indicators of outcomes for individuals. Their stated goal in doing so is to 'improve accountability and transparency by allowing anyone to use the reported data to inform decision-making and assess the progress an agency is making toward achieving its strategic goals. In practice, each organisation (or facility within an organisation) is reported against a 'balanced score card'. This includes a range of management objectives (e.g., Increase the percentage of families who indicated satisfaction with their child's functioning as a result of the mental health services that their child received), which are given current value that can be compared with a pre-determined target value. Definitions are provided as necessary, and individual indicators are progressively updated.
- The Care for Quality Commission (<http://www.cqc.org.uk/>) regulates all health care (for adults and children) and social care (for adults) in the United Kingdom, and has a particular focus on mental health care. They review organisations to ensure that they meet specified standards of care, and register those which do. They provide current, independent information about the quality of given providers' care, in order to assist people to make decisions about their care. They report 'overall quality scores' and 'overall financial management scores' for National Health Service trusts and for individual services, although the way in which these ratings are derived is not completely clear.
- The Quality Outcomes Framework in the United Kingdom (<http://www.qof.ic.nhs.uk/index.asp>) is described as 'a voluntary annual reward and incentive programme for all GP surgeries in England, detailing practice achievement results ... [and] ... resourcing and then rewarding good practice.' Its Online GP Practice Results Database allows users to search for general practices in a particular area, and then compare their performance in treating a range of conditions against a



selection of indicators. In mental health, there are six indicators: (1) the ability of the practice to produce a register of people with schizophrenia, bipolar affective disorder and other psychoses; (2) the percentage of patients on lithium therapy with a record of serum creatinine and TSH in the previous 15 months; (3) the percentage of patients on lithium therapy with a record of lithium levels in a therapeutic range within the previous six months; (4) the percentage of patients on the register who have a comprehensive care plan documented in the records agreed between individuals, their family and/or carers as appropriate; (5) the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who do not attend the practice for their annual review who are identified and followed up by practice team within 14 days of non-attendance; and (6) the percentage of patients with schizophrenia and bipolar affective disorder and other psychoses with a review recorded in the previous 15 months (in the review there is evidence that the patient has participated in routine health promotion and prevention advice appropriate to their age and health status).

There are a range of views about public reporting, both within and across stakeholder groups. In general, however, consumers seek readily accessible, user-friendly information that can assist them with decisions about where they go to seek care; where information is provided in a complex way, consumers have difficulties extracting meaning from it. Clinicians can be skeptical about public reporting, because they believe that indicators often do not capture what they purport to capture and can be misinterpreted. Managers and senior staff hold a range of views, but are generally most positive when public reporting is combined with internal quality assurance processes and opportunities for reflection on practice.

Systematic reviews suggest that public reporting has a modest impact on certain consumer choices and a consistent influence on quality improvement at a service level. The jury is still out, however, on whether these positive impacts translate to improvements in the effectiveness of treatment. There may also be some unintended consequences of public reporting, such as ‘gaming’ on the part of managers.

A range of issues must be considered as public reporting is introduced in the Australian mental health context. Some relate to the nature of reporting – for example, what data should be reported and how this should be done. Others relate to how best to maximise data quality on particular indicators.

The way in which comparative data are presented will have an impact on the conclusions that given users will be able to draw from it. One of the key issues is how to ensure that services are being fairly compared with their peers. The process of ‘levelling the playing field’ is known as risk adjustment, and this is a relatively new enterprise in mental health. Consideration will need to be given to conceptual issues (i.e., what consumer-based and environmental factors to adjust for) and technical issues (i.e., which statistical approaches might be most appropriately used in the risk adjustment process).

The literature review concluded that public reporting has the potential to improve the quality of mental health services across Australia. We are in the fortunate position of being able to draw on the experiences of the general health sector in Australia and the mental



health sector from overseas, and can hopefully avoid some of the pitfalls that others have faced. The advice of others is to view public reporting as an evolutionary process which becomes progressively more sophisticated and comprehensive over time,⁵ and this would seem to make sense in the Australian mental health context.



Public Reporting Working Group Recommendations

The recommendations of the Public Reporting Working Group in regard to key areas that should be considered when implementing a system of public reporting are provided below.

1. **Scope – i.e. which service streams and provider groups within the specialised mental health sector should be expected to participate in public performance reporting?**

Recommendations:

- i. State and Territory managed clinical mental health services would be the initial focus of public performance reporting.**
- ii. Commonwealth and Medicare funded programs should be included in public reporting subject to development and testing of appropriate indicators.**
- iii. NGOs should be included at a later phase, but this will need data development and negotiation with the sector.**
- iv. Consideration should be given to public reporting of new and relevant data as opportunities arise e.g. consumer perceptions of care.**

The pre-requisites of public reporting include data availability and the availability of agreed indicator specifications. Public reporting requires an existing information foundation that has been tested and is well established. Embarking upon public reporting as a means to drive data development in areas where the basic work has not been undertaken (e.g. definitions, information collection and reporting infrastructure, data quality and validation processes) is likely to be ineffective. In this sense, public reporting is best seen as a byproduct of other information development activities.

The PRWG agreed that public reporting should focus on identified organisations from State and Territory managed clinical mental health services. Service delivery level data will provide consumers with evidence of service activity and managers with the information that they require to implement processes to improve the performance of their organisation.

As reporting on the Commonwealth and Medicare funded programs will require identification of appropriate indicators and other data development work, the PRWG recommend that these programs should not be included in initial reporting. However, options for inclusion in the public reporting framework should be explored and implemented as soon as possible subject to the development and testing of appropriate data. The data currently published by Medicare Australia may provide an initial step towards more comprehensive public reporting. Options for reporting include: i) reporting of mental health access, activity or indicators by mental health service organisation or ii) development of access to and utilisation of Medicare-funded specialist mental health care services by region.



The organisation of Medicare-funded providers is a challenge for reporting. In many instances the “organisation” of these services may be an individual provider or small group of providers. The PRWG notes that public reporting on individual providers and practices has occurred internationally, however it did not feel that this was a reasonable starting point for public reporting. The National Mental Health Plan and proposed reforms by the Australian Government focus on reporting of *organisational* performance. The PRWG has not outlined a specific strategic direction for the very complex task of reporting on individual private providers.

Given the significant role of non government organisations (NGOs) within the mental health sector across Australia, the PRWG also considered their inclusion in any broad public reporting. Recognising that no routine data collection currently exists for all for NGOs, and in an effort to better determine the feasibility of including NGOs in public reporting, it was agreed that the Mental Health Council of Australia representative would further consult with State and Territory non government sector peak bodies and a range of community mental health organisations. The summary of this consultation appears in Appendix 2.

The NGOs consultation suggested a two staged approach. Those that currently do have reasonably robust data collections might elect to be involved in initial public reporting processes. Other NGOs, that do not have established and reliable data collection procedures and infrastructure, will require some support to either establish or improve their collection of data and to then ultimately report that publicly. The consultation suggested the need for a National Minimum Data Set (NMDS) for the sector.

It was noted that, currently, the Australian Institute of Health and Welfare (AIHW) are undertaking a scoping project on the data development work required to implement an NMDS for the NGO sector. This scoping process could be extended to consider the utility of the NGO data for future public reporting. This work might also provide some determinations about the suitability of the current set of Key Performance Indicators (KPIs) for use in the NGO sector.

As the development of an NMDS for the NGO sector will take some time, PRWG members considered the applicability of other available data collections that might, in the interim, be used by the NGO sector from which data could be reported publicly: the Community Mental Health Care NMDS and the Disability Services National Minimum Data Set (DS NMDS). Given the collaborative nature of service delivery between the community mental health and the non government sector, it was suggested that, for the purpose of public reporting, some NGOs may wish to utilise the Community Mental Health Care NMDS. As some play a significant role in delivering services in the community, they may feel that this NMDS is appropriate to them.

While it is recognised that reporting some data might sometimes be better than reporting none at all, the PRWG had concerns about the variable quality of the current NGO data and thus its suitability for public reporting.

The PRWG believes that the public reporting of data for NGOs will require a broader consultation with the sector and needs to be considered in association with the work being done by the AIHW on an NMDS for the NGO sector. NGOs would likely be part of the vision for public reporting in the longer term.



Initially, the focus of the public reporting commitments under the 4th National Mental Health Plan centred upon State and Territory public clinical mental health services. However, given the financial resources involved and the volume of work being undertaken via initiatives such as the MBS Better Access to Psychiatrists, Psychologists and General Practitioners, the PRWG determined that they should also consider and make recommendations about the public reporting of this data.

The PRWG recommend that consideration should be given to public reporting of data collected for specific purposes, as the opportunities arise. For example, proposed activity regarding the collection of consumers' perceptions of their experience of care would provide a reasonable dataset with a rich source of information and thus should be made available to the general community. This will continue to reinforce one of the central tenets of the 4th National Mental Health Plan – to build a more accountable and transparent mental health system.

2. Governance – who should be responsible for the reporting process and what structural arrangements are needed to manage the various interests of stakeholders?

Recommendations:

- i. **Jurisdictions responsible for the extraction, testing, collation and release of data should continue to have clearly defined responsibilities as data custodians. They should continue to have primary responsibility for ensuring the accuracy and integrity of the data which they collect which forms a basis for public reporting.**
- ii. **The PRWG are unable to make definitive recommendations regarding governance of report production and release as this will depend upon the model of public reporting that is ultimately chosen.**
- iii. **Current advisory frameworks and structures - MHISS, NMHPSC, Expert Panels - provide jurisdictional and clinical expertise that will enable the provision of relevant advice during the public reporting development and implementation phases.**

The PRWG noted that public reporting processes will comprise different stages and responsibilities, each with differing governance requirements. These include:

- Data preparation. Jurisdictions responsible for the extraction, testing, collation and release of data will have responsibilities as data custodians and for ensuring the accuracy and integrity of publicly released data.
- Report preparation and release. One or more organisations will be responsible for collation of data into a report or reporting medium, and for authorisation of publication of this data.



- **Steering and guidance.** A national reporting process will require an advisory structure for issues such as development and maintenance of meta-data, indicator development and selection, and changes to indicator sets over time.

The PRWG note that State and Territory health services will have a significant data preparation responsibility. The control of data quality will be essential and there is a need to ensure consistency of information between national publicly reported data, state reported data and the information maintained and reported more locally by mental health units. Therefore, the provision of publicly reported data about organisational performance should ideally be managed by the central jurisdictional offices rather than submitted individually by local mental health organisations.

Governance arrangements for report preparation and release cannot be finalised until the organisational responsibility for this has been determined.

Regarding steering and guidance responsibilities, recent National Mental Health Plans have emphasised the use of mental health information. Therefore, the Mental Health Standing Committee has developed advisory structures (including MHISS, NMHPSC and Expert Panels) on the use of mental health information at both policy level and service delivery level. These structures - comprising jurisdictional, clinical, consumer, carer, non government and private sector expertise - are thus well placed to continue to provide advice to emerging organizations as part of the government's health reform agenda, on the continued development of public reporting.

3. Content and structure – what aspects of mental health service performance should reported, and how should services be grouped to facilitate fair, 'like with like' comparisons?

Recommendations:

- In Phase 1, the current set of 16 Key Performance Indicators (KPIs), established under the national mental health performance framework, should be reported wholly or in parts, acknowledging the appropriateness and relevance of the KPIs to different organisations. Phase 1b should include revisions and refinements to the current KPI set.**
- In Phase 2, further work might be undertaken to develop KPIs that provide more information about services and enrich the clinical utility of the information.**
- Within organisations, public reporting should be stratified by target population: Adult, Child and Adolescent, Older Persons, Forensic.**
- Contextual information should be incorporated into the reports made available to the public.**
- Further advice to be provided by the National Mental Health Performance Subcommittee of MHISS.**



The PRWG noted that the main mental health provider entity is the mental health service organisation – generally providing an integrated service across inpatient and community mental health. They are a central part of the current data collection and reporting framework. Ongoing development work is occurring to ensure alignment of the service entities that are reported in the various data collections – Community Mental Health Care, Mental Health Establishments, National Outcomes and Casemix Collection, etc.

Public reporting should focus on mental health service organisations (MHSOs). However, it should be recognised that variations exist across jurisdictions regarding terminology and the sizes of areas and organisations. For example, in Victoria, the MHSOs comprise Area Mental Health Services that are actually components of larger legal organisational entities; in NSW, the Area Health Services (AHSs) are the principle organisational units but include a number of catchment-area based service organisations. Public reporting should include contextual information that helps to explain observed differences especially as these may be related to the size and governance arrangements of organizations.

While recognising that the focus is on mental health service organisations, public reporting should be at a level that still has meaning for the consumer but should not be so small that it identifies small individual teams or individual clinicians.

The recommendation of the PRWG is that the current set of 16 KPIs should be reported wholly or in parts. There are, however, within jurisdictions, contrasting views regarding the current set of 16 KPIs. There is some argument that not all are still relevant to mental health services across Australia. To this end, some jurisdictional work is underway on the development of indicators that provide additional information about the performance of services and which can be used by clinicians to improve service delivery.

The PRWG acknowledge the work being done by jurisdictions and recommend that public reporting should be rolled out in phases. During Phase 1, the existing 16 KPIs would be used for reporting purposes. A later part of Phase 1 (i.e. Phase 1b) would include revisions and refinements to the current KPI set. This will require consultation with jurisdictions and other key stakeholders to identify how the current set might be modified to ensure relevance to the models of service delivery across Australia but, importantly, to ensure that the reported data does provide valuable information that can be used improve quality.

Phase 2 activity would see the development of other specific KPIs e.g. indicators relevant for specific groups. This targeted reporting would add value to the information already reported, facilitate better “like-with-like” comparisons and drive greater collaboration and benchmarking between services. Phase 2 would likely require a broader consultation process to enable identification of the targeted KPIs and the establishment of priorities for development.

As stratification is the most common form of risk adjustment, the PRWG recommend stratification for public reporting according to target population – Child and Adolescent, Adult, Older Person and Forensic. During Phase 1, it is likely that there will not be the capacity to undertake more micro peer group comparisons (e.g. comparing a child service focusing on eating disorders with another one with the same focus). However, this should be considered as part of future development work. It is also suggested that additional



stratification according to rural/metropolitan location should be considered for the purpose of reporting.

The PRWG noted the importance of contextual information in any reporting of service performance. The literature review and the experience within the National Mental Health Benchmarking Project highlighted the importance of contextual information to better interpret and understand the reasons for service variation. Thus reporting should include provision for jurisdictions and /or services to include contextual details. It is recommended that elements such as disadvantage, cultural back ground and indigenous status should be considered for inclusion in public reporting.

4. Methods for reporting – what options should be pursued for how information on mental health service performance should be made available to the public?

Recommendations:

- i. Public reporting should be web-based with “drill down” and customized reporting functionality.**

To ensure that the reports on mental health service performance, and the data that underpin them, can be readily updated and tailored for inquirers with specific areas of interest, the PRWG envisage a web-based reporting format with the functionality to select specific target populations, service settings or other pertinent stratifications. Significant complexity exists in building appropriate websites and these are highlighted in the literature review (see Appendix 3).

5. Relative Commonwealth and State/Territory roles – what roles need to be played by each level of government in introducing public reporting by mental health services, and is there a place for collaborative or centrally-led national activity?

Recommendations:

- i. New reporting bodies established as part of current health reform initiatives are likely to play a major role in the public reporting of health performance information. However, the extent of this reporting for mental health performance is yet to be determined.**
- ii. It is desirable under any proposed reform agenda that jurisdictions establish complementary reporting processes that fulfill the commitments under the 4th National Mental Health Plan and which provide comprehensive reporting on the performance of the mental health sector.**



Prior to the announcement of the public reporting initiatives under the health reform agenda, the PRWG considered various models for public reporting involving the Commonwealth and States or Territories.

One model visualized the States and Territories managing the public reporting at individual jurisdiction level within an agreed national framework. Within this approach, state / territory public reporting websites would be established, based upon consistent agreed national definitions and indicators. The national KPIs (all or some, to be resolved) would form the core element. Other indicators used by individual jurisdictions would be made available as additional information.

Another model suggested the establishment of a national public reporting website where jurisdictions control the provision of data to the national site. Within this approach, the national website could be a collaborative initiative between the 8 state and territory governments, managed by an agreed independent party (not necessarily the Commonwealth). The national website could have a public portal only, or be backed by additional functionality for private access by participating organisations that allowed access to peer group formation and comparative data that supported benchmarking and local quality improvement activities.

Following the announcement of the recent health reform initiatives, the PRWG reviewed the roles of the Commonwealth and the States and Territories and the commitments in the 4th National Mental Health Plan regarding transparency and accountability.

PRWG members noted that uncertainties exist in terms of the extent of public reporting about the mental health sector under the proposed initiatives, e.g. a central authority could take a minimalist approach and focus on a small number of indicators. However, the central authority may not have the initial capacity to support the type of detailed reporting that would assist targeted benchmarking and promote interactions between peer services within the mental health sector. The capacity to “drill down” into the data to better identify “like-with-like” services will engage clinicians and drive quality improvement processes.

States and territories are likely to differ in the capacity of their information systems to deliver this more detailed data. Therefore, in parallel with the developments in public reporting at a national level, the PRWG recognises that some jurisdictions may, for their own purposes or to meet commitments under the 4th National Mental Health Plan, establish some level of public reporting on service performance for mental health service organisations within their own state or territory. This jurisdictional reporting would complement the work being done nationally, potentially meet some of the specific informational needs of consumers in that jurisdiction and provide additional tools and incentives to service managers and clinical leaders to establish a culture of continuous quality improvements. States and Territories will have a role to play in developing mental health workforce skills to ensure that clinicians and managers understand the data and how it can be used. The jurisdictions will also need to ensure that local consumer consultation processes are employed to support the dissemination of publicly reported information.



6. Resources, supports, incentives and infrastructure - what is required to introduce public reporting in the Australian mental health sector?

Recommendations:

The introduction of public reporting will require:

i. Technical capacity:

- for the development of other indicators e.g. development of indicators of greater relevance to consumers and carers and indicators that highlight performance of services delivered under Medicare arrangements);
- to progress data development initiatives, particularly with a focus on the data sets for the NGO sector;
- to establish appropriate reporting systems - either multi-site systems or one national site - that are supported by an infrastructure which enables seamless submission of data.
- to develop comprehensive user friendly reporting web sites that can be understood by all stakeholders – the general community, consumers, carers, clinicians, service managers.

ii. Consumer capacity:

- to ensure consumers, carers and the general community can access advice – written / telephone / web based – regarding the content of any public reporting website.
- to allow effective consultation with stakeholders regarding the implementation of public reporting.

iii. Mental health sector capacity:

- to ensure service providers (clinicians, service managers) have access to training, education and benchmarking opportunities that will flow from the implementation of public reporting.
- to support the production and dissemination of contextual and narrative information on organisational processes that explain service variation and models of care.

The PRWG acknowledged the resource implications for public reporting - both at a national and jurisdictional level. Technical capacity will underpin the development of systems of public reporting that have maximum utility, clarity and flexibility - that allow for ongoing data development of both additional indicators and data sets. Mechanisms will need to be established to ensure consumers, carers and the general community can understand and interpret the data being reported and use it to inform decisions. The mental health sector, both at clinician and manager level, will also require training and resources to ensure that



they understand the data, can articulate the reasons for the differences between services and can use the data to progress quality improvement initiatives.

7. Communication and consultation strategy – how do these need to be planned both within the mental health sector and more broadly?

Recommendations:

- i. **Consultation regarding the implementation of public reporting should occur with consumer and carer groups and other peak stakeholder bodies.**

The PRWG identified that it was difficult to make recommendation on the scope of the consultation process given the current implications of national agreements. However, it was agreed that a consultation process with representatives from peak stakeholder organisations, such as professional organisations and industrial bodies, is essential to the process of implementation of public reporting.

8. Timeframe – what is a feasible timeframe for implementing public reporting by Australian mental health services, with reference to short term, medium term and long term goals?

Recommendations:

- i. **Timeframes for the implementation of public reporting are primarily driven by the expectations for accountability described in the 4th National Mental Health Plan.**
- ii. **Timeframes are also influenced by the timelines put forward under the proposed government reform agenda, noting however that the mental health sector has robust data currently available for public reporting.**

The focus on transparency and accountability within the 4th National Mental Health Plan (2009-14) is a key driver of public reporting for the mental health sector. Implementation of public reporting is likely to occur in stages; an initial focus should be on commencement of reporting on some indicators as early as possible within the 2009-14 period.

This timeframe will be influenced by the timelines indicated within the proposed government reform agenda. The PRWG noted that interim reporting will occur via the Australian Institute of Health and Welfare (AIHW) post July 2010, with further development of central reporting capacity post July 2011. These reforms may therefore accelerate progress with public reporting.

The PRWG agreed that, relative to other parts of the health sector, the mental health sector is in a position to publicly report now using the data currently available. Data is being collected by services and would be available for reporting pending the development of a suitable reporting platform.



In regard to publicly reporting data from the non government sector, the PRWG believe that it may take 3 years or more before consistent and robust data collection can be established and suitable for reporting.

Experience and previous consultation work has also shown that the development of new consumer relevant indicators would also take 3 years of more.



Conclusion

The reform efforts under the National Mental Health Strategy, that have taken place over the last decade, have brought about significant changes within the mental health sector. Increased emphasis on the safety and quality and the outcomes of care have promoted the development of a solid information base which will be further enhanced under the direction provided by the 4th National Mental Health Plan.

The mental health sector is well placed to begin public reporting of performance data given the establishment of relevant structures and the ongoing implementation of the government's health reform agenda.

It is recommended that this takes place in a staged process, focusing on State and Territory managed clinical mental health services, with initial reporting around the 16 Key Performance Indicators and allowing for revisions and modifications to those KPIs. This would then be followed by the development of additional specific indicators that might facilitate more detailed peer group comparisons. Non government sector organisations and Commonwealth and Medicare funded services should also be included in the later implementation phases.

Reporting using web based functionality, ensuring that data can be accessed according to target population - Child and Adolescent, Adult, Older Persons and Forensic - will help ensure that consumers, carers, clinicians and service managers can more readily identify services of specific interest to them. Importantly, contextual information should also be included that assists in the interpretation of service variation.

Given the commitment of the jurisdictions to the 4th National Mental Health Plan, States and Territories may pursue separate public reporting initiatives that may meet the information needs of their own general community and mental health sector. This work would continue to enhance accountability and transparency and would encourage consistency of data made publicly available.

Current mental health information advisory structures are well established and should be a key element of the consultation process in the development phases of public reporting.



References

1. Australian Health Ministers. *Fourth National Mental Health Plan*. Canberra: Commonwealth Department of Health and Family Services, 2009.
2. Council of Australian Governments. *National Health and Hospitals Network Agreement*. Canberra: COAG, 2010
3. Australian Institute of Health and Welfare. *Towards national indicators of safety and quality in health care*. Cat. no. HSE 75. Canberra: AIHW, 2009.



APPENDIX 1



Developing Systems for Public Reporting Working Group Terms of Reference

At the MHISS meeting of 19-20 November 2009, it was agreed that a working group would be established to progress the development of systems for public reporting by mental health services organisations on performance indicators. The Fourth National Mental Health Plan commits governments to the introduction of new reporting arrangements and foreshadows that these will be achieved through incentives and supports to organisations seeking to participate in these new developments. The Plan indicates that this will include providing access to national benchmarking data, forums for interaction between peer organisations to share performance data and to learn from each other, and other leadership development opportunities. Web-based systems of reporting and benchmarking are also suggested to better inform consumers, carers and the general community about local service performance.

Terms of Reference

1. The working group is required to develop a draft implementation strategy for introducing public reporting on performance indicators by state and territory mental health services that will be submitted under MHISS auspice for endorsement by the AHMAC Mental Health Standing Committee (MHSC).
2. Without restricting the scope of the strategy, the implementation strategy should make recommendations in each of the following areas:
 - a. *Scope* – i.e. which service streams and provider groups within the specialised mental health sector should be expected to participate in public performance reporting?
 - b. *Level of reporting* – what levels (e.g., regions, areas/districts, services, teams) of the mental health system should be targeted for public reporting?
 - c. *Governance*– who should be responsible for the reporting process and what structural arrangements are needed to manage the various interests of stakeholders?
 - d. *Content and structure* – what aspects of mental health service performance should be reported, and how should services be grouped to facilitate fair, ‘like with like’ comparisons?
 - e. *Methods for reporting* – what options should be pursued for how information on mental health service performance should be made available to the public?
 - f. *Relative Commonwealth and State/Territory roles* – what roles need to be played by each level of government in introducing public reporting by mental health services, and is there a place for collaborative or centrally-led national activity?



- g. *Resources, supports, incentives and infrastructure* - what is required to introduce public reporting in the Australian mental health sector?
 - h. *Communication and consultation strategy* – how do these need to be planned both within the mental health sector and more broadly?
 - i. *Timeframe* – what is a feasible timeframe for implementing public reporting by Australian mental health services, with reference to short term, medium term and long term goals?
3. The implementation strategy should also:
- a. take account of state and territory current initiatives and plans for public reporting, and be developed in a way that is complementary to the work being undertaken by states and territories;
 - b. consider the opportunities for extending public reporting on mental health service delivery to Commonwealth- administered programs, particularly Medicare-funded services; and
 - c. take account of the range of options developed internationally and within Australian for public reporting on performance indicators by health services.

Review of evidence and experience of public reporting at the health service provider level

The working group will be assisted and guided by a review of both grey and published literature on public reporting at the level of individual health service organisations. This review is to focus on public performance reporting of mental health service organisations and include published experience and evidence drawn from other human service sectors where they are relevant to the issues under current consideration in Australia.

The review will be undertaken by the Australian Mental Health and Outcomes and Classification Network (AMHOCN), working under contract to the Department of Health and Ageing. The working group will act as the steering committee to the review project and will provide guidance and feedback on the report's final scope and structure.

Membership

The working group will consist of: Robyn Milthorpe (Australian Government), Bill Buckingham (Consultant), Deb Ophof (SA), Grant Sara (NSW), Nick Legge (VIC), Brian Stokes (TAS) and representatives from AMHOCN.

This working group will be time limited; however it may be extended with the agreement of MHISS. Currently the completion date is (date)

The new consumer and carer representatives for MHISS, when endorsed, will be asked to join this working group. Broader representation from other MHISS members will also be offered at the MHISS meeting of 11-12 February. In addition, specific expertise maybe co-opted as required.

AMHOCN will provide the secretariat services to this working group on behalf of the chair, Dr Grant Sara (NSW representative).



Report structure

The final report will be developed as a consultation paper and structured so that it can be used for consultations with different audiences. The final report will provide an analysis of options and offer recommendations regarding the introduction of public reporting on performance indicators by state and territory mental health services, including recommendations regarding both a broader consultation strategy and implementation strategy.

Timelines

The working group will provide a report to the MHISS meetings on 11-12 February and 22-23 April, addressing the outcomes from the literature review, other research, jurisdictional fact finding and the development of recommendations. The final report will be presented to MHISS at the meeting of 19-20 August 2010 and will be finalised for consideration of MHSC by September 2010.

DRAFT TIMELINE

Date	Task
15 December 2009	1 st teleconference: <ul style="list-style-type: none">• Discussion of ToR and review of the literature
28 January 2010	2 nd teleconference: <ul style="list-style-type: none">• Presentation by AMHOCN to working group on scope and structure of literature review report and progress on initial findings.• Discussion of structure of report• Discussion of jurisdictional fact finding strategy• Timelines
11-12 February 2010	Presentation to MHISS by working group Chair and AMHOCN on work undertaken to date.
Mid March	3 rd teleconference: <ul style="list-style-type: none">• Update from AMHOCN on literature review report• Update on jurisdictional fact finding
1 April 2010	First draft of report to working group, incorporating review of literature and jurisdictional fact finding.
8 April 2010	Meeting of working group <ul style="list-style-type: none">• Development of recommendations from nine specified areas described in ToR, e.g. scope, level of reporting etc.
22-23 April 2010	Presentation to MHISS by working group Chair and members and feedback from MHISS members
4 June 2010	Second draft incorporating the working group's initial analysis of options and recommendations.



Date	Task
June – July 2010	Teleconferences as required: <ul style="list-style-type: none"><li data-bbox="560 349 1222 383">• Discussion of draft report and then final report
19-20 August 2010	Presentation of final report from working group to MHISS and feedback from MHISS members.
September 2010	Revisions to report and final endorsement by MHISS
Date TBC 2010	Preparation of agenda paper and finalisation of paper for MHSC



APPENDIX 2



Public Reporting Working Group

Feedback on NGO sector inclusion

Prepared by the Mental Health Council of Australia representative

The non-government mental health sector in Australia provides a number of services not limited to, but including providing mental health services through community and disability programs. Many of these services are not specifically funded to provide mental health services, but do anyway. The contribution that the NGO sector makes to the mental health and wellbeing of Australians cannot be overstated. The majority of consumers utilising these services will never utilise the public system services, therefore there is a wealth of information about the sector that will not be captured without NGO sector inclusion.

There will be a number of challenges with reporting on the NGO sector, however, it is important that this matter is given proper consideration at the time that the mechanisms for public reporting are being developed. There would already be a substantial number of NGOs who could report upon their services, with the data that they currently collect being of the same standard as the public system. There has also been substantial work undertaken in jurisdictions, including the development of a comprehensive and minimum data set in NSW.

The NGO sector would recommend that there be two stages to NGO sector inclusion for public reporting. Firstly, those with adequate data systems should be given the opportunity to opt-in to the system for the release of information to the public commensurate with the public systems. Secondly, those organisations that do not yet have adequate data, the infrastructure to collect it or quality thereof, will be assisted to work towards achieving a minimum standard for future inclusion. NSW has assessed appropriateness of 11 existing data systems against 24 criteria including among others: cost, privacy, security, import and export capacity, flexibility and adaptability, HR integration, user friendliness and training support. There may be a large number of very small NGOs who will not have the capacity to contribute to any public reporting system; however it is important that we capture at least a minimum dataset, with the goal of strengthening and developing it into the future.

One way of moving towards ensuring standardised data collection systems across both the public and NGO sectors could be through funding agreements with state, territory and commonwealth departments. Part of the contractual requirements for NGOs could be to maintain databases that record minimum datasets which could then be fed into the public reporting system. Given the largely standardised 'template' nature of government funding agreements, this should not be an overly onerous task.

The information management needs of the NGO sector are changing dramatically. An increasing number of NGOs have contractual agreements with both Commonwealth and state government departments. NGOs are required to report separately to each of their funding bodies on different aspects of their work. Much of this reporting could be streamlined to decrease administrative burden on organizations. Whilst many organizations



have implemented mechanisms to understand consumer outcomes at the individual and organizational level there is no over-arching mechanism by which to understand the service delivery characteristics and outcomes of NGO mental health programs or the total impact of the sector.

In regards to the 4th National Mental Health Plan Indicators, the NGO sector can make a sizeable contribution against the priority areas as follows:

Priority area 1: NGOs have access to a lot of information in this area

Priority area 2: Workforce

Priority area 3: NGO sector data needs to be included in % of population receiving mental health care, and prevalence among homeless population

Priority area 4: NGO sector data could be included in the first, second and fourth indicator

Priority area 5: NGO sector wants better performance data that is outcomes/client focused

There are a number of challenges to be faced with the inclusion of the NGO sector into a public reporting system, however if this is to be done, then this must be fully considered now, rather than being cast aside due to being too overwhelming.

Recommendations

The NGO peak bodies propose that in the first instance, the relevant state peak bodies make contact with their member organisations to seek a response about capacity and interest in providing data to the public reporting system. Further to that we would be seeking information about what data NGOs could provide and the timeliness of this. Once this has been established, a report would be prepared by the CMHA in consultation with and on behalf of the NGO sector for the Public Reporting Working Group to make recommendations upon regarding NGO sector inclusion, and in what capacity.

The NGO peak bodies support the inclusion of the NGO sector within the planned public reporting system. It would provide the sector with the opportunity to demonstrate their capacity to provide meaningful information to the public in a standardised way. It would also provide the public with the opportunity to compare services either with public or between other private service providers. This is an ideal time and opportunity to assist the growth of the NGO sector to achieve greater transparency and accountability through public reporting.



APPENDIX 3



A M H O C N

Australian Mental Health Outcomes and Classification Network

'Sharing Information to Improve Outcomes'

An Australian Government funded initiative

Public reporting of organisational performance: A review of the literature

Tim Coombs, Philip Burgess, Jane Pirkis, Grant Sara, Rosemary Dickson

June 2010



A joint Australian, State and
Territory Government Initiative

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Executive summary

Background

The Fourth National Mental Health Plan¹ emphasises improved accountability and transparency in mental health reform and service delivery. Specifically, it commits to building ‘... a service delivery system that monitors its performance on service quality indicators and makes this information available to consumers and other stakeholders.’ This commitment to publicly reporting service quality indicators is new in Australia’s mental health sector.

The directions of the Fourth National Mental Health Plan align with a broader Council of Australian Government (COAG) reform agenda that has a commitment to increasing accountability through more transparent public reporting of meaningful, understandable, timely, comparable, administratively simple, cost effective and accurate indicators of Government performance. The reform acknowledges that reporting should be hierarchical with national high level indicators underpinned by lower level sector specific indicator reporting.^{2,3}

In health, the creation of a central authority as flagged in the National Health and Hospitals Network Agreement,^{3,4} will report on the performance of individual hospitals against national standards and performance indicators. This type of reporting will result in the public reporting of the organisational performance of mental health services.

The current report represents a review of relevant literature on exercises in public reporting.

Method

Peer-reviewed journal articles on public reporting were sought via a search of the electronic databases Medline and Cinahl. Relevant published and unpublished reports and websites were sought via a web search conducted through Google.

Key findings

In Australia, public reporting is relatively unexplored territory in the mental health sector, although there are some examples of public reporting in the general health sector which include one or two indicators that are relevant to mental health. There are a number of international examples of public reporting systems that pertain to the performance of mental health systems, and these may have lessons for the Australian context.

There are a range of views about public reporting, both within and across stakeholder groups. In general, however, consumers seek readily accessible, user-friendly information that can assist them with decisions about where they go to seek care; where information is provided in a complex way, consumers have difficulties extracting meaning from it. Clinicians can be sceptical about public reporting, because they believe that indicators often do not capture what purport to capture and can be misinterpreted. Managers and senior staff hold a range of views, but are generally most positive when public reporting is combined with internal quality assurance processes and opportunities for reflection on practice.

Systematic reviews suggest that public reporting has a modest impact on certain consumer choices, and a consistent influence on quality improvement at a service level. The jury is still out, however, on whether these positive impacts translate to improvements in the effectiveness of treatment.

There may also be some unintended consequences of public reporting, such as ‘gaming’ on the part of managers.

A range of issues must be considered as public reporting is introduced in the Australian mental health context. Some relate to the nature of reporting – for example, what data should be reported and how this should be done. Others relate to how best to maximise data quality on particular indicators.

The way in which comparative data are presented will have an impact on the conclusions that given users will be able to draw from it. One of the key issues is how to ensure that services are being fairly compared with their peers. The process of ‘levelling the playing field’ is known as risk adjustment, and this is a relatively new enterprise in mental health. Consideration will need to be given to conceptual issues (i.e., what consumer-based and environmental factors to adjust for) and technical issues (i.e., which statistical approaches might be most appropriately used in the risk adjustment process).

Conclusions

Public reporting has the potential to improve the quality of mental health services across Australia. We are in the fortunate position of being able to draw on the experiences of the general health sector in Australia and the mental health sector from overseas, and can hopefully avoid some of the pitfalls that others have faced. The advice of others is to view public reporting as an evolutionary process which becomes progressively more sophisticated and comprehensive over time,⁵ and this would seem to make sense in the Australian mental health context.

Chapter 1: Background

The policy context

The Fourth National Mental Health Plan¹ emphasises improved accountability and transparency in mental health reform and service delivery. Specifically, it commits to building ‘... a service delivery system that monitors its performance on service quality indicators and makes this information available to consumers and other stakeholders.’ This commitment to publicly reporting service quality indicators is new in Australia’s mental health sector, although it represents a logical extension of recent efforts to collect performance-related information with a view to guiding practice and thereby improving the quality and outcomes of care.

The directions of the Fourth National Mental Health Plan align with a broader Council of Australian Government (COAG) reform agenda that has a commitment to increasing accountability through more transparent public reporting of meaningful, understandable, timely, comparable, administratively simple, cost effective and accurate indicators of Government performance. The reform acknowledges that reporting should be hierarchical with national high level indicators underpinned by lower level sector specific indicator reporting.^{2 3}

In health, the creation of a central authority as flagged in the National Health and Hospitals Network Agreement,^{3 4} will report on the performance of individual hospitals against national standards and performance indicators. This type of reporting will result in the public reporting of the organisational performance of mental health services.

The rationale for public reporting

Various authors have considered the question of why public reporting might be desirable. They differ in the terminology they use to describe the rationale for public reporting, but essentially agree that public reporting is a lever that may improve service quality, and that it may have potential benefits for consumers of services, purchasers of services, regulators of services, and providers of services.⁵⁻⁹

- For **consumers**, the benefit is that they will be in a position to make informed choices about the services they use.
- For **purchasers**, the benefit is similar: public reporting will equip them with the necessary information to select services that offer high quality care at the most reasonable price, and will provide them with a mechanism through which they can monitor these services’ ongoing performance.
- For **managers** and **regulators**, public reporting will provide an accountability tool.
- For **clinicians**, public reporting allows comparison of services with identified peer services, and can support the monitoring and improvement of the quality of care .

The potential benefits of public reporting are clearly inter-related, and will influence the behaviour of all relevant stakeholders in a manner that is designed to improve overall service quality. In addition, there may be useful by-products of public reporting, such as performance data that can inform important epidemiological and clinical research questions.¹⁰

The current report

Although the Fourth National Mental Health Plan's¹ commitment to public reporting charts new territory for public sector mental health services in Australia, the process is not without precedent. Australia has introduced public reporting in other areas of health service delivery as well as in various human service sectors. Other countries have implemented public reporting in mental health services.

There are clearly opportunities to learn from these experiences. This report represents a review of relevant literature on local and international exercises in public reporting. It draws on both the peer-reviewed academic literature and the 'grey' literature, and examines issues associated with the implementation of public reporting at the level of individual services.

Chapter 2: Method

Peer-reviewed journal articles on public reporting were sought via a search of the electronic databases Medline and Cinahl. Relevant published and unpublished reports and websites were sought via a web search conducted through Google. In both cases, the following search terms were used in the first instance: 'public', 'reporting', 'organisational' and 'performance'. More specific search terms were used to follow up leads, as necessary. The reference lists of retrieved journal articles, reports and websites were scanned, and previously-unidentified references were followed up.

Chapter 3: Key findings

Local and international precedents

As noted in Chapter 1, although Australia has no history of publicly reporting on indicators of the quality of mental health service delivery, there are relevant precedents to draw on. Australian health services (in particular, public and private hospitals) are required to submit a range of activity-related data which are made available to the public. International health systems have taken this further, and now publicly report on indicators that go beyond activity to encompass elements of quality. Relevant, contemporary examples of public reporting from Australia and overseas are summarised below and described in more detail at Appendix 1.

Examples of Australian public reporting systems

In Australia, both public and private hospitals publicly report on their performance through various systems. These reporting systems are presented in a range of different formats. Some rely on hard copy reports, whereas others are web-based. Some of the web-based systems are static, and take the user through a series of pre-determined views; others are more advanced, and draw on data cube technology which allows users to specify the data they wish to see. The way in which these reporting systems present indicator information varies too. At the most basic level, they present one-off information for a given area as a whole, offering no opportunities for comparisons over time, across entities or jurisdictions, or between certain population sub-groups. More advanced systems present more detailed information to facilitate these sorts of comparisons.

A description of public reporting by public and private hospitals in Australia is provided below:

- Aggregated information on the performance of Australia's public hospitals is made available through an annual report by the Department of Health and Ageing.¹¹ Individual states and territories also publish quarterly or annual reports on their respective health department websites, often – though not always – providing data that allows comparisons to be made between individual hospitals. Typical indicators include data on hospital admissions (e.g., numbers of hospital separations, average length of stay) and emergency department presentations (e.g., numbers of emergency department presentations). Some states and territories include some information on mental health-related activities in their public reporting systems, although in the main this is activity-based and does not relate to consumer-level outcomes. For example, Queensland presents data on the number of acute readmissions and long-stay admissions for two mental disorders, depression and schizophrenia. Similarly, Western Australia provides an indication of the number of public mental health admissions and the number of attendances for mental health services at outpatient clinics. Tasmania also reports a number of mental health indicators, including inpatient separations, numbers of community and residential consumers, and 28-day readmission rates. The Australian Capital Territory reports on the use of seclusion. The Northern Territory reports on several mental health indicators, including the number of inpatient separations and the average number of bed days, as well as the of individuals receiving community-based public mental health services (breaking this down by socio-demographic factors).
- Australia's private hospitals also report on their performance, again providing a number of metrics related to hospital admissions, and doing so on an annual basis. Public reporting by the private sector is arguably more advanced in terms of providing information about

consumers' mental health outcomes. In addition to reporting information on the number of hospital separations and the proportion of separations accounted for by unplanned readmissions, the private sector reports on average change scores on the Health of the Nation Outcome Scales (HoNOS) and the Mental Health Questionnaire (MHQ-14). Not all of this information is available at an individual hospital level, however.

Examples of international public reporting systems

Overseas, there are examples of quite advanced systems designed to enable users to make informed choices about health care. Again, these vary in their format, and in the information they present and how they present it, but they all allow users to compare given organisations on the basis of relevant indicators of quality. Some of these are generic, and some have an explicit mental health focus or at least defined mental health components.

Two examples of generic public reporting systems (both from the United States) are provided below:

- Hospital Compare (<http://www.hospitalcompare.hhs.gov/>) presents hospital-level data based on responses to the 27-item Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey, which is administered annually to consumers discharged from 90% of all United States hospitals. The survey, which is completed anonymously, covers such domains as staff responsiveness and communication skills. The results are reported as percentages (e.g., the percentage of patients who reported that their nurses always communicated well; the percentage of patients who reported that they always received help as soon as they wanted). This information is available via a web-based platform which allows users to compare up to three hospitals at once.
- Medicare Home Health Compare in the United States (www.medicare.gov/hhcompare/) presents information on quality measures of home nursing and paramedical services, broken down by agency. It differs from Hospital Compare (described above) in that it does not collect the relevant information via consumer survey, but it is similar in that it makes this information available through a website. Users are given an indication of a particular facility's performance on a range of indicators, most of which relate to activities of daily living (e.g., the percentage of patients who get better at walking or moving around). As with Hospital Compare, Medicare Home Health Compare allows users to make comparisons between individual facilities. It also provides state and national averages for each indicator.

Three examples of public reporting which have a greater emphasis on mental health (one from the United States and two from the United Kingdom) are described below:

- In the United States, the New York State Office of Mental Health (<http://www.omh.state.ny.us/>) provides a quarterly, web-based report of the performance of public sector organisations against critical indicators of outcomes for individuals. Their stated goal in doing so is to 'improve accountability and transparency by allowing anyone to use the reported data to inform decision-making and assess the progress an agency is making toward achieving its strategic goals. In practice, each organisation (or facility within an organisation) is reported against a 'balanced score card'. This includes a range of management objectives (e.g., Increase the percentage of families who indicated satisfaction with their child's functioning as a result of the mental health services that their child received), which are given current value that can be compared with a pre-determined target value. Definitions are provided as necessary, and individual indicators are progressively updated.

- The Care for Quality Commission (<http://www.cqc.org.uk/>) regulates all health care (for adults and children) and social care (for adults) in the United Kingdom, and has a particular focus on mental health care. They review organisations to ensure that they meet specified standards of care, and register those which do. They provide current, independent information about the quality of given providers' care, in order to assist people to make decisions about their care. They report 'overall quality scores' and 'overall financial management scores' for National Health Service trusts and for individual services, although the way in which these ratings are derived is not completely clear.
- The Quality Outcomes Framework in the United Kingdom (<http://www.qof.ic.nhs.uk/index.asp>) is described as 'a voluntary annual reward and incentive programme for all GP surgeries in England, detailing practice achievement results ... [and] ... resourcing and then rewarding good practice.' Its Online GP Practice Results Database allows users to search for general practices in a particular area, and then compare their performance in treating a range of conditions against a selection of indicators. In mental health, there are six indicators: (1) the ability of the practice to produce a register of people with schizophrenia, bipolar affective disorder and other psychoses; (2) the percentage of patients on lithium therapy with a record of serum creatinine and TSH in the previous 15 months; (3) the percentage of patients on lithium therapy with a record of lithium levels in a therapeutic range within the previous six months; (4) the percentage of patients on the register who have a comprehensive care plan documented in the records agreed between individuals, their family and/or carers as appropriate; (5) the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who do not attend the practice for their annual review who are identified and followed up by practice team within 14 days of non-attendance; and (6) the percentage of patients with schizophrenia and bipolar affective disorder and other psychoses with a review recorded in the previous 15 months (in the review there is evidence that the patient has participated in routine health promotion and prevention advice appropriate to their age and health status).

Stakeholder's views of public reporting

Various studies have considered stakeholders' views of and experiences with public reporting. The findings suggest that there are varying views, both within and across stakeholder groups. This underscores the need identified by various commentators for comprehensive consultation processes to support the introduction of public reporting.¹⁰

Studies of consumers suggest that consumers seek information that is readily accessible, frequently updated, provides sufficient detail for informed choices to be made, and focuses on the processes of care (e.g., whether appointments can be made in a timely manner) as well as the impacts and outcomes of care. Where information is not presented in a user-friendly way, consumers often have difficulties comprehending it.^{12 13}

Studies of clinicians indicate that this group can be sceptical about public reporting, because they believe that indicators often do not capture what they are intended to capture and can be misinterpreted, particularly if their limitations are not understood. There are also suggestions that clinicians may favour indicators that focus on access to care, the processes of care and satisfaction with care.¹⁴⁻¹⁶

Studies of managers and senior staff have produced mixed results. Some of these stakeholders appear to have negative views of public reporting, displaying indifference, resignation or outright

hostility. Others seem to hold much more positive views, particularly when public reporting is combined with internal quality assurance processes and opportunities for reflection on practice, and when sufficient resources are set aside for the collection and reporting of data.¹⁷⁻¹⁹

Positive impacts of public reporting

In considering the positive impacts of public reporting, it is worthwhile to consider the rationale behind it. As noted in Chapter 1, the implicit or explicit rationale for introducing public reporting is to improve service quality. It is assumed that this will occur because public reporting will influence the behaviour of a range of stakeholders: consumers and purchasers will make choices about which services to support on the basis of their performance; managers and regulators will use publicly reported data as an accountability tool; and clinicians will strive to improve their performance.

Four systematic reviews have considered the extent to which public reporting influences the decision-making and actions of relevant stakeholders and, in turn, have an impact on service quality. The earliest of these systematic reviews, conducted in 2000 and 2001 by Marshall et al⁵ and Schaufler and Mordavsky,⁹ respectively, were not particularly positive about the impact of public reporting. Marshall et al⁵ concluded that it encouraged hospitals to respond with internal changes, but that there was little evidence of other impacts. Schaufler and Mordavsky⁹ also concluded that public reporting did not appear to influence the behaviour of stakeholders, nor to influence quality.

These early reviews were conducted at a point when public reporting had only relatively recently emerged as a quality assurance tool. As a consequence, both considered a small number of studies and an even smaller number of public reporting systems. For this reason, Fung et al²⁰ and Shekelle et al²¹ updated these early reviews. As an indicator of the burgeoning research in the field since the original reviews, Fung et al²⁰ identified 45 relevant journal articles published since 1986, adding 27 to the number found by Marshall et al⁵ in their review. Fung et al²⁰ and Shekelle et al²¹ found that public reporting had a modest influence on consumers' choice of health plans, but an inconsistent impact on their choice of individual hospitals and providers. They also found that public reporting had a consistent influence on quality improvement activity at a hospital level, although this did not necessarily translate into improved effectiveness of treatment. Both sets of authors noted, however, that where particular impacts were not apparent it was usually a reflection of the kinds of evaluation activities that had been undertaken. Either the particular evaluation question had not been asked, or the studies in the given area were small in scale and/or relatively weak in design. Both Fung et al²⁰ and Shekelle et al²¹ warned that absence of evidence should not be regarded as evidence of absence, and suggested that further work (particularly in the area of the effects of public reporting on effectiveness, safety and patient-centredness) is required.

Risks associated with public reporting

Potential unintended consequences of public reporting

Various authors have concerned themselves with the potential unintended consequences of public reporting. Pidd,²² for example, noted that public reporting may influence the behaviour of managers in various ways. For instance, managers may: focus too heavily on the indicators and not on what they mean in terms of outcomes; emphasise indicators that are the easiest to achieve and/or can be achieved within the shortest timeframe; operate in ways that benefit only part of the system and not its whole; misrepresent, manipulate or misinterpret data; or continue to report on indicators that remain achievable but are no longer relevant. Other commentators like Davies¹⁸ have reiterated some of these concerns, focusing particularly on the fact that 'what gets measured gets attention'. Table 1 summarises some of the unintended consequences of public reporting^{22,23}.

Table 1 Unintended Consequences of Reporting Information

Tunnel Vision	Here faced with many different targets managers choose the one easiest to measure and ignore the rest
Sub-optimisation	Here managers operate in ways that benefit their own operation but impact on the overall system performance in a negative way
Myopia	Managers for whatever reason focus on short term targets at the expense of longer term goals
Measures fixation	Outcomes can sometime be difficult to measure and managers may focus on indicators rather than the desired outcomes
Misrepresentation	Data is either misreported or distorted to create a good impression
Misinterpretation	Here reported differences in organisational performance may be more measurement error and there may be o difference in organisational performance
Gaming	Here managers manipulate data to achieve their own ends
Convergence	They place greater emphasis on not being exposed as an outlier rather than a desire to be outstanding
Ossification	The indicator has past its use by date for whatever reason but it continues to be reported

Marshall²³ has identified a number of strategies for reducing the unintended consequences of public reporting. These include: ensuring that staff are involved at all levels in the organization; being flexible regarding the way in which indicators are used; keeping the number of indicators at a manageable level; ensuring that indicators of consumer impact (e.g., satisfaction) and outcome (e.g., changes in levels of functioning) are included to complement indicators associated with processes of care; making use of independent benchmarks; seeking expert interpretations of indicators; constantly reviewing the reporting system; taking a longer term perspective; and highlighting the importance of continuous learning over one-off absolute judgements about performance.

The nature and quality of publicly reported data

At a practical level, there are a number of issues around what data should be publicly reported, and how this should be done. Various authors have observed that different stakeholders will respond differently to different types of information, presented in different ways. Edgeman-Levitan and Cleary²⁴ found that consumers varied in the amount of detail they sought. Leatherman and McCarthy²⁵ argued that information that is useful to providers may not be useful to consumers and vice versa, and suggested that different versions of the same report for the general public and for providers may sometimes be warranted. Whatever information is presented, and regardless of who the intended audience is, most commentators agree that simplicity, clarity, brevity and flexibility are desirable.²⁶⁻³⁰

There are also issues about the types of indicators that are reported. Often indicators are associated with inputs (e.g., costs) or processes (e.g., average length of stay; numbers of contacts, proportion of consumers follow-up post-discharge; proportion of consumers receiving appropriate medication regimens), rather than impacts (e.g., proportions of consumers who are satisfied with their care; rates of unplanned readmissions) or outcomes (e.g., proportions of consumers whose symptom severity reduces and/or level of functioning improves). There is a lack of consensus on which indicators of performance are important, but there is growing agreement that they should be of optimal relevance to the particular stakeholder group whose behaviour might be influenced by the indicators.³¹ Again, this suggests that there may be occasions where different reports are required, depending on the intended audience.

Given indicators will often be amenable to presentation in a number of different ways. By way of example, an indicator of change on a given standardised outcome measure might be presented as the proportion of consumers who achieve a minimum level of change, as a mean change score, or as a breakdown of change scores by quartile. It might also be presented in absolute terms, or relative to an overall average. Careful consideration needs to be given to the way in which indicators are presented, because their presentation will have implications in terms of the likelihood of their being achieved, the incentives they create and the way in which they are interpreted. Mor³² has warned, for example, that setting minimum targets may not be appropriate in instances where there is not a sufficient evidence base on which to draw, and that doing so may sometimes encourage providers to be satisfied with achieving the minimum and not strive for improvement.

The question of whether to present a range of indicators or an aggregate as a single, composite measure of performance has also been discussed in the literature. Most commentators favour the former approach.²⁸ Fong et al³³ considered the question from an empirical perspective, developing a single indicator (the Hospital Quality Performance Report) using measures of patient satisfaction, patient safety and overall quality, as well as Hospital Compare data (described above). They found low correlations between these different sets of measures, which led them to highlight the importance of reporting performance across individual domains. O'Brien et al^{34,35} conducted a similar exercise in the cardiac surgery field, combining data from a range of process and outcome measures. They found higher correlations between the different sets of measures than Fong et al³³ did, but still observed that there were significant differences in the overall rankings of hospitals depending on the specific approach used to combine the measures. Pidd²² has discussed this issue at a conceptual level, and has warned that combining multiple indicators into a summary measure requires careful consideration of the relative weight that should be given to individual indicators, and who should be responsible for determining these weights.

Finally, there are issues associated with data quality. As a general rule, objective indicators of inputs and processes (e.g., average length of stay) are likely to be fairly accurately reported whereas indicators that require a subjective judgement on the part of a particular stakeholder may require special attention to ensure data quality. Mor and colleagues^{32,36} found that the reliability of nurses' ratings of nursing home residents' health problems was reasonably good, but that there were systematic biases which had an impact on the relative rankings of different facilities. Sangl et al³⁷ reported similar findings. Elliot and colleagues^{38,39} found that consumers' ratings of their satisfaction with care were associated with both consumer characteristics and the mode by which their views were sought, and that these variations had an impact on hospital rankings. Taken together, these findings suggest that particular consideration may be required to maximise data quality on particular indicators.

Interpretation of publicly reported data

The way in which publicly reported data is presented will have a major impact on the way in which it is interpreted. Stakeholder groups who are not necessarily familiar with the kinds of indicator data presented in public reports may require additional assistance to aid their interpretation. Authors like Hibbard and Jewett⁴⁰ and Marshall et al⁵ have discussed the particular difficulties that consumers face because they do not always understand the context within which a given indicator is presented. Plain language explanations of what indicators mean and the use of intermediaries to assist with interpretation have been proposed as ways of increasing the likelihood that consumers will be able to interpret indicators in a meaningful way.

Over and above issues related to the interpretation of individual indicators, there are issues around the way in which indicator-based comparisons between clinicians, hospitals or area-level groupings of services should be understood. There is unanimous agreement that comparisons should be fair, and pit 'like' against 'like'. The processes, impacts and outcomes of care will depend not only on the performance of given services, but also on the characteristics that consumers bring to treatment (e.g., diagnosis, severity of illness, level of social support) and the characteristics of the broader environment (e.g., whether the service is located in a rural or urban area) outside of the control of services. Unless the presentation of indicators takes into account these factors, interpretation of any rankings of services will be limited. The process of adjusting indicators for these sorts of consumer-related and environmental factors is known as 'risk adjustment'. Risk adjustment is relatively under-developed in mental health⁴¹, and conceptual and technical issues will need to be carefully considered if public reporting is to be implemented in this field. The conceptual issues relate to what to adjust for, particularly in terms of consumer-related characteristics – in mental health, diagnosis alone is a poor predictor of process, impact and outcome indicators, so thought will need to be given to other clinical factors,⁴² such as baseline scores on particular standardised outcome measures.⁴³ The technical issues relate to the statistical approaches that might be used in the risk adjustment process.^{44 45}

Chapter 4: Discussion

Summary of key findings

In Australia, public reporting is relatively unexplored territory in the mental health sector, although there are some examples of public reporting in the general health sector which include one or two indicators that are relevant to mental health. There are a number of international examples of public reporting systems that pertain to the performance of mental health systems, and these may have lessons for the Australian context.

There are a range of views about public reporting, both within and across stakeholder groups. In general, however, consumers seek readily accessible, user-friendly information that can assist them with decisions about where they go to seek care; where information is provided in a complex way, consumers have difficulties extracting meaning from it. Clinicians can be sceptical about public reporting, because they believe that indicators often do not capture what purport to capture and can be misinterpreted. Managers and senior staff hold a range of views, but are generally most positive when public reporting is combined with internal quality assurance processes and opportunities for reflection on practice.

Systematic reviews suggest that public reporting has a modest impact on certain consumer choices, and a consistent influence on quality improvement at a service level. The jury is still out, however, on whether these positive impacts translate to improvements in the effectiveness of treatment. There may also be some unintended consequences of public reporting, such as 'gaming' on the part of managers.

A range of issues must be considered as public reporting is introduced in the Australian mental health context. Some relate to the nature of reporting - that is, what data should be reported and how this should be done. Others relate to how best to maximise data quality on particular indicators.

The way in which comparative data are presented will have an impact on the conclusions that given users will be able to draw from it. One of the key issues is how to ensure that services are being fairly compared with their peers. The process of 'levelling the playing field' is known as risk adjustment, and this is a relatively new enterprise in mental health. Consideration will need to be given to conceptual issues (i.e., what consumer-based and environmental factors to adjust for) and technical issues (i.e., which statistical approaches might be most appropriately used in the risk adjustment process).

What the findings might mean for introducing public reporting in the mental health sector in Australia

Overall, the findings suggest that introducing public reporting in the mental health sector in Australia will be a worthwhile exercise. Overseas experience suggests that public reporting can influence quality improvement at a service level, which in turn suggests that public reporting could serve as a potentially useful tool for operationalising the Fourth National Mental Health Plan's¹ goal of building a more accountable and transparent mental health system.

The findings also suggest, however, that considerable care needs to be taken as public reporting is introduced in order for the positive benefits can be realised. Firstly, consideration will need to be given to the targeting of public reports. The Fourth National Mental Health Plan¹ explicitly discusses

the introduction of public reporting as a means of providing consumers and carers with access to information about the performance of services responsible for their care, but it may be the case that other stakeholders will also gain benefits from a public reporting system. Consultation with consumers, carers and other relevant stakeholder groups will be necessary to inform some of the questions around what is reported and how it is reported. There is a likelihood that information may need to be presented in different ways for different stakeholder groups, in order to ensure that it is maximally useful. The intended purposes of public reporting should be made clear to all stakeholders from the outset.

These consultations should help to settle questions such as: the suite of indicators that are to be measured and the domains they should cover; the specifics of how each indicator is framed (e.g., what it measures, how it measures it, the format in which it is reported); whether results from individual indicators are aggregated into any sort of composite score (and if so, how they are weighted); how comparative information across services will be presented; what sort of platform will be used to present this information; how this information will be made accessible to users; how frequently it will be updated. Additional information will also be required to inform these judgements, including information on the feasibility of collecting data on particular indicators, and the likelihood that these data will be of high quality.

The consultations and the other information sources should also guide decisions about how to make sure that indicators allow meaningful comparisons to be made. Some of these decisions relate to how best to define peer groups of services, in order to ensure that 'like' is really being compared with 'like'. Other decisions relate to the issue of risk adjustment, including what consumer-related and environmental factors should be taken into account to ensure that potential statistical confounding is dealt with.

In Australia, a central authority may report on hospital performance across all hospitals (albeit for a small range of indicators). In mental health, however, 'starting small' in terms of the number of reporting entities as well as the number of indicators might be an appropriate way to roll out public reporting. Interested services might be given the opportunity to participate, and provided with the appropriate resources to do so. These services might trial a small number of indicators, and do so only in a semi-public way in the first instance. Under this approach, the pilot should be used to inform a broader roll-out of a larger number of indicators across a wider group of services. Careful consideration should be given to the level of resourcing required to ensure that the data collection for any given indicator is comprehensive and accurate from the outset and remains so over time.

Evaluation of public reporting should start in the pilot phase and continue beyond this. Ultimately, this evaluation should assess the extent to which the following stated outcome of the Fourth National Mental Health Plan is achieved: *'The public will be able to make informed judgements about the extent of mental health reform in Australia, including the progress of this Fourth Plan, and have confidence in the information available to make these judgements. Consumers and carers will have access to information about the performance of services responsible for their care across the range of health quality domains and be able to compare these to national benchmarks.'* The Plan itself sets *'The proportion of services publicly reporting performance data'* as an indicator of achievement of the outcome. Ideally, the evaluation should go beyond this to consider the quality of the indicator data being reported, and how that indicator data is being interpreted and used by a range of stakeholders. It should also examine the impacts and outcomes of public reporting at a range of levels, in order to determine whether, for example, it influences consumers' decision-making with respect to the services they use, or whether it leads to better quality and more effective service delivery. Potential negative consequences should also be considered in the evaluation, including the influence of any perverse incentives on the behaviour of clinicians and managers.

Conclusions

Public reporting has the potential to improve the quality of mental health services across Australia. The mental health sector is in the fortunate position of being able to draw on the experiences of the general health sector in Australia and the mental health sector from overseas, and can hopefully avoid some of the pitfalls that others have faced. The advice of others is to view public reporting as an evolutionary process which becomes progressively more sophisticated and comprehensive over time,⁵ and this would seem to make sense in the Australian mental health context.

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Appendix 1: Local and international examples of public reporting

Australian public hospitals

An Australian Government Report¹¹ includes a section on State and Territory public hospital performance it indicates that most states and territories report information on their individual public hospitals in annual or quarterly reports that are published on State and Territory Government Health Department websites. In addition to these, some states and territories also provide websites that allow individuals to access comparative data, for example on elective surgery waiting times for common procedures across hospitals.

The following section provides a brief overview of each jurisdictions reports.

New South Wales

The NSW report may be found at:

http://www.health.nsw.gov.au/resources/reports/2009/pdf/200912_QHPR_0910_q2.pdf. It provides quarterly activity data for emergency department activity, admitted patients, and elective surgery for Area Health Services and selected hospitals. The report starts with a summary.

NSW public hospitals at a glance

From October to December 2009 ...	For the same period last year...	The difference ...
There were 514,733 attendances at Emergency Departments	494,309 attendances	↑ 20,424 attendances (4.1%)
There were 113,872 admissions from Emergency Departments	108,503 admissions	↑ 5,369 admissions (4.9%)
There were 401,469 admitted patient episodes	390,100 episodes	↑ 11,369 episodes (2.9%)
The average length of stay for acute admitted patients was 3.4 days	3.6 days	↓ 0.2 days (5.6%)
The proportion of Elective Surgery patients treated 'on time' was 89%	90%	↓ 1.0%
There were 16,968 babies born	17,947 babies	↓ 979 (5.5%) babies

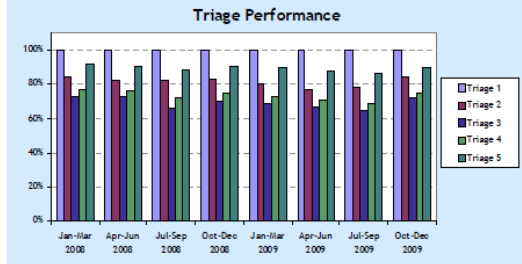
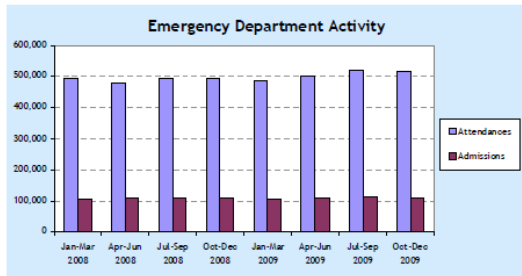
Source: Health Information Exchange, NSW Health. Data extracted on 29/01/2010

On average each day in NSW public hospitals*...
5,595 people attend an Emergency Department
1,237 people are admitted from an Emergency Department
4,364 people are discharged from hospital
184 babies are born

The next three screen shots show the statewide longitudinal figures for emergency departments, admitted patients and elective surgery.

Emergency Department activity

(Includes 85 facilities for which electronic data is reported. This covers 83% of NSW Emergency Department activity)



Attendances refers to presentations to Emergency Departments at public hospitals in New South Wales. Admissions includes patients admitted from the Emergency Department to a hospital ward, including Intensive Care Unit, or admitted via the operating suite.

	Jan-Mar 2008	Apr-Jun 2008	Jul-Sep 2008	Oct-Dec 2008	Jan-Mar 2009	Apr-Jun 2009	Jul-Sep 2009	Oct-Dec 2009
Attendances	493,771	477,668	494,162	494,309	486,132	501,553	517,453	514,733
Admissions	104,927	108,798	111,473	108,503	106,659	111,219	113,682	113,872

Source: Health Information Exchange, NSW Health. Data extracted on 29/01/2010

Triage Categories developed by the Australasian College for Emergency Medicine (ACEM) are used for rating clinical urgency in New South Wales public hospital Emergency Departments. Performance indicator thresholds recommended by the ACEM are:

- Triage 1 - 100% seen within 2 minutes
- Triage 2 - 80% seen within 10 minutes
- Triage 3 - 75% seen within 30 minutes
- Triage 4 - 70% seen within 1 hour
- Triage 5 - 70% seen within 2 hours

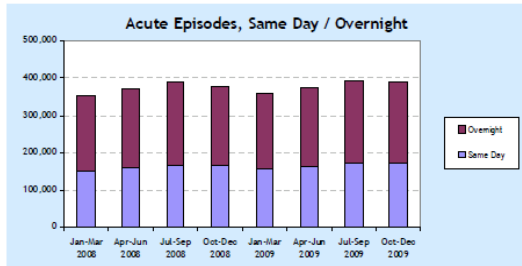
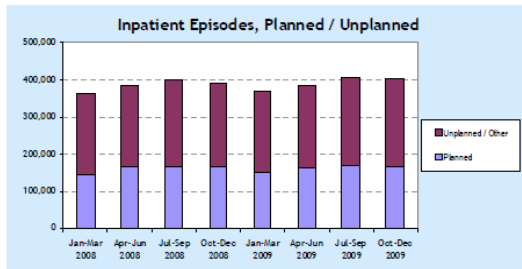
Off Stretcher Time (OST) performance refers to the percentage of patients arriving by ambulance who are transferred to the care of the Emergency Department within 30 minutes of arrival.

Emergency Admission Performance (EAP) is the percentage of admissions transferred from the Emergency Department to a ward or operating suite within 8 hours of commencement of active treatment.

	Jan-Mar 2008	Apr-Jun 2008	Jul-Sep 2008	Oct-Dec 2008	Jan-Mar 2009	Apr-Jun 2009	Jul-Sep 2009	Oct-Dec 2009
Triage performance								
Triage 1	100%	100%	100%	100%	100%	100%	100%	100%
Triage 2	84%	82%	82%	83%	80%	77%	78%	84%
Triage 3	73%	73%	66%	70%	69%	67%	65%	72%
Triage 4	77%	76%	72%	75%	73%	71%	69%	75%
Triage 5	92%	91%	89%	91%	90%	88%	87%	90%
Off Stretcher Time	78%	77%	70%	75%	74%	69%	66%	71%
Emergency Admission Performance	80%	78%	71%	76%	74%	72%	71%	76%

Source: Health Information Exchange, NSW Health. Data extracted on 29/01/2010

Admitted Patients – Public Hospitals



An admitted patient episode is a national standard measure referring to a defined period of care of a patient admitted to hospital. During a stay in hospital there can be one or more episodes, each defined by a Service Category such as Acute, Newborn, Rehabilitation, or Palliative Care.

Planned episodes include booked admissions for elective surgery or other procedures as well as regular planned same-day admissions, such as renal dialysis or chemotherapy. Unplanned/Other episodes include emergency, maternity and newborn admissions.

	Jan-Mar 2008	Apr-Jun 2008	Jul-Sep 2008	Oct-Dec 2008	Jan-Mar 2009	Apr-Jun 2009	Jul-Sep 2009	Oct-Dec 2009
Total Episodes	362,186	384,260	399,633	390,100	368,414	384,941	404,915	402,218
- Planned	145,997	164,186	166,679	164,036	150,147	163,402	169,684	166,019
- Unplanned/Other	216,189	220,074	232,954	226,064	218,267	221,539	235,231	236,199
Babies born	17,504	17,497	18,065	17,947	17,563	17,408	17,846	16,968

Source: Health Information Exchange, NSW Health. Data extracted on 29/01/2010

Acute episodes refer to episodes with a Service Category of Acute or Newborn. Episodes are classified as Same Day when admission and discharge are on the same date.

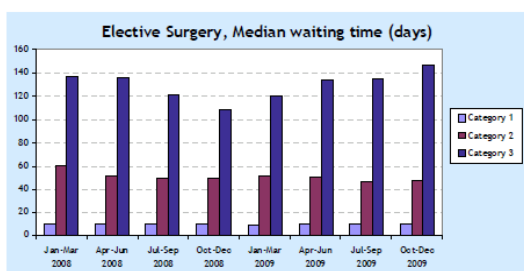
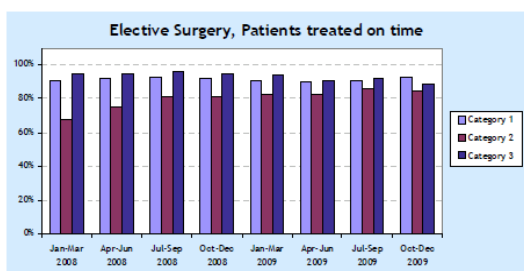
For Overnight episodes, Bed Days refers to the number of days between admission and discharge, excluding any leave days. Same Day episodes are each allocated one bed day.

Average Length of Stay is the sum of Acute bed days divided by acute episodes (including Same Day episodes).

	Jan-Mar 2008	Apr-Jun 2008	Jul-Sep 2008	Oct-Dec 2008	Jan-Mar 2009	Apr-Jun 2009	Jul-Sep 2009	Oct-Dec 2009
Acute Episodes	351,557	372,402	387,371	378,487	357,583	372,686	391,072	389,036
- Same Day	149,793	160,332	165,474	165,318	155,808	162,309	170,824	171,647
- Overnight	201,764	212,070	221,897	213,169	201,775	210,377	220,224	217,389
Bed Days	1,268,663	1,349,787	1,412,448	1,359,484	1,272,369	1,312,244	1,385,559	1,330,627
Avg Length of Stay	3.6	3.6	3.6	3.6	3.6	3.5	3.5	3.4

Source: Health Information Exchange, NSW Health. Data extracted on 29/01/2010

Elective Surgery



Elective Surgery refers to non-emergency procedures generally performed in an operating theatre, by a surgeon, under some form of anaesthesia. It excludes specific procedures frequently done by non-surgical clinicians.

All patients on the Elective Surgery Waiting List are allocated a Clinical Priority Category by the referring doctor. The categories are:

- Category 1 - Admission within 30 days desirable
- Category 2 - Admission within 90 days desirable
- Category 3 - Admission within 365 days desirable

Patients treated on time refers to the proportion of patients admitted from the Elective Surgery Waiting List who were admitted within the desirable timeframe for their Category.

	Jan-Mar 2008	Apr-Jun 2008	Jul-Sep 2008	Oct-Dec 2008	Jan-Mar 2009	Apr-Jun 2009	Jul-Sep 2009	Oct-Dec 2009
Patients treated on time - All Categories	85%	87%	91%	90%	90%	88%	90%	89%
Category 1	91%	92%	93%	92%	91%	90%	91%	93%
Category 2	68%	75%	81%	81%	83%	83%	86%	85%
Category 3	95%	95%	96%	95%	94%	91%	92%	89%

Source: Health Information Exchange, NSW Health. Data extracted on 29/01/2010

Median waiting time is the number of days within which half the patients admitted from the Waiting List (in the relevant category) were admitted for treatment.

	Jan-Mar 2008	Apr-Jun 2008	Jul-Sep 2008	Oct-Dec 2008	Jan-Mar 2009	Apr-Jun 2009	Jul-Sep 2009	Oct-Dec 2009
Median waiting time (days)								
Category 1	10	10	10	10	9	10	10	10
Category 2	61	52	49	49	52	51	46	47
Category 3	137	136	121	108	120	134	135	146

Source: Health Information Exchange, NSW Health. Data extracted on 29/01/2010

These are followed by hospital / Area level reports that look like this.

Emergency Department activity by Hospital and Area Health Service

(Includes 85 facilities for which electronic data is reported. This covers over 83% of NSW Emergency Department activity)

Principal Referral Hospitals and Major Acute Hospitals are listed. Other hospitals are included in Area Totals.

October to December 2009	Activity Measures		Performance measures							
	HOSPITAL / AREA HEALTH SERVICE	Attendances	Admissions	Triage performance					Off Stretcher Time	Emergency Admission Performance
				Triage 1	Triage 2	Triage 3	Triage 4	Triage 5		
THE CHILDREN'S HOSPITAL AT WESTMEAD										
THE CHILDREN'S HOSPITAL AT WESTMEAD	12,103	2,740	100%	100%	77%	75%	83%	93%	81%	
GREATER SOUTHERN AREA HEALTH SERVICE										
Wagga Wagga Base Hospital	8,403	2,009	100%	82%	80%	80%	90%	71%	74%	
Other GSAHS	9,778	1,643	100%	78%	71%	77%	91%	93%	96%	
GREATER SOUTHERN AREA HEALTH SERVICE - TOTAL	18,181	3,652	100%	80%	75%	78%	91%	83%	84%	
GREATER WESTERN AREA HEALTH SERVICE										
Dubbo Base Hospital	7,171	1,287	100%	77%	66%	68%	85%	NA	75%	

Admitted Patient activity by Hospital and Area Health Service

Principal Referral Hospitals and Major Acute Hospitals are listed. Other hospitals are included in Area Totals.

October to December 2009	All episodes			Acute Episodes				
	HOSPITAL / AREA HEALTH SERVICE	Total Episodes	Planned	Unplanned/Other	Same Day	Overnight	Total Bed Days	Average Length of Stay
THE CHILDREN'S HOSPITAL AT WESTMEAD								
THE CHILDREN'S HOSPITAL AT WESTMEAD	7,029	3,783	3,246	3,128	3,901	22,745	3.2	
GREATER SOUTHERN AREA HEALTH SERVICE								
Wagga Wagga Base Hospital	6,858	2,558	4,300	3,385	3,339	18,157	2.7	
Other GSAHS	20,212	5,996	14,216	8,585	10,501	49,821	2.6	
GREATER SOUTHERN AREA HEALTH SERVICE - TOTAL	27,070	8,554	18,516	11,970	13,840	67,978	2.6	
GREATER WESTERN AREA HEALTH SERVICE								
Dubbo Base Hospital	4,834	2,172	2,662	2,132	2,656	12,330	2.6	

Elective Surgery Performance by Hospital and Area Health Service

Principal Referral Hospitals and Major Acute Hospitals are listed. Other hospitals are included in Area Totals.

October to December 2009 HOSPITAL / AREA HEALTH SERVICE	Patients treated on time				Median Waiting Time (days)		
	All Categories	Category 1	Category 2	Category 3	Category 1	Category 2	Category 3
THE CHILDREN'S HOSPITAL AT WESTMEAD							
THE CHILDREN'S HOSPITAL AT WESTMEAD	87%	97%	72%	92%	5	50	25
GREATER SOUTHERN AREA HEALTH SERVICE							
Wagga Wagga Base Hospital	67%	90%	60%	62%	19	72	353
GREATER SOUTHERN AREA HEALTH SERVICE - TOTAL	82%	92%	74%	82%	15	56	274
GREATER WEST AREA HEALTH SERVICE							
Dubbo Base Hospital	97%	95%	92%	99%	6	32	64

Victoria

Victoria's public reports are at <http://www.health.vic.gov.au/yourhospitals/index.htm>. The home page orients the reader to the organisation of the information under the Government's four goals:

- treating people quickly – reducing time to treatment
- improving communication – a better patient experience
- preventing illness – reducing avoidable hospital admissions
- investing in health professionals

The examples below are taken from a variety of metropolitan and rural Victorian hospitals.

Emergency care performance data

St Vincent's Hospital
July 2008 to June 2009

% Time hospital on bypass	3.9%
% Emergency Department Category 1 patients seen immediately	100
% Emergency Department Category 2 patients seen within 10 minutes	85
% Emergency Department Category 3 patients seen within 30 minutes	70
% Emergency Department patients not admitted whose stay is less than 4 hours	66
% Emergency Department patients admitted to an inpatient bed within 8 hours	66

Elective surgery performance data

Ballarat Health Services (Ballarat Base Hospital)
July 2008 to December 2008

Elective surgery data - patients who have been treated	
Total number of patients admitted from the elective surgery list	4159
Total number of patients cancelled from the elective surgery list	586
Number of elective surgery Category 1 patients treated within 30 days	995
% elective surgery Category 1 patients treated within 30 days	100
Number of elective surgery Category 1 patients overdue	0
Number of elective surgery Category 2 patients treated within 90 days	1650
% elective surgery Category 2 patients treated within 90 days	77
Number of elective surgery Category 2 patients overdue	492
Number of elective surgery Category 3 patients treated within 365 days	863
% elective surgery Category 3 patients treated within 365 days	84
Number of elective surgery Category 3 patients overdue	159

Elective surgery data - patients listed for treatment as at June 2009	
Number of elective surgery patients waiting	1332
Number of elective surgery Category 1 patients	37
Number of elective surgery Category 1 patients listed for less than 30 days	37
Number of elective surgery Category 2 patients	544
Number of elective surgery Category 2 patients listed for less than 90 days	400
Number of elective surgery Category 3 patients	751
Number of elective surgery Category 3 patients listed for less than 365 days	553

Patients treated performance data

Maroondah Hospital
July 2008 to June 2009

Total number of patients admitted	32638
Total number of emergency patients admitted	18628
Total number of patients treated in emergency department	49900
Average daily hours of care in intensive care units	107

Queensland

Queensland's public reports are at <http://www.health.qld.gov.au/performance/default.asp>. This home page provides links to reports grouped into Public hospital performance reports; Monthly emergency department reports; Access; Safety and quality; Staffing; and Scientific services.

For example, within the public hospital performance section, the next table is available (http://www.health.qld.gov.au/performance/docs/phpr_chapters_8-9.pdf).

Patient cost per weighted separation 2006-07

Hospital	Weighted separations	Cost	Cost per weighted separation
Principal referral and specialised			
Cairns Base	33,942	\$119,195,901	\$3,469
Gold Coast	54,001	\$181,798,552	\$3,579
Nambour	34,004	\$117,540,803	\$3,401
Princess Alexandra	80,144	\$302,892,460	\$3,837
Royal Brisbane and Women's	84,403	\$392,107,501	\$4,052
Royal Children's	18,237	\$72,841,941	\$3,852
The Prince Charles	42,861	\$197,888,610	\$4,482
Townsville	45,327	\$161,597,953	\$3,500
Total/average	Total 392,919	Total \$1,545,863,721	Average \$3,934
Large			
Bundaberg	13,681	\$47,981,216	\$3,465
Caboolture	16,829	\$50,698,043	\$2,969
Hervey Bay	12,631	\$38,686,250	\$3,201
Ipswich	27,092	\$80,675,028	\$2,946
Logan	28,958	\$95,069,330	\$3,231
Mackay Base	16,993	\$58,982,291	\$3,402
Maryborough	4,479	\$14,593,156	\$3,592
Queen Elizabeth II	15,318	\$49,004,180	\$3,273
Redcliffe	27,128	\$73,891,348	\$2,700
Redland	13,922	\$34,946,678	\$2,466
Rockhampton	19,340	\$65,791,814	\$3,395
Toowoomba	24,529	\$87,772,355	\$3,555
Total/average	Total 220,900	Total \$698,091,689	Average \$3,160
Medium and small			
Gladstone	4,514	\$12,540,036	\$2,740
Queensland totals/average	Total 618,333	Total \$2,256,495,446	Average \$3,649

At <http://www.health.qld.gov.au/performance/docs/QHQPHPR.pdf> the user can see a snapshot of hospital-level performances in emergency, outpatients, elective surgery, and obstetrics. Hospitals are listed alphabetically within size category.

hospital snapshot, December quarter 2009



hospital/peer group	people who attended emergency departments	people admitted to hospital	outpatient services*	people received elective surgery	babies born	
larger and specialised	Cairns Base Hospital	11,015	11,059	29,832	1,272	654
	Gold Coast Hospital [†]	28,676	20,274	56,072	3,096	803
	Mater Children's Public Hospital	9,978	3,860	14,244	952	0
	Nambour Hospital	8,944	10,411	29,261	1,552	514
	Princess Alexandra Hospital	11,322	20,213	86,073	3,700	0
	Royal Brisbane & Women's Hospital	17,430	19,906	79,104	3,553	1,145
	Royal Children's Hospital	7,405	5,051	23,377	1,145	0
	The Prince Charles Hospital	10,457	7,942	25,245	1,129	0
	Townsville Hospital	14,670	13,467	52,704	1,732	553
	total	119,797	112,183	395,912	18,131	3,669
medium	Bundaberg Hospital	9,570	7,052	18,017	485	289
	Caboolture Hospital	11,166	6,132	14,856	560	449
	Hervey Bay Hospital	8,721	4,986	10,001	238	258
	Ipswich Hospital	11,854	8,437	26,753	1,812	635
	Logan Hospital	15,835	9,404	25,750	1,076	872
	Mackay Base Hospital	9,640	5,479	17,080	572	286
	Maryborough Hospital	6,121	1,172	5,706	236	0
	Mater Adult Public Hospital	7,929	5,931	16,304	1,354	0
	Mater Mothers' Public Hospital	0	2,370	14,600	321	1,188
	Mount Isa Hospital	8,015	1,446	4,969	113	134
	QUEI Jubilee Hospital	8,736	5,241	15,826	1,369	0
	Redcliffe Hospital	13,326	8,588	21,510	1,003	373
	Redland Hospital	10,892	5,082	12,281	341	506
	Rockhampton Base Hospital	10,384	6,166	15,606	600	292
Toowoomba Hospital	10,141	7,762	40,612	1,059	450	
total	142,330	85,248	259,871	11,139	5,732	
smaller	Atherton Hospital	3,337	1,334	3,114	108	50
	Beaudesert Hospital	3,214	527	1,171	2	0
	Caloundra Hospital	5,654	2,773	5,629	408	0
	Emerald Hospital	3,602	727	1,141	47	72
	Gladstone Hospital	6,019	1,756	6,591	127	112
	Gympie Hospital	5,900	2,929	6,229	173	89
	Innisfail Hospital	2,840	940	2,230	60	61
	Kingaroy Hospital	3,772	970	2,681	36	100
	total	34,338	11,956	28,786	961	484
Queensland reporting hospitals (n=32)	296,465	209,387	684,569	30,231	9,885	
Surgery Connect patients	-	-	-	1,080	-	
Queensland total (n=173)	385,186	228,203	833,923	31,311	10,389	

At http://www.health.qld.gov.au/performance/docs/Additional_Table.pdf a detailed table of organisational performance can be found.



Mental Health Admissions

What do these figures show?

In the September 2009 quarter, there was an increase of 238 (or 10.8%) public mental health admissions compared with the same quarter in the previous year.

For the same period, metropolitan public hospital mental health admissions increased by 234 (or 12.0%). For country public hospitals there were 4 (or 1.6%) more mental health admissions for the September 2009 quarter compared with the September 2008 quarter.

Figures include mental health admissions at all authorised hospitals and designated mental health inpatient units at public hospitals and the authorised mental health inpatient unit at Joondalup Health Campus. Peel Health Campus is excluded as it is not a designated mental health facility.

Admissions to mental health services can vary from year to year. Factors that can impact on admissions during any year include availability of beds and staffing levels.

Figure 9: Number of public mental health admissions (WA State)

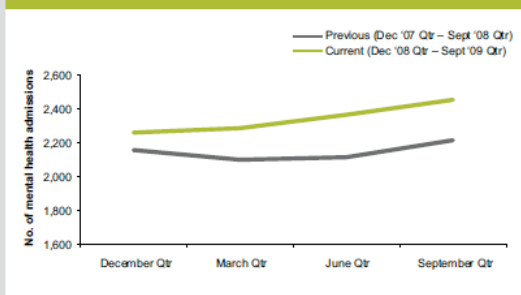


Table 9: Number of public mental health admissions*

Area	December 2007 Quarter	March 2008 Quarter	June 2008 Quarter	September 2008 Quarter	December 2008 Quarter	March 2009 Quarter	June 2009 Quarter	September 2009 Quarter	% change Sept 08 to Sept 09 Quarters
Metropolitan	1,956	1,898	1,881	1,958	1,963	2,005	2,095	2,192	12.0%
Country	198	199	231	254	294	278	267	258	1.6%
WA State	2,154	2,097	2,112	2,212	2,257	2,283	2,362	2,450	10.8%

*Figures are preliminary. Figures may change within the 2007-08 and 2008-09 reporting period due to timing of coding and editing.



Public Outpatient Services

Mental Health Outpatients

What do these figures show?

Preliminary figures indicate that in the September 2009 quarter there was an increase of 19,551 (or 13.2%) attendances for services at public mental health outpatient clinics compared with the same quarter in the previous year.

Preliminary figures indicate that attendances for mental health outpatient services in the metropolitan area increased by 14,812 (or 11.9%) and in the country attendances increased by 4,739 (or 19.9%) for the September 2009 quarter compared with the same quarter in the previous year.

Figures include all public outpatient mental health services. All outpatient services for Peel and Joondalup areas are provided by the metropolitan public mental health services.

Figure 22: Number of attendances for mental health services at outpatient clinics (WA State)

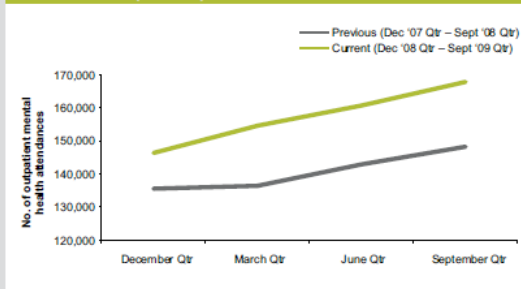


Table 22: Number of attendances for mental health services at outpatient clinics*

Area	December 2007 Quarter	March 2008 Quarter	June 2008 Quarter	September 2008 Quarter	December 2008 Quarter	March 2009 Quarter	June 2009 Quarter	September 2009 Quarter	% change Sept 08 to Sept 09 Quarters
Metropolitan	114,492	115,465	120,701	124,386	121,378	127,313	131,828	139,198	11.9%
Country	21,024	20,918	22,149	23,797	24,921	27,205	28,777	28,536	19.9%
WA State	135,516	136,383	142,850	148,183	146,299	154,518	160,605	167,734	13.2%

*Figures are preliminary and may change within the 2007-08, 2008-09 and 2009-10 reporting period.

South Australia

South Australia publishes hospital activity data that can be found at <http://www.health.sa.gov.au/Default.aspx?tabid=416>. At this site the user can choose between separations, patient days, average length of stay, average daily numbers of patients, emergency department presentations, admissions from emergency departments, and outpatient services. The top of the patient days table looks like this.

Patient Days for public hospitals by quarter

Region/Hospital	2006-07				2007-08				2008-09			
	September Quarter	December Quarter	March Quarter	June Quarter	September Quarter	December Quarter	March Quarter	June Quarter	September Quarter	December Quarter	March Quarter	June Quarter
Central Northern Adelaide Health Service												
0008 Hampstead Rehabilitation Centre	11,285	11,259	9,232	8,703	7,627	11,121	12,738	12,215	11,779	11,552	10,121	
0014 The Queen Elizabeth Hospital	40,372	39,182	37,501	38,687	39,601	37,038	36,050	38,034	38,500	38,415	36,463	
0019 Royal Adelaide Hospital	67,102	63,964	61,996	65,273	66,953	66,331	61,049	62,887	66,543	63,770	59,506	
0027 Lyell McEwin Hospital	25,036	24,686	24,750	26,581	26,347	28,652	29,120	29,125	31,254	30,928	30,446	
0028 Oakden Hospital	7,765	4,566	7,281	6,845	6,712	5,167	6,616	21,252	7,150	12,031	11,851	
0030 Modbury Hospital	15,853	15,891	15,216	16,045	17,076	15,855	14,018	16,289	15,328	14,445	13,771	
0042 St. Margaret's Hospital	3,827	3,528	3,403	3,300	3,288	3,950	3,320	3,804	3,614	3,764	3,765	
0300 Glenside Hospital	27,563	16,405	18,241	26,398	16,844	27,314	21,608	12,366	13,453	15,504	18,956	
Child Youth and Women's Health Service												
0003 Women's and Children's Hospital	26,281	24,732	25,189	23,948	26,352	25,258	23,615	25,680	26,766	24,436	23,486	
Southern Adelaide Health Service												
0005 Flinders Medical Centre	50,523	49,125	47,633	49,423	55,311	53,279	51,271	52,415	55,956	53,316	53,905	
0018 Repatriation General Hospital	25,210	25,163	24,060	24,972	28,209	25,392	26,586	28,187	28,431	27,068	25,946	
0033 Noarlunga Public Hospital	8,288	8,389	7,597	7,889	8,791	8,857	8,375	8,559	8,960	8,865	8,713	
Country Health SA												
0020 Gawler Health Service	3,251	2,985	2,848	2,920	3,143	2,958	2,651	2,871	3,183	3,143	2,875	
0049 Angaston Hospital	1,526	1,198	1,069	1,034	1,296	1,264	1,144	1,155	1,591	1,357	1,044	
0052 Balaklava Hospital	774	543	663	596	630	543	761	436	579	478	415	

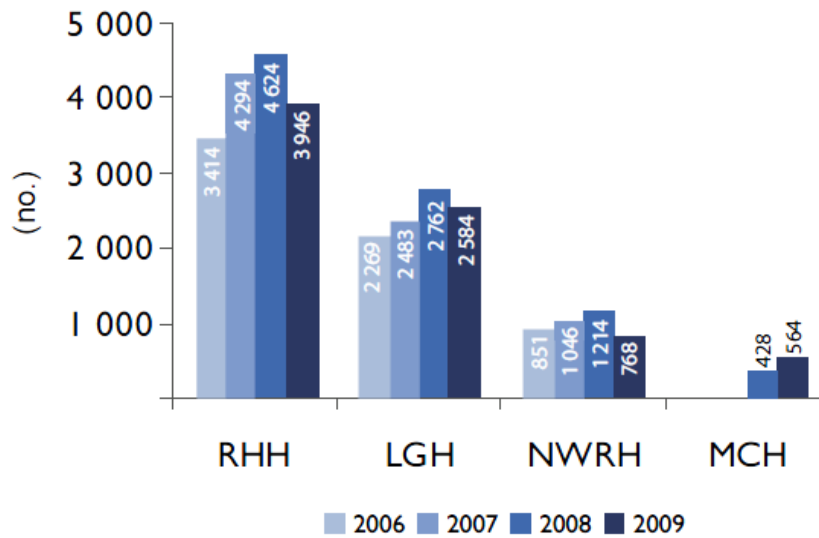
A very similar looking table presents the average daily number of inpatients for major metropolitan hospitals.

Tasmania

According to the national document,¹¹ the Tasmanian site (http://www.dhhs.tas.gov.au/news_and_media) provides performance information for individual hospitals on inpatient activity; outpatient clinic numbers; emergency department activity and performance; readmission rates; elective surgery activity, performance and waiting times; and ambulance activity and response times.

The hospital performance data is presented for the four main Tasmanian hospitals. For a number of hospital activity indices, there are graphs like this:

Figure 8: Waiting List (as at 30 September)



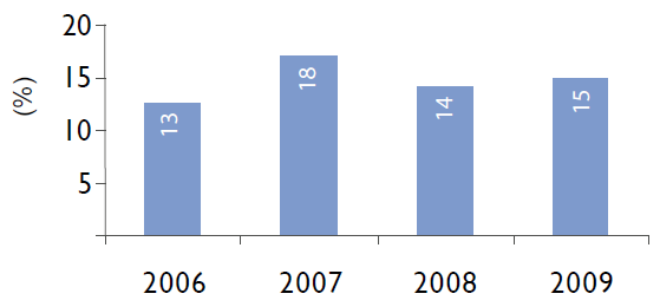
A number of mental health indices are reported including inpatient separations, numbers of active community and residential clients, and 28 day readmission rate. The graph for the last of these, with its accompanying text, is reproduced below.

This shows the percentage of people whose readmission to the same acute psychiatric inpatient unit or another public sector acute psychiatric inpatient unit within 28 days of discharge was unplanned or unexpected. This could be due to a relapse or a complication resulting from the illness for which the patient was initially admitted.

For people who experience mental illness, and particularly those who require acute mental health care, the episodic nature of their condition generally means that they are likely to require further treatment.

This indicator is a percentage calculated on relatively small numbers and as such, is susceptible to large fluctuations.

Figure 20: 28-Day readmission rate – all hospitals (for the 3 months ending September)



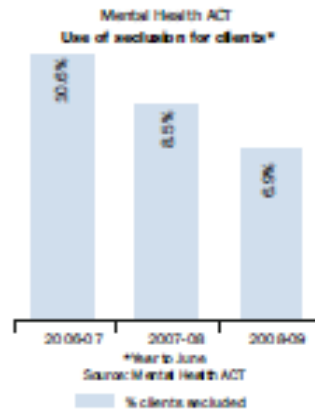
Australian Capital Territory

The ACT Public Health Services Quarterly Performance Report is at:

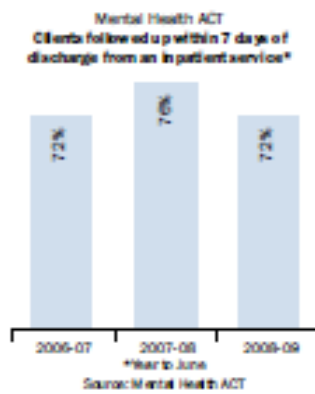
<http://health.act.gov.au/c/health?a=da&did=10011741&pid=1139962687>

It has one page on mental health services, reproduced below.

Mental Health ACT has implemented a number of initiatives to reduce the level of clients secluded during an inpatient episode. These initiatives are working with the rate of seclusion decreasing considerably in the year-to-June 2008-09 compared to two years ago. The current result of 6.8 percent is significantly better than the target set at nine percent and shows constant improvement on recent years' results.



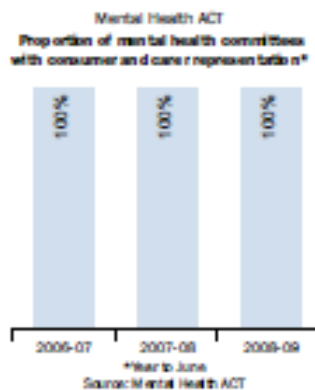
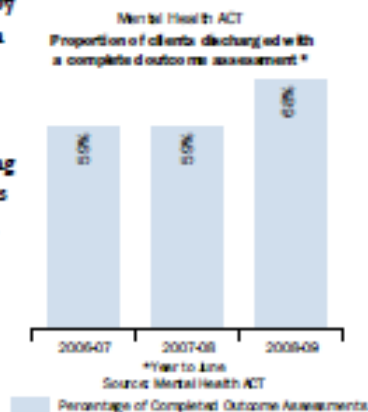
Mental Health ACT continues to report strong results for the proportion of patients discharged from an inpatient service who receive follow-up care within seven days (right). Timely follow-ups can reduce the number of people who need to be readmitted to an inpatient service. The result for 2008-09 is slightly lower than for that reported in 2007-08, this is due to an increase in voluntary short-stay admissions, with this client group more likely to elect to receive follow-up with their GP or private psychiatrist, rather than from ACT Mental Health services.



ACT Health is committed to its mental health clients. All Mental Health ACT committees include consumer and carer member involvement. This consultation process provides the best possible integrated mental health services for our community.

A total of 68 percent of patients discharged from an inpatient mental health service have completed outcome assessments.

New measures implemented by Mental Act Health have had a positive impact on the proportion of clients discharged with a completed outcome assessment, resulting in a 9% growth in assessments compared to the same period in 2007-08.



It shows a reducing use of seclusion over the past three years, about 75% of patients followed up within seven days of discharge from inpatient services, around 70% of clients discharged with complete outcome measurement, and 100% of mental health committees with consumer and carer representation.

Northern Territory

The Northern Territory Annual report can be found at http://www.health.nt.gov.au/Publications/Corporate_Publications/Annual_Report_2007-2008/index.aspx

It is over a 200 page report with a section on mental health. The mental health relevant sections are shown below.

Performance Measure	2007-08 Actual	2008-09 Estimate	2008-09 Actual	2009-10 Estimate
Quantity				
Individuals receiving community based public mental health services ¹	4 737	4 890	5 020	4 900
Individuals under 18 years of age receiving community based public mental health services ²	837	900	911	900
Non-weighted occupied bed days by designated services ³	10 992	12 000	11 631	10 900
Non weighted inpatient separations from designated services ⁴	1 037	1020	1 042	1 020
Mental health budget allocated to non government organisations ⁵	14%	12%	14%	12%
Quality				
Public mental health services accredited	100%	100%	100%	100%
Post discharge community mental health care ⁶	NA	30%	18%	30%
28 day mental health readmissions ⁷	NA	10%	11%	10%

Table 12: Mental Health inpatient separations by region, Aboriginal status and gender

Unit	Persons	2007-08		2008-09	
		Total	Female	Male	Total
Central Australian Inpatient Unit	Aboriginal	156	46	81	127
	Non Aboriginal	127	28	82	110
	Sub-total	283	74	163	237
Top End Inpatient Unit	Aboriginal	299	158	183	341
	Non Aboriginal	455	214	250	464
	Sub-total	754	372	433	805
	Total	1037	446	596	1042

Table 13: Persons provided with community Mental Health services by Aboriginal status and age group

Persons	2007-08		2008-09	
	Total	Under 18 years	18+ years	Total
Aboriginal	1 852	319	1 652	1 971
Non Aboriginal	2 885	592	2 457	3 049
Total	4 737	911	4 109	5 020

Australian private hospitals

Reporting of private hospital mental health care is currently available at <http://www.pmha.com.au/cdms/statistics>

This includes some hospital level reporting

Table 2: Variability in participating Hospitals adherence to the National Model's collection requirements for measures of patients' clinical status during the Financial Year.

Episodes of Overnight Inpatient Care			
	Had poor adherence	Met expectation	Attained benchmark
Clinician ratings (HoNOS)	11%	80%	43%
Patient self-assessments (MHQ-14)	17%	57%	23%
Periods of Ambulatory Care			
	Had poor adherence	Met expectation	Attained benchmark
Clinician ratings (HoNOS)	57%	26%	9%
Patient self-assessments (MHQ-14)	69%	14%	6%

Table 6: Range of variation between participating Hospitals in key statistics for Episodes of Overnight Inpatient Care during the Financial Year.

	Min	Percentiles			Max
		25th	50th	75th	
Number of Separations	65	380	561	937	1,740
Average HoNOS Total Score at Admission	7.7	10.0	11.2	12.8	19.4
Average MHQ-14 Total Score at Admission	20.4	24.3	26.2	28.4	35.2
Average Length of Stay (Days)	5.9	17.2	19.8	22.2	29.7
Average HoNOS Total Score Change (E.S.)	0.72	1.02	1.17	1.36	2.22
Average MHQ-14 Total Score Change (E.S.)	0.88	1.59	1.67	1.81	2.27
Subsequent Re-Admission Within 28 Days	4.2%	8.8%	12.3%	15.5%	20.5%

As this section has shown there is a significant amount of public reporting occurring both overseas and here in Australia.

The following section identifies examples of public reporting both from overseas and in Australia. What is striking about current public reporting is the wide variety of different formats and information being reported, from short summaries to long detailed reports, from hard copy documents to very detailed web based reporting systems.

United Kingdom

Care for Quality Commission

<http://www.cqc.org.uk/>

The Care Quality Commission (CQC) is responsible for regulating all health and adult social care in England. Their work includes registration of organisations and reviews to ensure that organisations meet the specified standards of care. They provide independent and up-to-date information about the quality of providers' care. In particular they focus on protecting those whose rights are restricted under the mental health act. Their stated intention is to regularly publish information on the quality of care, to help people make decisions about their care.

Care Quality Commission

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Keyword search

About CQC | Find care services | Using care services | Get involved | Publications | Guidance for professionals | News and events

Welcome to CQC

The Care Quality Commission is the independent regulator of health and social care in England.

We regulate care provided by the NHS, local authorities, private companies and voluntary organisations. We aim to make sure better care is provided for everyone - in hospitals, care homes and people's own homes. We also seek to protect the interests of people whose rights are restricted under the Mental Health Act. [Visit About CQC.](#)

All NHS trusts in England are now registered with CQC. [Read more](#)

Complaints | **New registration** | State of Care

Find and choose services

Social care services

Healthcare services

Social care services include
Nursing homes, residential homes, care at home and adult placement schemes.

Health care services include
Hospitals, maternity units, ambulances, beauty clinics and district nurses.

Advice

Our advice and information will help you find and choose the right health and social care for you.

Find out how to get started, where to find local services and what you

[▶ What to ask when choosing social care](#)

[▶ How to choose where to get hospital care](#)

[▶ Get financial support for carers](#)

[▶ See all our advice](#)

For professionals

Registration

The new registration process comes into effect from April 2010.

[▶ Learn more about registration](#)

Health and social care guidance

Understand our inspection and assessment processes and find useful information.

[▶ Read our guidance](#)

Our assessments and reports

View inspection reports and ratings for your care services.

On this site at the time of writing users are able to access a 2009 report that summarises the following;

- Performance assessments for 148 adult social services in England, including the quality of care services purchased by councils and those councils that were classed as a priority for improvement.
- An overview of the quality and performance of more than 24,000 regulated adult social care services.
- Assessment of the performance of 392 NHS trusts.
- A detailed report on the operation of the Mental Health Act.
- The performance of 3,650 registered independent health care services, provided by 2,326 establishments.

This summarised report shows

3: Patterns in quality and trends in performance

Overall quality scores	Excellent	Good	Fair	Weak
2008/09: number of trusts assessed = 392	59 15%	186 47%	127 32%	20 5%
2007/08: number of trusts assessed = 391	100 26%	138 35%	131 34%	22 6%
2006/07: number of trusts assessed = 394	65 16%	121 31%	175 44%	33 8%
2005/06: number of trusts assessed = 570	25 4%	207 36%	286 50%	52 9%
Overall financial management scores	Excellent	Good	Fair	Weak
2008/09: number of trusts assessed = 392	103 26%	176 45%	102 26%	11 3%
2007/08: number of trusts assessed = 391	94 24%	145 37%	132 34%	20 5%
2006/07: number of trusts assessed = 394	57 14%	91 23%	142 36%	104 26%
2005/06: number of trusts assessed = 570	19 3%	71 12%	270 47%	210 37%

Organisation type	Excellent	Good	Fair	Weak
Acute and specialist trusts	37 22% ↓	81 48% ↑	43 25% ↑	8 5% ↔
Ambulance trusts	0 0% ↓	2 18% ↓	6 55% ↑	3 27% ↑
Learning disability and community trusts	1 33% ↔	0 0% ↔	2 67% ↑	0 0% ↓
Mental health trusts	18 32% ↓	26 46% ↑	8 14% ↑	5 9% ↑

Exactly how these ratings are arrived at is not clear.

Online GP practice results database

The Quality Outcomes Framework (QOF) is described, at <http://www.qof.ic.nhs.uk/index.asp>, as “a voluntary annual reward and incentive programme for all GP surgeries in England, detailing practice achievement results. It is not about performance management but resourcing and then rewarding good practice”.



QUALITY AND OUTCOMES FRAMEWORK • Online GP practice results database
0845 300 6016 • enquiries@ic.nhs.uk

Welcome > **Search for practice results** > Frequently asked questions > Glossary

QOF 2008/09 results

The Quality and Outcomes Framework (QOF) is a voluntary annual reward and incentive programme for all GP surgeries in England, detailing practice achievement results. It is not about performance management but resourcing and then rewarding good practice.

The QOF has undergone several revisions since its introduction in 2004. The 2008/09 QOF contains four main components, known as domains. Each domain consists of a set of measures of achievement, known as indicators, against which practices score points according to their level of achievement.

- clinical care:** the domain consists of 80 indicators across 19 clinical areas (e.g. coronary heart disease, heart failure, hypertension)
- organisational:** the domain consists of 36 indicators across five organisational areas – records and information; information for patients; education and training; practice management and medicines management.
- patient experience:** the domain consists of five indicators that relate to length of consultations and to patient surveys
- additional services:** the domain consists of eight indicators across four service areas which include cervical screening, child health surveillance, maternity services, contraceptive services

The QOF gives an indication of the overall achievement of a surgery through a points system. Practices aim to deliver high quality care across a range of areas for which they score points. Put simply, the higher the score, the higher the financial reward for the practice. The final payment is adjusted to take account of surgery workload and the prevalence of chronic conditions in the practice's local area.

To report the latest annual QOF points, The NHS Information Centre for health and social care (The NHS IC) has developed this online database to allow patients and public easy access to this useful data that indicates how well their surgery is doing. The NHS IC is working to make information more relevant and accessible to the public, regulators, health and social care professionals and policy makers, leading to improvements in knowledge and efficiency.

Understanding the results

Browse the online database to find the results for your local surgery.

Other searches will compare your local GP practice against other GP practices in the local area and the national results across England.

The online database provides easy access to comprehensive information on the pattern of common chronic diseases such as asthma, diabetes and coronary heart disease. In terms of scale, the data for QOF is collected from over 8,000 GP practices with over 54 million registered patients in England.

The QOF helps practices compare the delivery and quality of care currently provided against the achievements of previous years. Ultimately, the aim is to improve standards of care by assessing and benchmarking the quality of care patients receive. The QOF has undergone some revisions since it was first introduced. Some changes were made at the start of 2008/09, with the most significant change being the introduction of two new indicators within the Patient Experience domain. These indicators, P27 and P28, are derived from the results of the national GP Patient Survey.

Welcome page sections

- Understanding the results
- Example of the results
- What this site can tell you
- What this site cannot tell you

Feedback and contacts

- Send us your comments
- General enquiries and press office

Task list

- QOF on the The NHS IC's website
- QOF 08/09 bulletin and data tables

Weblinks

- The NHS Information Centre
- Department of Health
- NHS Employers (for QOF guidance)
- QMAS (Connecting for Health)
- Primary Care Commissioning

QOF publications in other UK countries

- Scotland
- Wales
- Northern Ireland

You can search for general practices in particular areas.

Centre
for health and social care

01493 300 0010 enquiries@ch.sus.ac.uk

[Welcome](#)
[Search for practice results](#)
[Understanding the results](#)
[Frequently asked questions](#)
[Glossary](#)

SEARCH FOR GP PRACTICE:

Search for your GP practice by typing in a single word: e.g. city, town or district name, practice name, street name, first part of the postcode or the practice code. For example: poole, grange or LS11.

liverpool

Practices matching "liverpool" have been found in the location listed below. The number in brackets following the location indicates the number of all the practices in that location.

PRACTICES FOUND IN:

LIVERPOOL (136)
 LUTON (2)
 MANCHESTER (4)
 PRESTON (3)
 OTHER TOWNS (6)

PRACTICES FOUND IN PCTS:

KNOWSLEY PCT (29)
 SEFTON PCT (55)
 LIVERPOOL PCT (96)

Results summary

3 GP practices found Display page 1 of 1 Sorted alphabetically by practice name

- LONGTON HEALTH CENTRE**
 LONGTON HEALTH CENTRE, FRANKLANDS, LIVERPOOL ROAD, LONGTON, PRESTON PR4 5HA
- ST. FILLANS MEDICAL CENTRE**
 ST FILLAN'S MEDICAL CTRE, 2 LIVERPOOL ROAD, PENWORTHAM, PRESTON PR1 0AD
- THE BEECHES MEDICAL CENTRE**
 BEECHES MEDICAL CENTRE, LIVERPOOL ROAD, LONGTON, PRESTON PR4 5AB

3 GP practices found Display page 1 of 1 Sorted alphabetically by practice name

Display options

- Practice address details
- Total Achievement Results
- Total Clinical Results
- Individual Clinical Indicator Group Results:

Select indicator group...

Practice locations

Map showing practice locations in the Liverpool area, including Penwortham Golf Club, Higher Penwortham, Penwortham, Hutton, New Longton, and Whitegate.

At the individual general practice you can get detailed reporting of indicators across a variety of conditions.

Display results for latest year: 2008/09

■ TOTAL ACHIEVEMENT:

Percentage of total achievement points	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Total Achieved Results	<div style="display: flex; justify-content: space-between;"> 93.9% 939.20 out of 1,000.0 points </div>									

■ DOMAIN TOTALS:

Percentage of total domain points	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Clinical Results	<div style="display: flex; justify-content: space-between;"> 96.4% 626.36 out of 650.0 points </div>									

■ CLINICAL DOMAIN INDICATOR GROUPS:

Percentage of total	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
▶ Asthma 4 indicators ? 100.0% All the 45 points	<div style="display: flex; justify-content: space-between;"> 100.0% All the 45 points </div>									
▶ Atrial Fibrillation 3 indicators ? 100.0% All the 30 points	<div style="display: flex; justify-content: space-between;"> 100.0% All the 30 points </div>									
▶ Cancer 2 indicators ? 88.1% 9.69 out of 11 points	<div style="display: flex; justify-content: space-between;"> 88.1% 9.69 out of 11 points </div>									
▶ Chronic Kidney Disease 4 indicators ? 82.6% 22.30 out of 27 points	<div style="display: flex; justify-content: space-between;"> 82.6% 22.30 out of 27 points </div>									
▶ Chronic Obstructive Pulmonary Disease 5 indicators ? 95.7% 26.79 out of 28 points	<div style="display: flex; justify-content: space-between;"> 95.7% 26.79 out of 28 points </div>									
▶ Coronary Heart Disease 10 indicators ? 100.0% All the 89 points	<div style="display: flex; justify-content: space-between;"> 100.0% All the 89 points </div>									
▶ Dementia 2 indicators ? 100.0% All the 20 points	<div style="display: flex; justify-content: space-between;"> 100.0% All the 20 points </div>									
▶ Depression 2 indicators ? 60.2% 19.87 out of 33 points	<div style="display: flex; justify-content: space-between;"> 60.2% 19.87 out of 33 points </div>									
▶ Diabetes Mellitus (Diabetes) 16 indicators ? 99.8% 92.78 out of 93 points	<div style="display: flex; justify-content: space-between;"> 99.8% 92.78 out of 93 points </div>									
▶ Epilepsy 4 indicators ? 99.5% 14.93 out of 15 points	<div style="display: flex; justify-content: space-between;"> 99.5% 14.93 out of 15 points </div>									
▶ Heart Failure 3 indicators ? 100.0% All the 20 points	<div style="display: flex; justify-content: space-between;"> 100.0% All the 20 points </div>									
▶ Hypertension 3 indicators ? 100.0% All the 83 points	<div style="display: flex; justify-content: space-between;"> 100.0% All the 83 points </div>									

Results domains:

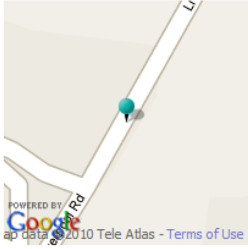
- Clinical ?
- Organisational ?
- Patient Experience ?
- Additional Services ?

Prevalence:

- Clinical Prevalence ?

Show comparisons on chart:

- PCT Average ?
- England Average ?

Practice location


POWERED BY Google
Map data ©2010 Tele Atlas - Terms of Use

QOF 2005/06 & 2004/05

- ▶ Search for this practice on the archived QOF 2005/06 & 2004/05 results site

Task list

- ▶ QOF on the The NHS IC's website
- ▶ QOF 08/09 bulletin and data tables

Weblinks

- ▶ The NHS Information Centre
- ▶ Department of Health
- ▶ NHS Employers (for QOF guidance)
- ▶ QMAS (Connecting for Health)
- ▶ Primary Care Commissioning

Within specific conditions you gain access to very detailed indicators of performance for these specific conditions.

CLINICAL INDICATOR GROUPS: THE 6 MENTAL HEALTH INDICATORS: UNDERLYING ACHIEVEMENT

Mental health problems cover a wide spectrum, from distress to depression and loss of touch with reality, and may interfere with the ability to cope on a day to day basis.

The practice can produce a register of people with schizophrenia, bipolar affective disorder and other psychoses ✓

Percentage of patients from register	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%	
The percentage of patients on lithium therapy with a record of serum creatinine and TSH in the previous 15 months	92.9%										
The percentage of patients on lithium therapy with a record of lithium levels in a therapeutic range within the previous 6 months	100.0%										
The percentage of patients on the register who have a comprehensive care plan documented in the records agreed between individuals, their family and/or carers as appropriate	94.6%										
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who do not attend the practice for their annual review who are identified and followed up by practice team within 14 days of non attendance	0.0%										
The percentage of patients with schizophrenia and bipolar affective disorder and other psychoses with a review recorded in the previous 15 months. In the review there is evidence that the patient has participated in routine health promotion and prevention advice appropriate to their age and health status	91.1%										

CLINICAL PREVALENCE:

Percentage of practice list size	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%	
Mental Health	0.58%										

Detail page for **1: LONGTON HEALTH CENTRE, PRESTON** of 3

Additional Services

Additional Services

Prevalence:

Clinical Prevalence

Show comparisons on chart:

PCT Average

England Average

Practice location

POWERED BY Google
Map data ©2010 Tele Atlas - Terms of Use

QOF 2005/06 & 2004/05

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QOF publications in other UK countries

- Scotland

United States

New York State: Office of Mental Health

<http://www.omh.state.ny.us/>

The New York State Office of Mental Health reports quarterly via the web on the outcomes for individuals served in their public mental health system through the reporting of what they refer to as critical indicators of organisational performance. The stated intentions of reporting is to “improve accountability and transparency by allowing anyone to use the reported data to inform decision making and assess the progress an agency is making toward achieving its strategic goals”. This is undertaken via their balanced score card <http://bi.omh.state.ny.us/scorecard/index>

NEW YORK STATE

Office of Mental Health

Balanced Scorecard
An OMH measure of quality

Business Intelligence | Contact

BSC Menu | Related Resources | External Links | Contacts

View Balanced Scorecard March 2010 Edition

Navigation Notes - Click an individual Management Objective to view additional data when available.

- All Objectives are shown. To limit the display of information, select either Domain/Goal or Target Population from the Filter Data function below.
- Click the icon to open another window for more information about a specific Management Objective.
- Some objectives have been successfully completed and can be viewed on the [Accomplishments](#) Page accessed from the BSC Menu.

Filter Data - All management objectives are displayed below unless filtered.

Domain: **Mental Health Services**

Definition	Management Objective (Program Area)	Target Value (Target Date)	Current Value (As of Date)	Past Values	% Target Achieved
	Develop and license additional Personalized Recovery Oriented Services (PROS) programs. Personalized Recovery Oriented Services	55 Dec 31, 10	32 Feb 16, 10		58%
	Increase the percentage of families who indicated global satisfaction with the mental health services they received for their child. Children's Mental Health Services	100%	92% Mar 31, 09		92%
	Increase the percentage of families who indicated satisfaction with their child's functioning as a result of the mental health services their child received. Children's Mental Health Services	100%	73% Mar 31, 09		73%

Taskbar: BigPond..., 4 Micro..., OMH | Vie..., iTunes, AutoPlay, Public_re..., 10:07 AM

NEW YORK STATE

Office of Mental Health

Balanced Scorecard
An OMH measure of quality

Business Intelligence | Contact

BSC Menu | Related Resources | External Links | Contacts

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Taskbar: BigPond..., 4 Micro..., OMH | Vie..., iTunes, AutoPlay, Public_re..., 10:07 AM

The data are progressively updated, individual indicators are updated separately, drill down into facilities and organisations, click to get definitions, targets are indicated. No confidence intervals.

Hospital Compare

<http://www.hhs.gov/>

Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey was implemented in the United States in 2006. Participation is voluntary but non-participation results in a 2% reduction in one funding stream. This website went live in 2008 and 90% of hospitals participate.

Patients discharged from care complete an anonymous 27 item survey tapping such domains as staff responsiveness and communication skills. Following detailed risk adjustment results of surveys are publicly reported

At <http://www.hospitalcompare.hhs.gov/Hospital/Home2.asp> users can search for hospitals by name, zip code or city/state/county. Users can compare up to three hospitals. As the following screen shots show, users are able to compare across hospitals on for example a number of indicators of patient satisfaction with users able to access a more detailed description of the indicator.

Hide Information
Survey of Patients' Hospital Experiences [What is This?]
Back to Top

HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) is a national survey that asks patients about their experiences during a recent hospital stay. Use the results shown here to compare hospitals based on ten important hospital quality topics. [Read more information about survey of patients' hospital experiences .](#)

	ST JOSEPH MEDICAL CENTER KANSAS CITY, MO	ST LUKES HOSPITAL OF KANSAS CITY KANSAS CITY, MO	ST LUKES NORTHLAND HOSPITAL KANSAS CITY, MO
	Acute Care	Acute Care	Acute Care

Check the boxes next to the topics for which you would like to view correlating graphs or tables.

Select All

Reset Checkboxes

View Graphs

View Tables

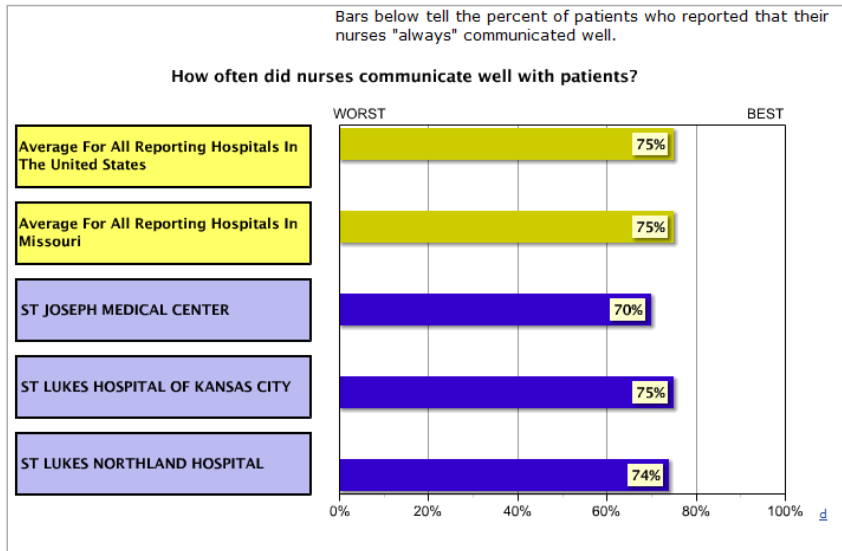
<input checked="" type="checkbox"/> Percent of patients who reported that their nurses "Always" communicated well.	70%	75%	74%
<input type="checkbox"/> Percent of patients who reported that their doctors "Always" communicated well.	78%	74%	79%
<input type="checkbox"/> Percent of patients who reported that they "Always" received help as soon as they wanted.	59%	60%	64%
<input type="checkbox"/> Percent of patients who reported that their pain was "Always" well controlled.	65%	67%	67%
<input type="checkbox"/> Percent of patients who reported that staff "Always" explained about medicines before giving it to them.	51%	57%	60%
<input type="checkbox"/> Percent of patients who reported that their room and bathroom were "Always" clean.	60%	59%	73%
<input type="checkbox"/> Percent of patients who reported that the area around their room was "Always" quiet at night.	53%	52%	64%



How often did nurses communicate well with patients?

These results are from patients who had overnight hospital stays from July 2008 through June 2009.

Patients reported how often their nurses communicated well with them during their hospital stay. "Communicated well" means nurses **explained things clearly, listened carefully** to the patient, and treated the patient with **courtesy and respect**.



Medicare 'Home Health Compare'

The Home Health Compare system (<http://www.medicare.gov/HHCompare>) presents information on quality measures of home nursing and paramedical services in the US, by agency. As such, it is very similar to the Hospital Compare system, shown above. Through the website, anyone can see, for example, the "Percentage of patients who stay at home after an episode of home health care ends", for any agency, compared with any other agency and to the state and national average.

At the home screen, the user can choose to search by State, County, ZIP code, or name of the facility. Having made this choice, the user next decides whether the user wants to see some or all of nursing care, physical therapy, occupational therapy, speech pathology, social work, or home health aide services. The system then tells you how many agencies there are in the region you have selected. Selecting the State of Alaska produced a list of 13 agencies, along with contact details, and which of the six types of service they offered. The user can choose up to ten of these for detailed reports. A report on one such agency looks like this:

1ST CHOICE HOME HEALTH CARE, INC			
159 E REDOUBT AVENUE SOLDOTNA, AK 99669 (907) 260-5959			
Type of Ownership: Proprietary Agency's Initial Date of Medicare Certification: 1/2/1996			
Medicare-covered Services:			
Nursing Care Services: Yes Speech Pathology Services: Yes Physical Therapy Services: Yes Medical Social Services: Yes Occupational Therapy Services: Yes Home Health Aide Services: Yes			
Quality Measures	Percentage for 1ST CHOICE HOME HEALTH CARE, INC	State Average	National Average
HIGHER PERCENTAGES ARE BETTER			
Percentage of patients who get better at walking or moving around	35%	37%	46%
Percentage of patients who get better at getting in and out of bed	29%	46%	54%
Percentage of patients who have less pain when moving around	56%	55%	64%
Percentage of patients whose bladder control improves	38%	40%	47%
Percentage of patients who get better at bathing	50%	57%	65%
Percentage of patients who get better at taking their medicines correctly (by mouth)	38%	37%	43%
Percentage of patients who are short of breath less often	53%	57%	60%
Percentage of patients who stay at home after an episode of home health care ends	69%	72%	67%
NEW! Percentage of patients whose wounds improved or healed after an operation	68%	70%	80%
LOWER PERCENTAGES ARE BETTER			
Percentage of patients who had to be admitted to the hospital	30%	25%	29%
Percentage of patients who need urgent, unplanned medical care	7%	19%	22%
NEW! Percentage of patients who need unplanned medical care related to a wound that is new, is worse, or has become infected	0%	2%	1%

Then, as with Hospital Compare, illustrated earlier, the user can see the comparative statistics on selected indicators for a set of agencies that you have chosen, like this:

Percentage of patients who get better at taking their medicines correctly (by mouth)
This information comes from the Home Health Outcome and Assessment Information Set (OASIS) during the time period October 2008 - September 2009.

Why is this information important?

For medicines to work properly, they need to be taken correctly. Taking too much or too little medicine can keep it from helping you feel better and, in some cases, can make you sicker, make you confused (which could affect your safety), or even cause death. Home health staff can help teach you ways to organize your medicines and take them properly. Getting better at taking your medicines correctly means the home health agency is doing a good job teaching you how to take your medicines.

Percentage of patients who get better at taking their medicines correctly (by mouth)

