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Report on the evaluation of the National Minimum Data Set for Public Hospital Establishments

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Abbreviations

ABS	Australian Bureau of Statistics
ACHS	Australian Council on Healthcare Standards
ACT	Australian Capital Territory
AHCA	Australian Health Care Agreement
AHMAC	Australian Health Ministers' Advisory Council
AHSAC	Australian Hospital Statistics Advisory Committee
AIHW	Australian Institute of Health and Welfare
ASCO	Australian Standard Classification of Occupations
ATC	Anatomic Therapeutic Chemical
DRG	Diagnosis Related Group
DVA	Department of Veterans' Affairs
HDSC	Health Data Standards Committee
HEAC	Health Expenditure Advisory Committee
HSA	Health Service Agreements
IFRACS	Admitted patient fraction
LGA	Local Government Area
NHCDC	National Hospital Cost Data Collection
NHDC	National Health Data Committee
NHDD	*National health data dictionary*
NHIG	National Health Information Group
NHIMPC	National Health Information Management Principal Committee
NMDS	National Minimum Data Set
NPHED	National Public Hospital Establishments Database
NSW	New South Wales
NT	Northern Territory
OECD	Organisation for Economic Cooperation and Development
PHEC	Australian Bureau of Statistics' Private Health Establishments Collection
Qld	Queensland
SA	South Australia
SIMC	Statistical Information Management Committee
SLA	Statistical Local Area
Tas	Tasmania
Vic	Victoria
WA	Western Australia
WHO	World Health Organization

Summary and recommendations

The evaluation of the National Minimum Data Set (NMDS) for Public Hospital Establishments was conducted by the Australian Institute of Health and Welfare (AIHW) for the Australian Health Ministers' Advisory Council (AHMAC). Funding for the evaluation was provided by AHMAC through the Statistical Information Management Committee (SIMC).

The quality, usefulness and appropriateness of the NMDS were assessed. Recommendations have been made for future data development to improve the quality and comparability of the data collected.

The evaluation involved reviews of:

- compliance, that is, the extent to which data for 2003–04 were provided by states and territories in accordance with the specifications in the *National health data dictionary (*NHDD 2003*)*.
- utility. Data collectors and users were surveyed using a tool similar to that designed for the evaluation of the Admitted Patient Care NMDS (AIHW 2003). An additional questionnaire addressed state and territory reporting practices for expenditure and revenue.

The recommendations for new or modified data elements (together with priorities for data development) are summarised below. Any proposals arising from these recommendations will be submitted for approval to the Health Data Standards Committee (HDSC), the SIMC and then to the National Health Information Management Principal Committee (NHIMPC, formerly the National Health Information Group).

The recommendations are discussed in Chapters 3 to 6 of this report.

Overall findings

The respondents to the survey undertaken as part of the evaluation consider the NMDS to be both important and useful.

The scope of the collection is currently limited to hospital services provided by public hospitals. There was broad support to encompass other public hospital services within the scope of the collection. This could include services funded by state and territory health authorities including those provided by private hospitals under contract arrangements (subject to commercial-in-confidence arrangements).

A more comprehensive picture of public hospital services would thus be obtained. Comparisons could be made with data collected by the AIHW for the reporting of state and territory governments' expenditure and funding for health, as well as data published by the ABS based on the Private Health Establishment Collection (PHEC).

Overall recommendations

It is recommended that options to extend the scope of the NMDS from public hospitals to public hospital services be examined. A possible model similar to that adopted for the new

Mental Health Establishments NMDS involves hierarchical reporting. Data would be collected at establishment (and possibly campus) level. Additional data would be collected at state, regional, network/area level, reflecting the organisation of hospital services within each state and territory. These arrangements would encompass the provision of public hospital services through contracting with privately operated entities (subject to any commercial-in-confidence arrangements). Such a structure would allow the double counting associated with inter-hospital transactions to be reconciled at the higher levels of the organisational hierarchies. As with the NMDS for Mental Health Establishments, data collection relating to private hospitals would not be as detailed as for public hospitals.

Establishment identifiers could be developed to indicate relationships between individual hospital service units and higher levels of the organisational hierarchy. These enhanced identifiers would enable data to be reported against the different reporting entities depending on the nature of the data element and aggregated to higher levels as appropriate.

There is a need to revise the current description of the scope of the NMDS as it includes a reference to Department of Veterans' Affairs hospitals which no longer exists. This revision would not change the scope of the NMDS as it would bring the current description up to date. If the scope of the NMDS is to expand to encompass Government health services the description will require additional amendments.

Recommendation: Consider restructuring the NMDS to extend its scope to encompass public hospital services, rather than public hospitals, and incorporation of hierarchical structuring and establishment identifiers.

Recommendation: Revise the description of the scope of the NMDS for Public Hospital establishments.

Priority: High

Recommendations relating to data elements

System level expenditure elements

Capital expenditure, version 1

This data element has become obsolete because of the adoption of accrual accounting and reporting practices in all jurisdictions.

Recommendation: Delete.

Priority: High.

Capital expenditure—gross (accrual accounting), version 2
Capital expenditure—net (accrual accounting), version 2

Some respondents to the survey commented that the capital expenditure was poorly defined and inaccurately and inconsistently reported. In part, the problems may stem from reporting exclusively at the hospital level rather than at region or state/territory level. These definitions need to be reviewed following the development of a restructured NMDS and aligned with those used for the reporting of capital expenditure through the 'Government health expenditure' NMDS, which is under development.

Recommendation: Retain, pending the assessment of proposals to introduce a hierarchical reporting structure for the NMDS.

Priority: Medium.

Indirect health care expenditure, version 1

This data element is defined as 'Expenditures on health care that cannot be directly related to programs operated by a particular establishment…' It relates to expenditure, which in large part is not incurred on public hospital services per se and accordingly the data element is outside of the scope of the NMDS. It would appear to be an appropriate data element for the new 'Government health expenditure' NMDS.

Recommendation: Delete.

Priority: High.

Establishment identification elements

A reconfiguration of the establishment identification elements is required to underpin any hierarchal reporting structure. The recommendations in this report foreshadow the introduction of such a structure.

Establishment identifier, version 4

The establishment identifier is derived using the state/territory identifier, establishment sector, region code, area/network code and establishment number. The existing identifier is deficient because of inconsistencies in the assignment of identifiers by the states and territories. As a consequence, national comparisons of data are difficult to achieve. The establishment sector should not continue to be a part of the identifying data element (see recommendation in relation to the Establishment sector, version 3 (below)).

There will be a need to review this following the introduction of any hierarchal reporting structure.

Recommendation: Review.

Priority: High.

Establishment number, version 4

A numbering arrangement is used to identify separate establishments.

Recommendation: Retain.

Establishment sector, version 3

In this context, the *Establishment sector* is an attribute of the entity delivering the service and not a method for identifying the service itself. A distinction in the NMDS between public hospitals and private hospitals providing public hospital services is seen to be useful. This could require consideration of the definition for privately operated public hospital services.

Such a change would provide the means for combining the data reported from this NMDS with that reported by the Australian Bureau of Statistics (ABS) through the PHEC without double counting.

Recommendation: Amend to distinguish public hospitals from privately operated public hospital services.

Priority: Low.

Region code, version 2

The NHDD defines this data element as the geographical or administrative area for the location of the establishment. The coding used needs to reference the administrative structure used by the state/territory to categorise the provision of health services within their jurisdictions rather than the geographical locality.

Recommendation: Amend to specify that it applies to administrative rather than geographical region.

Priority: High.

State/territory identifier, version 3

Recommendation: Retain.

Establishment type, version 1

Comments indicated a need to up-date this element. There is a need for further work to be undertaken on reviewing the definition and domain values for this data element with the objective of rationalising the numerous concepts involved.

It may be possible to adopt a simpler classification of 'hospital type', for example reflecting the peer groups in the AIHW's peer group classification used for *Australian hospital statistics*, particularly for the types of hospitals that are not assigned a peer group based on activity levels and/or location.

The Report of the Evaluation of the Admitted Patient Care NMDS which was conducted in 2002 recommended that the collection of information on whether the hospital is a public psychiatric, other public, private freestanding day hospital facility or other private hospital be replaced with either an appropriate revision of the data domain for 'Establishment sector', or the creation of a new data element on 'hospital type'. Responding to this recommendation, the AIHW has undertaken preliminary work to develop the proposed new data element. This work could form the basis for up-dating the 'Establishment type' data element.

Recommendation: Review.

Priority: High.

Geographical location of establishment, version 2

Recommendation: Retain.

Establishment level expenditure elements

Suggestions were received to revise the input and output categories for expenditure in the NMDS to achieve a more useful representation of hospital expenditure. Some proposed a closer alignment of expenditure categories with those reported in the National Hospital Cost Data Collection.

Consistent with accrual accounting practices, the reporting needs to be in terms of 'expenses' rather than expenditure or payments, and more generally the definitions need to be updated to accord with current accounting practices.

The states/territories are inconsistent in their reporting of recruitment costs, fringe benefits tax, equipment-leasing arrangements and building/garden maintenance by an outside agency.

More and better quality information is being sought on health expenditure outputs. Output categories could include admitted patients (acute, specialised, rehabilitation and other), non-admitted patients and emergency departments. The development of admitted patient cost proportions (or IFRACs) could then be included as a formal data element, at least for admitted patients but also possibly for non-admitted outpatients and emergency department patients.

Recommendation: Incorporate the revision of recurrent expenditure data elements in any new program of data development work relating to the NMDS. In addition, amend the NHDD to clarify the categories for the reporting of recruitment costs, fringe benefits tax, equipment-leasing arrangements and building/garden maintenance by an outside agency.

Recommendations for improvements of specific items are outlined below.

Priority: High.

Administrative expenses, version 1

Recommendation: Retain, subject to the overall review of recurrent expenditure categories as outlined above.

Interest payments, version 1

Methods of measuring this data element vary between jurisdictions, with some gaps in reporting.

Recommendation: Review to improve the consistency of measurement and reporting among jurisdictions.

Priority: Low.

Depreciation, version 1

Methods of measuring this data (including the use of different depreciation schedules) vary between jurisdictions.

Recommendation: Review in conjunction with the review of capital expenditure items, to improve the consistency of measurement and reporting among jurisdictions.

Priority: Medium.

Patient transport, version 1

This data element is not consistently collected and reported by jurisdictions.

Recommendation: Review to improve consistency across jurisdictions.

Priority: Low.

Repairs and maintenance, version 1

Recommendation: Retain, subject to the overall review of recurrent expenditure categories as outlined above.

Superannuation employer contributions (including funding basis), version 1

The reference in the title to 'including funding basis' is misleading and confusing.

Recommendation: Delete the reference to 'including funding basis'.

Priority: Medium.

Domestic services, version 1

Recommendation: Retain, subject to the overall review of recurrent expenditure categories as outlined above.

Payments to visiting medical officers, version 1

Recommendation: Retain, subject to the overall review of recurrent expenditure categories as outlined above.

Drug supplies, version 1

Some respondents to the survey supported a disaggregation of this category, for example using WHO's Anatomic Therapeutic Chemical (ATC) classifications.

Recommendation: Review to consider a disaggregation into categories.

Priority: Low.

Food supplies, version 1

Recommendation: Retain, subject to the overall review of recurrent expenditure categories as outlined above.

Medical and surgical supplies, version 1

Similar comments to those received in relation to drug supplies were provided. A greater disaggregation of this category was considered likely to improve its usefulness.

Queensland, Victoria and South Australia include purchased pathology services in *Medical and surgical supplies*. Radiology services may also be included in some states. This is inconsistent with the NHDD definition for *Medical and surgical supplies*. However, the recurrent expenditure categories omit contracted or state-wide pathology or radiology services. It is likely that some of these issues can be resolved through the introduction of a hierarchal reporting structure.

Recommendation: Review to consider a disaggregation into categories.

Priority: High.

Recommendation: Consider how best to include or exclude state-wide and contract pathology and radiology services.

Priority: Low.

Other recurrent expenditure, version 1

This is a balancing item and described as such in the NHDD. In some cases, negative amounts are reported. This could suggest errors in reporting against other items in the NMDS although further investigation may be required to verify this.

Recommendation: Retain.

Salaries and wages, version 1

A review of staffing categories was supported. The compliance report also found problems in the reporting of registered nurses and other personal care staff. Categories could possibly be reviewed against the ABS *Australian standard classification of occupations*. They could also be reviewed with a view to aligning them with wider requirements for health labour force planning, for example to complement health care professional registrations and survey data. Comments on individual categories are outlined below.

Recommendation: Review, in conjunction with the review of *Full-time equivalent staff* categories.

Priority: Medium.

Salaries and wages—registered nurses
Salaries and wages—enrolled nurses

Two states were unable to report registered nurses separately from enrolled nurses.

Recommendation: Review the category split for registered and enrolled nurses.

Priority: Medium.

Salaries and wages—student nurses

Since 1998-99, the only jurisdiction to report against this category was South Australia, which did so for 2002-03 and 2003-04.

Recommendation: Delete subject to clarification of South Australia's use of this category.

Priority: High.

Salaries and wages—trainee/pupil nurses

Trainee or pupil nurses have not been reported by any jurisdiction since 1997-98.

Recommendation: Delete.

Priority: High.

Salaries and wages—salaried medical officers

Recommendation: Retain.

Salaries and wages—other personal care staff

Other personal care staff are either not reported at all, or included with other categories, for a majority of jurisdictions.

Recommendation: Review, with a view to its deletion.

Priority: High.

Salaries and wages—diagnostic and health professionals

Recommendation: Retain, subject to changes consequent upon the deletion of the *other personal care staff* category.

Salaries and wages—administrative and clerical staff

It has been suggested that medical and nursing staff engaged in administrative duties not be counted as staff employed in clinical work.

Recommendation: Retain, subject to changes consequent upon the deletion of the *other personal care staff* category and include details of medical and nursing staff engaged in administrative duties.

Salaries and wages—domestic and other staff

Recommendation: Retain, subject to changes consequent upon the deletion of the *other personal care staff* category.

Revenue data elements

The variations between jurisdictions in the reporting of expenditure also extend to the reporting of revenue. Interstate differences relate to the reporting of Commonwealth residential aged care payments, payments from private hospitals for contracted patients and revenue from business units and hospital boarders. A review of revenue categories would lead to greater consistency in the reporting of revenue.

Some revenue types are not reported. It may be possible to develop a data element which could capture revenue from all other sources, including state government funding or Specific Purpose Payments. In addition, the recommended hierarchical structure of reporting could provide a means for capturing revenue data in the NMDS at the appropriate level.

Recommendation: Review to take into account the reporting of Commonwealth residential aged care payments, payments from private hospitals for contracted patients, revenue from business units, hospital boarders and other sources.

Priority: Medium.

Patient revenue, version 1

Some jurisdictions experience difficulties determining the source for some revenue categories.

Recommendation: Review to clarify boundaries and reword as *Patient fee revenues* to make it simpler and to specify that it relates only to revenues from the provision of health services to patients.

Priority: High.

Other revenues, version 1

Respondents commented on difficulties in distinguishing between the revenue categories and definitional issues.

Recommendation: Review with a view to improving definitional boundaries, including a review of the wording of the definition.

Priority: High.

Recoveries, version 1

Respondents commented on difficulties in distinguishing between the revenue categories. There were also concerns that some inter-hospital transactions are causing expenditures to be double counted. An example is the supply on a cost recovery basis of laundry or maintenance services by larger hospitals to smaller hospitals. The associated expenses could be double counted when expenses and revenues are consolidated at a regional and state level. The issue of double counting could possibly be resolved by separately defining and recording *Recoveries from other (hospital) establishments* and would be reconciled with appropriate regional and state level reporting in a hierarchal structure.

Recommendation: Review to improve definitional boundaries. Consider separately defining and recording *Recoveries from other (hospital) establishments* to reduce double counting.

Priority: High.

Other data elements

Full-time equivalent staff, version 2

The *Full-time equivalent staff* data element categories need to be reviewed in conjunction with the *Salary and wages* data element.

Recommendation: Review in conjunction with the review of *Salaries and wages* categories.

Priority: High.

Specialised service indicators, version 1

The categories of specialised service units may not accurately reflect the hospital service units of current interest or importance. Respondents commented that the categories were out-of-date, too broad and ill-defined. Some data may be more easily reported using National Hospital Morbidity Database information.

Recommendation: Review.

Priority: Medium.

Type of non-admitted patient care, version 1

The categories in *Type of non-admitted patient care* may be out of date. Some are different from those collected in the Outpatient Care NMDS. It is timely to review these categories, particularly with reference to the Outpatient Care NMDS data elements *Establishment--number of occasions of service* and *Establishment--outpatient clinic type*. This data (and the corresponding *Group Sessions* data) need to be reported in this NMDS because the Outpatient Care NMDS only applies to peer group A and B hospitals.

Recommendation: Review in conjunction with the review of the *Group sessions* data element. This review to incorporate the issues for the following two categories for this data element:

Priority: Medium.

Type of non-admitted patient care—Accident and Emergency

There are differences between the data reported for *Type of non-admitted patient care--Accident and emergency* and *Occasions of service* data reported to the *Emergency department waiting times*

NMDS. In small hospitals, this might be expected because accident and emergency services may be provided outside of an 'Emergency Department'. However, in larger hospitals, which would be expected to have an Emergency Department, the counts are likely to be similar. Within jurisdictions, there is inconsistency between the two sets of data reported.

Recommendation: Clarify the relationship between the *Type of non-admitted patient care--Accident and emergency* and the *Occasions of service* data reported to the *Emergency department waiting times* NMDS (as part of the review of the categories in *Type of non-admitted patient care* as outlined above).

Type of non-admitted patient care—Mental health

The difference between the *Type of non-admitted patient care – Mental health* data element and the mental health service contacts data element(s) in the *Community mental health care* NMDS is unclear.

Recommendation: As part of the review of the categories in *Type of non-admitted patient care*, review to clarify the relationship with the mental health service contacts in the *Community mental health care* NMDS.

Type of non-admitted patient care (public psychiatric, alcohol and drug), version 1

This data element counts occasions of service in public psychiatric and alcohol and drug hospitals, of which there are fewer than 30 in total. *Occasions of service* and *Group session* data collected need to relate to all public hospital services. It would be more appropriate to collect *Type of non-admitted patient care* and *Group session*s data for all public hospitals and not different types of counts for acute versus public psychiatric and alcohol and drug hospitals.

Recommendation: Delete and amend the *Type of non-admitted patient care* and *Group session*s data elements to include public psychiatric and alcohol and drug hospitals.

Priority: Medium.

Group sessions, version 1

The categories in group sessions (group data for *Type of non-admitted patient care)* have become out of date. For example, no jurisdiction reports group sessions for radiology and endoscopy and data for dialysis, pathology, dental, pharmacy and drug and alcohol are reported by one state only. A review of these categories could also take into consideration categories specified in the Outpatient Care NMDS.

Recommendation: Review in conjunction with the review of the *Type of non-admitted patient care* categories.

Priority: Medium.

Number of available beds for admitted patients, version 2

A review of the data element is underway. The SIMC Working Party on Reporting of Bed Availability is seeking to:

- develop definitions to allow the number of available beds for admitted patients to be disaggregated into same day and overnight beds, and to consider whether definitions need to be disaggregated further

- consider how to include multipurpose services beds in the scope of the NMDS, and to consider whether multipurpose services beds be reported separately from other acute beds
- consider whether cots for normal neonates be brought into scope
- improve the definition of 'available'.

Recommendation: Review to incorporate recommendations from the SIMC Working Party on Reporting of Bed Availability.

Priority: High.

Teaching status, version 1

Comments indicated that this data element was not very useful nor in demand.

Recommendation: Review with a view to its deletion.

Priority: Medium.

Supporting data elements and data element concepts

Hospital, version 1

Some issues regarding the definition of hospital services require clarification. The inclusion or exclusion of 'business units' (which supply services to hospitals but are not part of the hospital) in expenditure and revenue measures is one such issue. Another issue is the funding but not the provision of services. For example NSW has reported a mental health service, which only provides expenditure data.

It is possible that the development of a hierarchal reporting structure will resolve this latter issue. More generally, it needs to be clarified that what is reported by a hospital for one purpose (for example, admitted patient activity) is matched by other reporting (for example, expenses and revenue).

Recommendation: Review.

Priority: Medium.

Hospital boarder, version 1

This data element does not relate to hospital services.

Recommendation: Delete this data element.

Priority: Medium.

Non-admitted patient, version 1

The definition of admitted versus non-admitted patient has implications for other data elements including *Number of available beds, Occasions of service* and non-admitted patient cost proportions. The HDSC Admitted/Non-admitted Patient Boundary Working Party has been investigating definitions and related issues.

Recommendation: Review to incorporate recommendations from the HDCS Admitted/Non-admitted Patient Boundary Working Party.

Priority: High.

Overnight-stay patient, version 3

This data element concept is not considered to be necessary for this NMDS.

Recommendation: Remove from the list of supporting data elements for the NMDS.

Priority: Medium.

Patient, version 2

Recommendation: Retain.

Same-day patient, version 1

This data element concept is not considered to be necessary for this NMDS.

Recommendation: Remove from the list of supporting data elements for the NMDS.

Priority: Medium.

Separation, version 3

This data element concept is not considered to be necessary for this NMDS.

Recommendation: Remove from the list of supporting data elements for the NMDS.

Priority: Medium.

Proposed new data elements

Admitted patient cost proportion

The cost per casemix adjusted separation is a useful indicator of hospital performance. It can only be calculated using the admitted patient cost proportion for which there is no definition in the NHDD. The development of a clear definition for this data item would be valuable.

Recommendation: Develop definitions for the admitted patient cost proportion categories; standard, acute and acute non-psychiatric.

Priority: High.

Safety and quality—counts of sentinel events

Some comments supported the inclusion of counts of sentinel events in the NMDS. This would then become part of the regular NMDS reporting. There may, however, be issues with confidentiality to be resolved.

Recommendation: Assess the proposal.

Priority: Medium.

Safety and quality—clinical indicators

Hospitals voluntarily collect clinical indicators for internal review and report them to groups such as the Australian Council on Healthcare Standards (ACHS) and the Health Roundtable. It has been suggested that the NMDS include some of those indicators, for example those which are reported by the *Report on Government Services* (Steering Committee for the Review of Government Service Provision). The report uses ACHS data to report information on public hospital unplanned re-admission rates and surgical site infection rates.

Recommendation: Assess the proposal to include clinical indicators in the NMDS.

Priority: Medium.

Safety and quality—quality accreditation/certification status

The following quality accreditation/certification status items are currently collected but not included in the NMDS:

- Establishment—quality accreditation/certification standard status (ACHS EQuIP).
- Establishment—quality accreditation/certification standard status (Australian Quality Council).
- Establishment—quality accreditation/certification standard status (International Organisation for Standardisation 9000 quality family).
- Establishment—quality accreditation/certification standard status (Quality Improvement Council).

Recommendation: Assess with a view to including them in the NMDS.

Priority: Medium.

Hospitals not currently included

Some Australian hospitals are not currently included in this NMDS, for example hospitals run by Department of Defence, corrections authorities and public hospitals in Australia's external territories.

Priority: Low.

Recommendation: Assess with a view to including them in the NMDS.

Operating theatre efficiency

Information on operating theatre utilisation and throughput could be useful. This could include information such as numbers of theatres, opening hours and numbers of patients or procedures.

Recommendation: Assess the feasibility of data elements relating to operating theatre efficiency.

Priority: Medium.

Admitted patient

The definition of admitted patient is applicable to the NMDS.

Recommendation: Add to the NMDS (using the specification in the NHDD).

Priority: Low.

Amendments in order of priority

High priority amendments

Data elements currently under review

Establishment type, version 1

Number of available beds for admitted patients, version 2

Non-admitted and admitted patient, version 1

Data elements to be deleted (or possibly deleted)

Capital expenditure, version 1

Indirect health care expenditure, version 1

Salaries and wages—trainee/pupil nurses

Salaries and wages—student nurses

Salaries and wages—other personal care staff

Data elements to be reviewed

Public hospital establishments NMDS—hierarchical reporting structure

Establishment identifier, version 4

Region code, version 2

Establishment level expenditure elements

Medical and surgical supplies, version 1

Patient revenue, version 1

Other revenues, version 1

Recoveries, version 1

Full-time equivalent staff, version 2

Proposed data element

Admitted patient cost proportion

Medium priority amendments

Data elements to be deleted or amended

Superannuation employer contributions (including funding basis), version 1

Type of non-admitted patient care (public psychiatric, alcohol and drug), version 1

Teaching status, version 1

Overnight-stay patient, version 3

Same-day patient, version 1

Hospital boarder, version 1

Separation, version 3

Data elements to be reviewed

Capital expenditure—gross (accrual accounting), version 2
Capital expenditure—net (accrual accounting), version 2
Depreciation, version 1
Salaries and wages, version 1
Salaries and wages—registered nurses
Salaries and wages—enrolled nurses
Specialised service indicators, version 1
Type of non-admitted patient care, version 1
Group sessions, version 1
Hospital, version 1

Proposed data elements

Operating theatre efficiency
Safety and quality—counts of sentinel events
Safety and quality—clinical indicators
Safety and quality—quality accreditation/certification status

Low priority amendments

Data elements to be deleted or amended

Establishment sector, version 3

Data elements to be reviewed

Interest payments, version 1
Patient transport, version 1
Drug supplies, version 1

Other data elements

Hospitals not currently included
Admitted patient

Data elements to be retained

Establishment number, version 4
State/territory identifier, version 3
Geographical location of establishment, version 2
Administrative expenses, version 1
Repairs and maintenance, version 1
Domestic services, version 1
Payments to visiting medical officers, version 1
Food supplies, version 1