## NSW Health Data Quality Statement 2021-22 National Hospital Cost Data Collection

#### Governance processes and results

The Round 26 (2021-2022) National Hospital Cost Data Collection (NHCDC) is based on the NSW Health District and Network Return (DNR). The DNR is prepared and submitted by costing practitioners in each of the 16 local health districts and 2 specialty health networks (districts/networks). Financial results are published and audited at district/network level and not at the hospital level.

#### 1. Governance arrangements

Provide details on changes to:

- structure of districts/networks and number of hospitals submitted
- costing or activity recording practices
- reporting processes, including review/approval processes and methodology (for example quality assurance tests undertaken and reconciliation).

# 1.1 Changes to the structure of districts/networks and number of hospitals submitted There were no changes to the structure of districts/networks between Round 25 and Round 26. A total of 139 facilities were submitted in Round 26, compared to 142 in Round 25.

#### 1.2 Changes in costing or activity recording practices

There were no significant changes to costing or activity recording practices for Round 26. Costing was undertaken in a consistent manner across all districts and networks. A highly standardised costing process exists where costing practitioners adhere to NSW Cost Accounting Guidelines (CAG). The CAG provides advice and guidelines on costing set-up, methodologies and quality assessments related to the DNR submission. The CAG is reviewed and updated regularly as costing processes are included or changed. The CAG complies with the Australian Hospital Patient Costing Standards (AHPCS).

## 1.3 Changes in reporting processes, including review/approval processes and methodology

Minor improvements were made to reporting and quality processes during Round 26. This included streamlining of the DNR reconciliation template and outlier identification.

#### 1.4 DNR quality control and processes

The NSW DNR process contains quality checks. This includes a DNR module to identify and resolve quality issues prior to the submission of final results. A number of these tests are designated as 'critical' errors which means data must be reviewed and corrected before a submission can be made.

Final DNR submissions are approved by the district/network chief executive (CE) at the time of final submission. District and network submissions are used to generate the National Hospital Cost Data Collection submission. A reconciliation is provided by districts/networks at the time of CE sign off.

In Round 26, DNR costing processes were undertaken for both half year (6 months July to December 2021) and full year (July 2021 to June 2022) financial periods. The half year DNR is subject to the same quality and submission processes as the full year DNR submission. This allows costing practitioners to assess data quality and reasonableness early and resolve any issues identified in the half year submission.

Volumes 2 and 3 of the CAG reflect business rules and technical specifications that guide costing practitioners within districts/networks. The CAG is reviewed regularly and updated as any costing processes or practices are changed or included. Volume 2 reflects version 4.1 of the AHPCS. Both volume 2 and 3 provide guidelines, practical and technical advice on a wide range of costing system set-ups, standardised allocation methodologies and data extracts.

A mandatory audit program of the DNR submission is undertaken. Completion of this audit program is part of a robust governance framework. Audit reports are submitted to local Audit and Risk Committee Board Subcommittees and District/Network Chief Executives.

Figure 1 below details the DNR Quality Assurance Program within NSW.

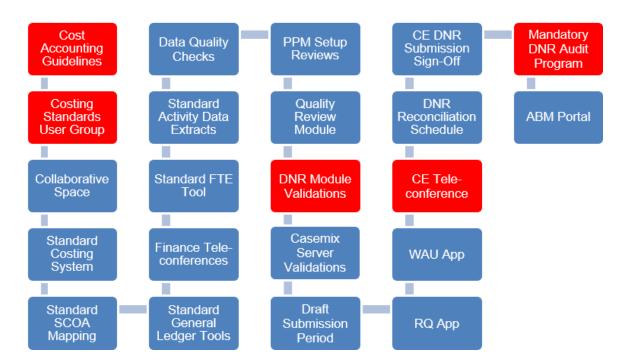


Figure 1 District and Network Return Quality Assurance Program

#### 2. Summary of 2021-22 results

Provide a summary of the 2021-22 and 2020-21 NHCDC submission, including but not limited to:

- number of hospitals
- general ledger costs included/excluded
- activity count compared to the previous year
- explanations of significant cost movements from previous year.

A summary of year on year in-scope activity and expense is shown in the table below.

Submission year	Number of hospitals/entities	In-scope activity	Expense (\$m)
Round 26 (2021-22)	139	14,165,321	\$17,750,837,098
Round 25 (2020-21)	142	14,823,935	\$16,552,313,797

The following changes are noted in Round 26, compared to Round 25:

District/network/facility inclusions and exclusions	Round 25	Round 26
Illawarra Shoalhaven Local Health District (LHD)	Included	Excluded
Nepean Blue Mountains LHD	Excluded	Included
Greenwich Hospital admitted mental health encounters	Included	Excluded
(Northern Sydney LHD)		
Broken Hill Palliative Care (Far West LHD)	Included	Excluded

• Like Round 25, application of non-admitted mental health phase of care grouping rules for the Australian Mental Health Care Classification resulted in some patients with costed services from more than one district/network that link to a single phase.

Strict application of the rule that a patient can only have one phase of care at a time means that organisational boundaries (district/network identifiers) are excluded from the phase grouping process. NSW therefore excluded these encounters from their natural district/network and submitted them in the virtual 'LHN 199'.

- Two aggregate datasets were submitted in a hybrid Cost C file by NSW for Round 26:
  - COVID-19 vaccinations due to significantly large numbers of activity for COVID-19 vaccinations, it was decided to submit aggregate level cost data.
     COVID-19 vaccination aggregate data was submitted at the district/network level
  - Highly Specialised Therapies (HST) there were a small number of HST encounters (8) that received payment in 2021-22 but did not have any patient activity (inpatient/emergency/non-admitted visits) to link to during that period. These have been submitted as the supplementary Cost C HST file.
- Given the volume (more than 3 million) of COVID-19 non-admitted data in Round 26 due to the Delta outbreak at the beginning and Omicron outbreak in the middle of the financial year, a sample was submitted to facilitate efficient processing of the NHCDC.
- For contracted care, the outsourced services amount charged at encounter level was
  the amount applied. This will be reflected in a goods and services line item. Given the
  volume of contracted care, breaking the goods and services amount into individual line
  items is not feasible.

#### 3. Compliance to the Australian Hospital Patient Costing Standards (AHPCS)

## 3.1 Provide confirmation that the AHPCS comply at hospital, network/district and jurisdictional level.

Guidelines for preparing and submitting the DNR are published in the CAG, which aligns to version 4.1 of the AHPCS. Costing practitioners across NSW adhere to the CAG.

## 3.2 Identify areas where the AHPCS have not been applied and provide explanations for these exceptions.

Compliance with the AHPCS for the Round 26 NHCDC submission remains unchanged from Round 25.

NSW Health is partially compliant with the following standards under the version 4.1 of the AHPCS. Explanations are noted below.

- Standard 1.2 Identify Relevant Expenses Third Party Expenses most third-party expenses are included in the cost ledger for the NHCDC. However, expenses such as pathology costs for private and compensable patients that are held centrally are not distributed to districts/networks for inclusion in DNR cost ledgers. Medical expenses for private patients recorded in trust accounts or non-operation accounts are also not included in the cost ledger.
- Standard 2.2 Create the Cost Ledger Matching Cost Objects and Expenses while the range and extent of service data expands with each DNR submission, not all districts/networks have the same levels of service data to match expense with the relevant cost objects.
- Standard 3.2 Create Final Cost Centres Allocation of Expenses in Overhead Cost Centres in some cases the preferred overhead allocation statistic detailed in the CAG is not used for the allocation of overhead expense as the allocation statistic data is not readily available.
- Standard 6.1 Review and Reconcile Data Quality Framework while NSW has a comprehensive data quality framework in place, a systematic review of product areas that do not have service data has not been undertaken at this time.
- Standard 6.2 Review and Reconcile Reconciliation to Source Data while an
  extensive expense and activity reconciliation process is embedded in the DNR
  submission process, further reconciliation of patient activity to the source systems
  is required.
- Like Round 25, NSW notes some deviation from Costing Guideline Critical Care.
   Many critical care services in NSW hospitals have critical care and step-down beds
   in the one ward. Examples of this include Intensive Care Unit (ICU)/High
   Dependency Unit (HDU) or Critical Intensive Care Unit (CICU)/Coronary Care Unit
   (CCU) wards. Typically, these services have one cost centre and one ward set up in
   the Patient Administration System, with 2 or more bed types to distinguish the ICU
   (CICU) hours/bed days separately to the HDU (CCU) hours/bed days. The bed type is
   used to calculate ICU hours.
- The final cost allocation reflects appropriate nursing levels for ICU/HDU patients. In some instances where a patient only has HDU hours, the cost will be reported under a critical care cost centre, as the cost centre maps to critical care even though there are no reported ICU hours. Additionally, only facilities with Level 3 ICUs map their cost centre to critical care, even though locally they may use the ICU bed type.

#### 4. Other relevant information

Please include other information relevant to your jurisdiction's annual NHCDC submission. This may include:

• impact of COVID-19 on the 2021-22 submission

 other significant factors and challenges that impacted the 2021-22 NHCDC submission.

There were no significant changes to the costing guidelines for COVID-19 between Round 25 and Round 26.

COVID-19 related expense that is attributable to patient care directly or indirectly was allocated to relevant encounters. Examples could include front door screening, increased infection control related expenditure, additional cleaning related expense and transport. Cost was included irrespective of the funding source to ensure total cost of operations was reflected.

#### 5. NHCDC Declaration

All data provided by NSW Health to the 2021-22 NHCDC has been prepared in accordance with the Independent Health and Aged Care Pricing Authority Three-Year Data Plan 2021-22 to 2023-24, Data Compliance Policy June 2021, and version 4.1 of the AHPCS. Best endeavours were taken to ensure complete and factual reporting and compliance. Data provided in this submission has been reviewed for adherence to version 4.1 of the AHPCS and is complete and free of known material errors.

Assurance is given that to the best of my knowledge, data provided are suitable to be used for the primary purpose of the NHCDC, which includes development of the National Efficient Price.

26/6/24

Susan Pearce AM

Secretary, NSW Health