Clinical Excellence Division

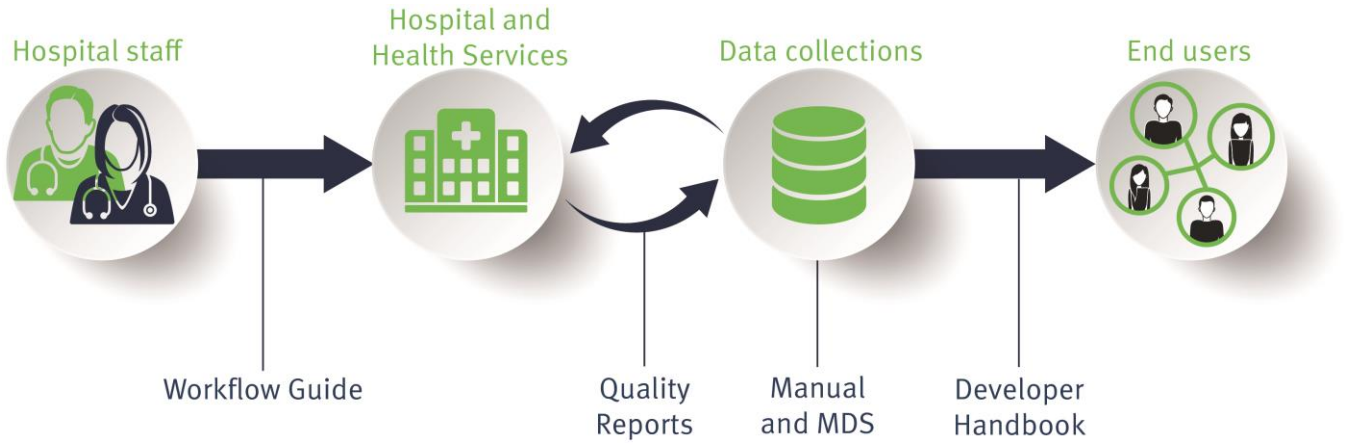
Supporting document 2

Information management framework

Improvement | Transparency | Patient Safety | Clinician Leadership | Innovation

Through the HIU Data Collections Project, an information management framework was developed to establish formal governance, standardised corporate data and a transparent process from data entry, collection and storage through to processing and output. The framework included a number of technical and customer focused artefacts to build a consistent information maturity foundation across each service delivery area.

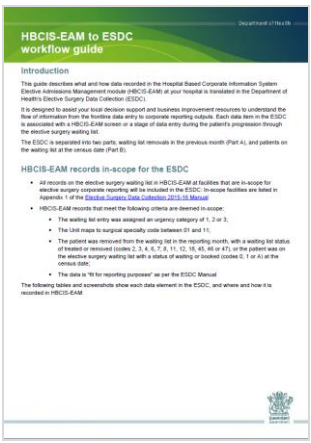
This overview provides further information on the four types of customer focused artefacts used in the framework, what each provide to the customer, and their place in the flow of information around the system. This is shown in the diagram below:

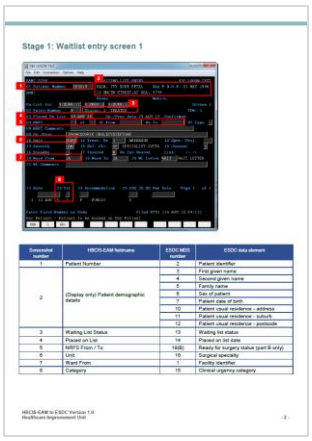


Workflow Guide

To minimise the burden on hospital staff providing data to the collections, information from clinical applications is automatically sourced where possible. The purpose of the Workflow Guide is to show how information entered into the application in the hospital is collected and transformed. This provides the customer with an understanding of how information gets from their actions in the system, to the formal data collection. Importantly, the Workflow Guide follows the steps undertaken by the customer when registering, reviewing, and treating the patient so as to best match their workflow.

On the next page is shown a Workflow Guide for users of the HBCIS system when entering elective surgery patients:

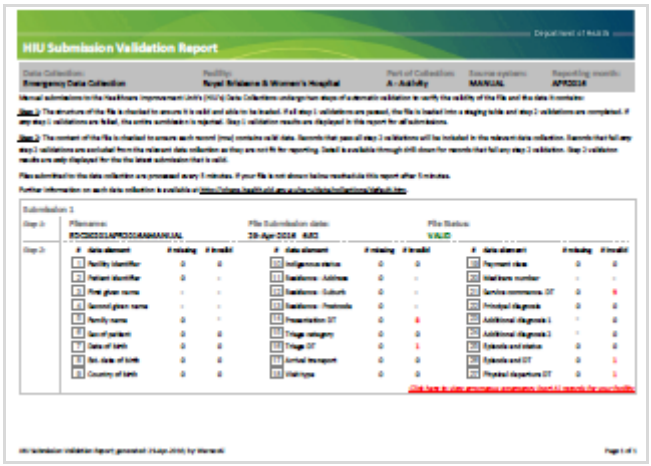


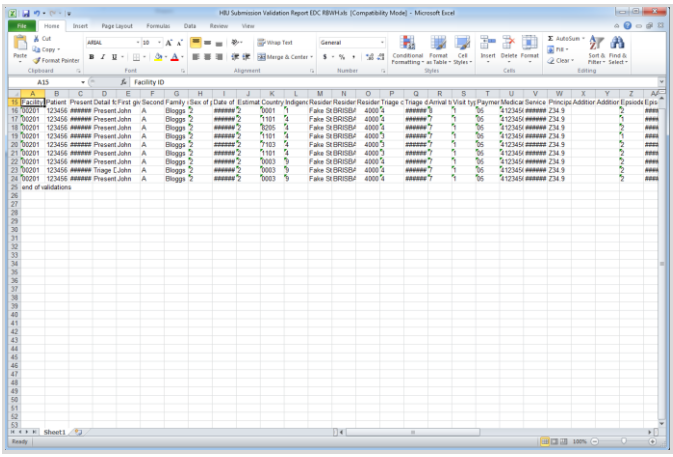


Quality reports

The feedback loop comparing the quality of the data entered in the hospital setting against the statewide quality standard is an important step in the creation of rich and valuable information. For this reason, a suite of quality reports were developed in the Project to provide customers with a mechanism to validate patient records. Additionally, a benefit to the customer is that the reports can be accessed at any time – reviewing the quality close to the time of the patient registration makes it easier for corrections to be made.

Below is a quality report which provides both a summary of the patient records that do not meet the quality standard, as well as a detailed view of the records that require attention:



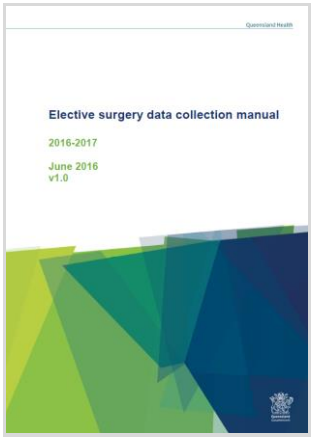


Data Collection Manual and Minimum Data Set

At the heart of the framework are the information standards that set out a statewide approach to the collection of information in each service delivery area. The information standards define the concepts, codes and terms in each area, incorporating best practice approach used both in Queensland and nationally. The standards have been developed considering the ability for hospitals to provide information, and the needs of customers performing service planning, funding and research, to allow for a single high quality statewide dataset to be established.

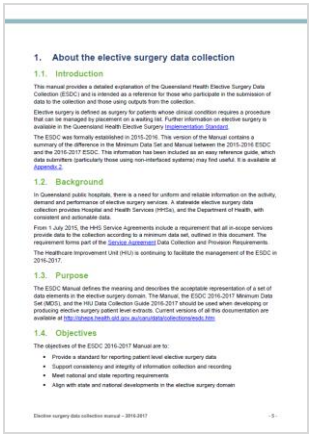
In practice, this is achieved through two artefacts; a Manual and Minimum Data Set (MDS).

The Manual provides a detailed view of the information standards, describing the purposes, objectives, uses and benefits of the information, scope, unit of count and special concepts included in each collection, and detailed information on each data standard including the definition, acceptable values and a guide to their use in practice. The detail and rigour in describing each element provides clarity to both customers in the hospital and customers of the end result. Below are excerpts from the Elective Surgery Data Collection Manual:


Elective surgery data collection manual

2016-2017

June 2016
v1.0

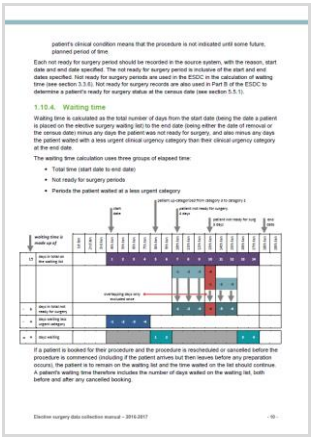

1. About the elective surgery data collection

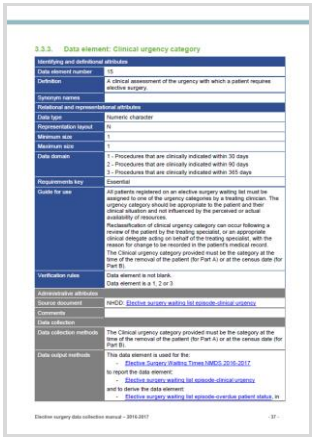
1.1. Introduction

1.2. Background

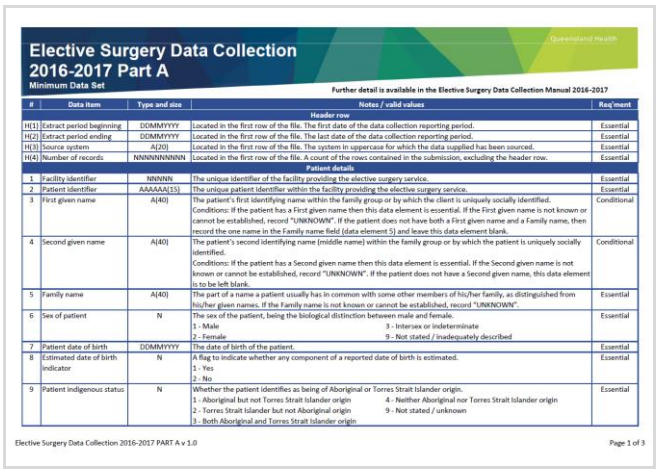
1.3. Purpose

1.4. Objectives


1.10.4. Waiting time


3.3.3. Data element: Clinical urgency category

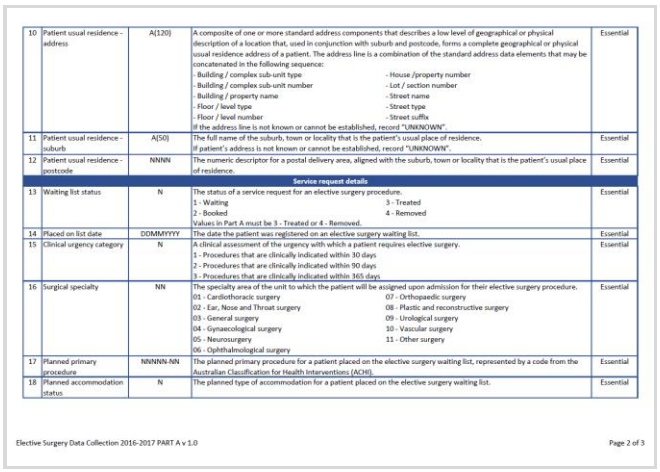
The MDS provides a cut down view of the information standards, designed for a technical resource. Below is the Elective Surgery Data Collection MDS:


Elective Surgery Data Collection
2016-2017 Part A
Minimum Data Set

Further detail is available in the Elective Surgery Data Collection Manual 2016-2017

#	Data Item	Type and size	Notes / valid values	Req'ment
			Header row	
H(1)	Extract period beginning	DDMMYYYY	Located in the first row of the file. The first date of the data collection reporting period.	Essential
H(2)	Extract period ending	DDMMYYYY	Located in the first row of the file. The last date of the data collection reporting period.	Essential
H(3)	Source system	A(20)	Located in the first row of the file. The system in uppercase for which the data supplied has been sourced.	Essential
H(4)	Number of records	NNNNNNNNNN	Located in the first row of the file. A count of the rows contained in the submission, excluding the header row.	Essential
			Patient details	
1	Facility Identifier	NNNNN	The unique identifier of the facility providing the elective surgery service.	Essential
2	Patient Identifier	AAAAAA(15)	The unique patient identifier within the facility providing the elective surgery service.	Essential
3	First given name	A(40)	The patient's first identifying name within the family group or by which the client is uniquely socially identified. Conditions: If the patient has a First given name then this data element is essential. If the First given name is not known or cannot be established, record "UNKNOWN". If the patient does not have both a First given name and a Family name, then record the one name in the Family name field (data element 5) and leave this data element blank.	Conditional
4	Second given name	A(40)	The patient's second identifying name (middle name) within the family group or by which the patient is uniquely socially identified. Conditions: If the patient has a Second given name then this data element is essential. If the Second given name is not known or cannot be established, record "UNKNOWN". If the patient does not have a Second given name, this data element is to be left blank.	Conditional
5	Family name	A(40)	The part of a name a patient usually has in common with some other members of his/her family, as distinguished from his/her given names. If the Family name is not known or cannot be established, record "UNKNOWN".	Essential
6	Sex of patient	N	The sex of the patient, being the biological distinction between male and female. 1 - Male 2 - Female 3 - Intersex or indeterminate 9 - Not stated / inadequately described	Essential
7	Patient date of birth	DDMMYYYY	The date of birth of the patient.	Essential
8	Estimated date of birth indicator	N	A flag to indicate whether any component of a reported date of birth is estimated. 1 - Yes 2 - No	Essential
9	Patient indigenous status	N	Whether the patient identifies as being of Aboriginal or Torres Strait Islander origin. 1 - Aboriginal but not Torres Strait Islander origin 2 - Torres Strait Islander but not Aboriginal origin 3 - Both Aboriginal and Torres Strait Islander origin 4 - Neither Aboriginal nor Torres Strait Islander origin 9 - Not stated / unknown	Essential

Elective Surgery Data Collection 2016-2017 PART A v 1.0 — Page 1 of 3


10	Patient usual residence - address	A(120)	A composite of one or more standard address components that describes a low level of geographical or physical description of a location that, used in conjunction with suburb and postcode, forms a complete geographical or physical usual residence address of a patient. The address line is a combination of the standard address data elements that may be concatenated in the following sequence: - Building / complex sub-unit type - House /property number - Building / complex sub-unit number - Lot / section number - Building / property name - Street name - Floor / level type - Street type - Floor / level number - Street suffix If the address line is not known or cannot be established, record "UNKNOWN"	Essential
11	Patient usual residence - suburb	A(50)	The full name of the suburb, town or locality that is the patient's usual place of residence. If patient's address is not known or cannot be established, record "UNKNOWN".	Essential
12	Patient usual residence - postcode	NNNN	The numeric descriptor for a postal delivery area, aligned with the suburb, town or locality that is the patient's usual place of residence.	Essential
			Service request details	
13	Waiting list status	N	The status of a service request for an elective surgery procedure. 1 - Waiting 2 - Booked 3 - Treated 4 - Removed Values in Part A must be 3 - Treated or 4 - Removed.	Essential
14	Placed on list date	DDMMYYYY	The date the patient was registered on an elective surgery waiting list.	Essential
15	Clinical urgency category	N	A clinical assessment of the urgency with which a patient requires elective surgery. 1 - Procedures that are clinically indicated within 30 days 2 - Procedures that are clinically indicated within 90 days 3 - Procedures that are clinically indicated within 365 days	Essential
16	Surgical specialty	NN	The specialty area of the unit to which the patient will be assigned upon admission for their elective surgery procedure. 01 - Cardiothoracic surgery 02 - Ear, Nose and Throat surgery 03 - General surgery 04 - Gynaecological surgery 05 - Neurosurgery 06 - Ophthalmological surgery 07 - Orthopaedic surgery 08 - Plastic and reconstructive surgery 09 - Urological surgery 10 - Vascular surgery 11 - Other surgery	Essential
17	Planned primary procedure	NNNNN-NN	The planned primary procedure for a patient placed on the elective surgery waiting list, represented by a code from the Australian Classification for Health Interventions (ACHI).	Essential
18	Planned accommodation status	N	The planned type of accommodation for a patient placed on the elective surgery waiting list.	Essential

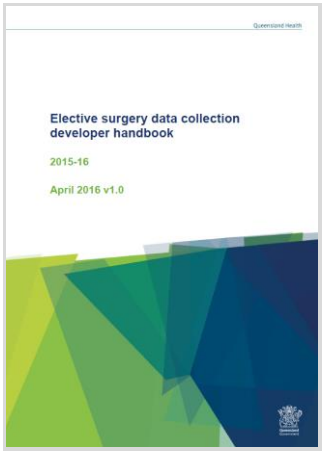
Elective Surgery Data Collection 2016-2017 PART A v 1.0 — Page 2 of 3

Developer Handbook

The final stage of our framework is the method in which the compiled, cleansed and enriched data is made available to reporting customers. After collection, the statewide data is refined and value added through the calculation and flagging of key metrics and measures pertaining to the service delivery area. The information is then provided to users directly and through each Queensland Health enterprise reporting platform, using both user level security, as well as patient identifiable and patient de-identified access. This ensures each customer can access the appropriate information in the format best suited to their needs.

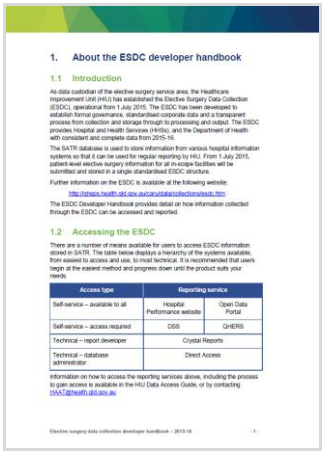
To support this access a Developer Handbook is provided to each user when granted access to the information. The Developer Handbook is a technical resource, detailing the reporting objects available, derived and calculated fields and flags, and reference datasets for coded fields. Clarity in the methods of calculating measures reinforces consistency in reporting, and reduces the chance of reporting error during use.

Below are excerpts from the Elective Surgery Data Collection Developer Handbook:


Elective surgery data collection developer handbook

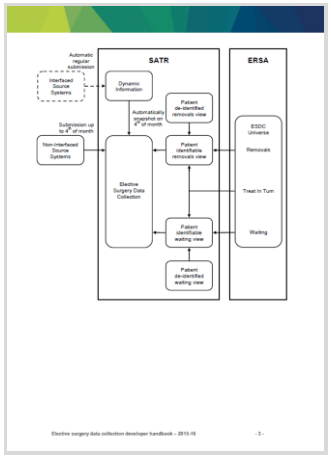
2015-16

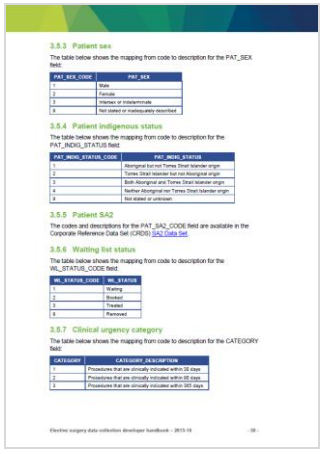
April 2016 v1.0


1. About the ESDC developer handbook

1.1 Introduction

1.2 Accessing the ESDC




3.5.3 Patient sex

3.5.4 Patient indigenous status

3.5.5 Patient SA2

3.5.6 Waiting list status

3.5.7 Clinical urgency category