NSW Health

Ref: HA25-3395

Professor Michael Pervan
Chief Executive Officer
Independent Health and Aged Care Pricing Authority
Via email: secretariat@ihacpa.gov.au

**NSW Data Quality Statement for National Hospital Cost Data Collection (NHCDC) 2023-24 (Round 28)**

Dear Professor Pervan,

Please find enclosed the NSW Data Quality Statement (DQS) for the National Hospital Cost Data Collection (NHCDC) 2023-24 (Round 28) and the signed declaration. NHCDC data has been prepared in adherence with V4.2 of the Australian Hospital Patient Costing Standards, and is complete and free of any known material issues.

If you require more information please contact Kylie Hawkins, Manager Clinical Cost Data Collections and Standards at kylie.hawkins2@health.nsw.gov.au

Yours sincerely

**Susan Pearce AM**
Secretary, NSW Health

Encl. NSW Data Quality Statement – 2023-24 National Hospital Cost Data Collection (NHCDC)

## Data Quality Statement

**National Hospital Cost Data Collection 2023-24**

**Instructions**

Jurisdictions are required to address all sections in this National Hospital Cost Data Collection (NHCDC) 2023-24 Data Quality Statement template that must be signed by their respective health department secretary or equivalent to secretariatihacpa@ihacpa.gov.au.

### 1. Governance processes

Provide details across the following areas, where jurisdictions cannot provide more detail, they should indicate as such. Points below are a guide to support commentary on the governance processes used by jurisdictions:

*1.1 Structure of Local Health Networks (LHN)/Hospitals and Health Services*

*1.2 Costing process guidelines, including the use of relative value units*

*1.3 Costing and activity reporting processes and methodologies*

*1.4 Consistency of costing practices across the jurisdiction*

*1.5 Contracted care arrangements across jurisdictions or LHNs/Hospitals*

*1.6 Any changes in the above governance processes from the previous year*

The Round 28 (2023-24) National Hospital Cost Data Collection (NHCDC) is based on the NSW Health District and Network Return (DNR). The DNR is prepared and submitted by the Local Health Districts/Specialty Health Networks (LHDs/SHNs) to the Clinical Cost Data Collections and Standards Team, System Financial Performance. Financial results are published and audited at LHD/SHN level, not at hospital level. There were no changes to the structure of districts/networks between Round 27 and Round 28.

Costing is undertaken by LHDs/SHNs in a consistent and standardised manner, with any changes to activity recording or costing practices communicated to LHD/SHN Costing Teams via the Costing Standards User Group which meets regularly.

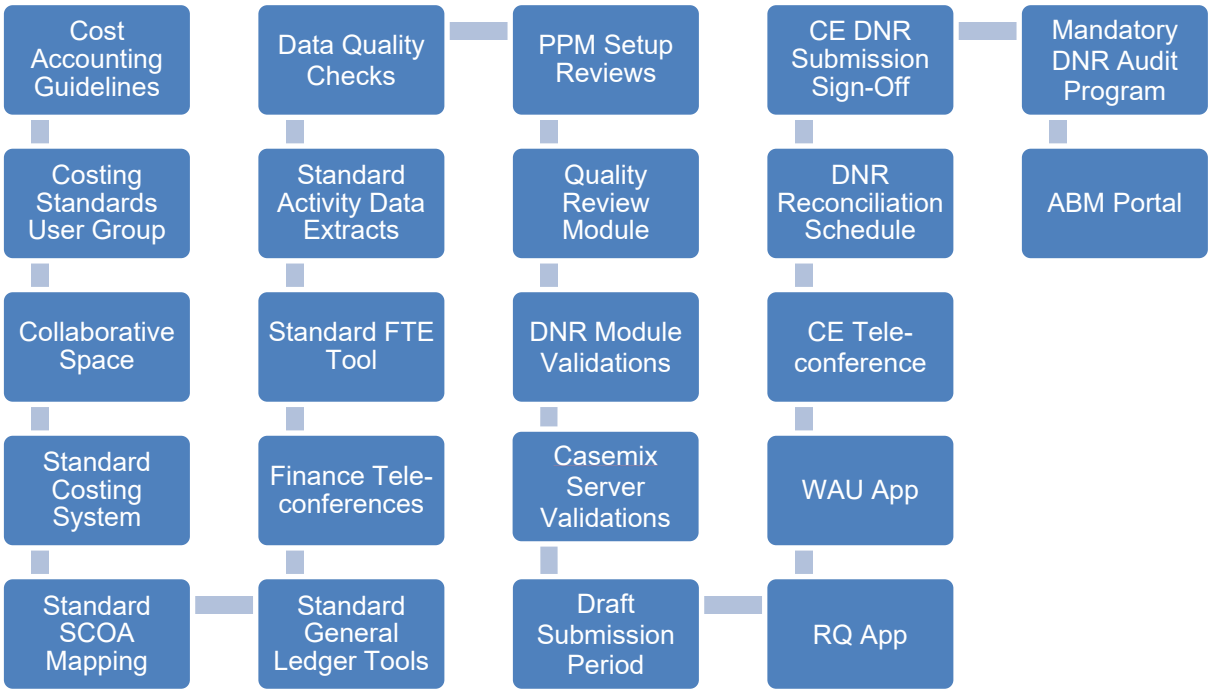
Costing Teams in LHDs/SHNs adhere to the Cost Accounting Guidelines (CAG), which is a series of documents that provide advice and guidelines on costing set-up, methodologies and quality assessments related to the DNR submission. The CAG complies with the Australian Hospital Patient Costing Standards (AHPCS) and is updated regularly to reflect any changes to costing practices within NSW. Volume 2 of the CAG reflects the AHPCS along with NSW specific business rules. Volume 3 reflects technical specifications and provides practical and technical advice on specific areas such as costing system set-ups, standardised allocation methodologies and data extract specifications.

The NSW DNR process contains many areas where quality checks are completed. This includes a DNR module to identify and resolve quality issues prior to the submission of final results. There is a draft DNR period where LHDs/SHNs are able to submit their DNR and have results validated and reviewed. Quality issues can be investigated and fixed, and LHDs/SHNs are then able to resubmit their DNR. LHDs/SHNs are able to submit multiple times during the DNR submission period. NSW provides a number of Applications (Apps) to assist LHDs/SHNs to review their DNR submissions. These include the WAU App, Percentile App (99$^{th}$ and 1$^{st}$) and the Reasonableness and Quality App (RQ

App). These apps are updated daily during the DNR submission period to reflect submissions received the afternoon prior. This ensures LHDs/SHNs have the most up to date data to review reflecting their most recent submission. In R28 there was an additional quality assessment provided to LHD/SHNs within the costing software. This new quality module is specific to NSW and incorporated into the new costing system as added functionality.

The final DNR submissions are approved by the LHD/SHN chief executive (CE) at the time of final submission. A reconciliation is provided by LHDs/SHNs at the time of CE sign off.

Figure 1 District and Network Return Quality Assurance Program




In R28 NSW implemented a new costing system, which was used to complete the R28 (2023/24) DNR and NHCDC submissions. The implementation of this new system provided NSW opportunities to review and refine current costing processes. There was a focus on increasing the opportunities for automation of source data extraction/ transformation and standardisation across LHDs/SHNs. The cost transformation program incorporating the new costing system allowed NSW to identify areas of the costing process where further value could be added by either reducing manual effort of costing practitioners, increasing access by all LHDs/SHNs to additional data sources to assist in the costing process and adding further value to our existing data reconciliation and analysis processes. The implementation project continues into R29.

For contracted care in NSW, including deferred care, the amount applied was the amount negotiated with individual private hospitals and charged at the encounter level for outsourced services. This expense is reported using the goods and services line item. Splitting the goods and services line item into individual line items has not been deemed feasible given the volume of contracted care within NSW. This is consistent with our approach for line items used for Statewide shared corporate and clinical services.

## 2. NHCDC 2023-24 result summary

Provide a summary of the NHCDC 2023-24 results compared to the NHCDC 2022-23 results. Points below are a guide to support commentary on the governance processes used by jurisdictions:

*2.1 Number of hospitals/facilities submitted*

*2.2 Number of records and costs submitted*

*2.3 Factors influencing submission*

- Cost and records exclusions
- Facilities excluded

*2.4 Key changes from NHCDC 2023-24 to NHCDC 2022-23*

**2023/24 R28**

| Hospitals submitted | Total Cost C records submitted | Total NHCDC costs submitted |
|---|---|---|
| 145 | 15,799,128 | $21,555,178,044 |

*includes UNQbabies
**3494 Unqualified babies excluded, totalling cost of $743413

**2022/23 R27**

| Hospitals submitted | Total Cost C records submitted | Total NHCDC costs submitted |
|---|---|---|
| 153 | 15,023,077 | $20,195,523,802 |

*includes UNQbabies

The NSW 2023-24 NHCDC includes LHD/SHN ABF Facilities. It also includes all Ambulatory Mental Health which is submitted under LHN199.

Post submission of NHCDC, it was identified that LHN104 included 'duplicates'. These were not originally identified in the Duplicates validation as they had a unique combination of duplicate 'EpiNo' but different EstabIDs. The impacted EstabIDs were 1174D2240 Westmead Hospital and 1174D2030 Blacktown Hospital.
These duplicates totalled 46 service events from the Non-admitted stream, all under Tier 2 10.18 Enteral Nutrition – Home Delivered.
NSW advised IHACPA these duplicate service events should be excluded from the NHCDC submission.
A total cost of $30,042 (linked cost $22,303) was excluded. This equated to 46 service events (23 linked service events) being excluded.

In Round 27 NSW requested that Illawarra Shoalhaven LHD (LHN 108) NHCDC submitted records be excluded from NEP determinations. This LHN has been submitted in Round 28 and should now be included once again.

NSW has undertaken a program to review and improve the costing of critical care services in R28. We note that many critical care services in NSW hospitals have critical care and step-down beds in the one ward. An example of this is an Intensive Care Unit (ICU)/High Dependency Unit (HDU) ward. Typically, these services have one cost centre and one ward set up in the Patient Administration System, with two or more bed types to

distinguish the ICU hours/bed days separately from the HDU hours/bed days. In these wards, the bed type is used to calculate ICU hours and to allocate ICU cost separately from HDU hour calculations and cost allocation.

The final cost allocation reflects appropriate costs for ICU and HDU patients. Additionally, only facilities with Level 3 ICUs map their cost centre to critical care, even though locally they may use the ICU bed type.

NSW has worked to refine ICU costing methodology and guidelines in R28, including working with the costing system vendor to separately report the ICU and the HDU expense in areas where they are combined in one cost centre/ward.

## 3. Compliance to the Australian Hospital Patient Costing Standards (AHPCS) Version 4.2

Provide confirmation that your jurisdiction has complied with the AHPCS Version 4.2 at the LHN and jurisdictional levels, specifying if any exceptions to the standards have been applied and an explanation for each. Points below are a guide to support commentary on the governance processes used by jurisdictions:

### *3.1 Summarisation of general ledger reconciliation*

| LHN | General Ledger Total | Adjustments to the GL– inclusions | Adjustments to the GL– exclusions | Post allocation adjustment - inclusions | Post allocation adjustment – exclusion | Jurisdictional adjustments | Total costing ledger (NHCDC Cost C) |
|---|---|---|---|---|---|---|---|
| 117 | 1,152,368,362 | 24,260,601 | 0 | 28,331,340 | -279,359,108 | -6,097,834 | 919,503,361 |
| 118 | 655,448,376 | 8,476,898 | 0 | 11,278,265 | -166,730,194 | 0 | 508,473,345 |
| 102 | 2,454,183,599 | 56,547,841 | 0 | 46,317,559 | -613,341,171 | -9,212,601 | 1,934,495,227 |
| 103 | 2,648,125,820 | 78,714,141 | 0 | 44,510,493 | -460,187,280 | -9,323,301 | 2,301,839,873 |
| 101 | 2,378,435,957 | 61,896,394 | 0 | 42,299,039 | -435,543,617 | -11,245,775 | 2,035,841,998 |
| 108 | 1,307,011,854 | 34,081,404 | 0 | 11,682,390 | -212,361,291 | -4,918,708 | 1,135,495,649 |
| 104 | 2,555,710,752 | 66,613,812 | 0 | 50,655,522 | -569,269,665 | -9,069,672 | 2,094,640,749 |
| 105 | 1,211,308,987 | 31,400,696 | -81,000 | 19,636,706 | -296,009,215 | -4,229,768 | 962,026,406 |
| 106 | 2,248,584,491 | 49,066,388 | 0 | 47,700,962 | -725,903,899 | -7,917,091 | 1,611,530,851 |
| 107 | 1,136,480,065 | 29,145,565 | -595,916 | 9,999,652 | -174,458,847 | -5,183,876 | 995,386,643 |
| 109 | 3,065,902,313 | 274,210,629 | -207,892,137 | 60,031,448 | -721,102,428 | -14,241,555 | 2,456,908,270 |
| 111 | 1,237,223,644 | 31,912,958 | 0 | 16,449,394 | -242,929,177 | -3,737,313 | 1,038,919,506 |
| 110 | 930,901,000 | 26,743,798 | -1,116 | 9,930,208 | -193,183,125 | -2,738,766 | 771,651,999 |
| 113 | 621,302,641 | 18,344,305 | 0 | 6,798,822 | -152,004,364 | -1,927,680 | 492,513,724 |
| 114 | 909,253,671 | 24,117,118 | 0 | 25,701,806 | -407,074,705 | -3,377,846 | 548,620,044 |
| 112 | 1,283,979,718 | 32,870,490 | 0 | 38,865,809 | -528,996,083 | -5,332,811 | 821,387,123 |
| 115 | 167,135,766 | 1,920,172 | 0 | 2,690,257 | -54,215,151 | -419,462 | 117,111,582 |
| 199 | | | 0 | | 0 | | 808,831,696 |
| | 26,303,454,574 | 854,714,023 | -208,570,169 | 489,869,603 | -6,592,500,810 | -100,620,871 | 21,555,178,046 |

Please note in the General Ledger reconciliation provided above, LHN199 is community mental health for all LHNs. This amount is therefore already included in the LHN general ledger total. This amount is removed from the LHN line and added to the LHN199 line under NHCDC Cost C total.

### *3.2 Compliance or deviations to the AHPCS Version 4.2*

Jurisdictions should articulate exceptions, deviations or partial compliance with AHPCS Version 4.2. Areas to consider by jurisdictions include:

- Stages 1: Have all relevant expenses been identified and included in the NHCDC submission? How is accuracy and completeness of the collected cost data ensured?
- Stage 2: What validation checks are performed? How are discrepancies in data addressed and resolved?
- Stage 3: What methods are used for cost allocation?
- Stage 4: Have all establishment activity been identified and included in the costing process? What activities, if any, were excluded in the costing process?
- Stage 5: How have costs been allocated to patients?
- Stage 6: What is the process for reconciling cost and activity data?

Guidelines for preparing and submitting the DNR are published in the CAG, which aligns to the AHPCS. Costing practitioners across NSW adhere to the CAG. Compliance to the AHPCS has been unchanged from R27. NSW Health is partially compliant with the following standards and explanations are noted below.

- Standard 1.2 – Identify Relevant Expenses – Third Party Expenses: There is pathology expense for private and compensable patients that are held centrally and are not included in DNR cost ledgers. This would not impact NEP determinations as the expense is excluded.
- Standard 2.2 – Create the Cost Ledger – Matching Cost Objects and Expenses: The range and extent of service data improves with each DNR submission with LHDs/SHNs adding new service files or refining linking rules . The implementation of the new costing system in NSW currently provides LHDs/SHNs an opportunity to further enhance and refine service data and linking rules. LHDs/SHNs all have the required statewide intermediate products at service level to cost to patients. The improvement in service level feeders relates to localised and/or specialised feeders at LHD/SHN level, or new systems that are coming onboard within NSW at a statewide level that can be leveraged from a costing perspective.

  Costs associated with the Newborn and Paediatric Emergency Transport Service (NETS) reflect actual transport costs and exclude and pre- or post-transport clinical consultation, assessment, stabilisation or handover related costs. The cost associated with NETS consultations which do not result in patient transport are not included. NSW is working toward providing the full cost of NETS in the NHCDC.

**4. Other relevant information**

Please include other information relevant to the 2023-24 NHCDC submission, which may include significant factors and challenges that impacted the NHCDC submission 2023-24.

NSW's NHCDC Submission for R28 was impacted by the transition of our activity Data Warehouse, which resulted in a delay in our submission to IHACPA. This transition whilst significantly impacting the timing of the DNR submission, also required significant work from NSW Costing Team to ensure new variables, updated variables and updated data loads were incorporated into our submission. NSW concurrently implemented a new costing system for the R28 submission. Both of these projects required review and update of costing methodologies for the completion of the DNR.

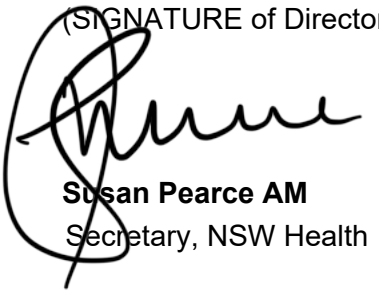
***5.*** **NHCDC declaration – please ensure the below declaration is included*.***

All data provided by (Add Jurisdiction) to the 2023-24 NHCDC has been prepared in accordance with the IHACPA's Three Year Data Plan 2024-25 to 2026-27, Data Compliance Policy June 2023, and the AHPCS Version 4.2.

Best endeavours were undertaken to ensure complete and factual reporting and compliance. Data provided in this submission has been reviewed for adherence to the AHPCS Version 4.2 and is complete and free of known material errors.

Assurance is given that to the best of my knowledge the data provided are suitable to be used for the primary purpose of the NHCDC, which includes the development of the national efficient price

(SIGNATURE of Director General/Chief Executive/Secretary)



**Susan Pearce AM**
Secretary, NSW Health