



ACCHS DATA IN ACCHS HANDS

AH&MRC HEALTH DATA WORKSHOP
19TH FEBRUARY 2013

*FINAL
REPORT*

ACKNOWLEDGEMENTS:

We gratefully acknowledge the contributions made by each of the ACCHS delegates who attended the AH&MRC Health Data Workshop in February. Your participation and feedback has provided essential information and views to help direct the development of ACCHS health data indicators in the future.

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Funding for the AH&MRC CQI Program is provided by NSW Health.

AH&MRC CQI PROGRAM

The AH&MRC CQI Program objectives are to:

1. Build ACCHSs infrastructure, skills, good practice and effective systems for data collection, management and use
2. Support ACCHSs to build sustainable and effective continuous quality improvement systems with a focus on chronic disease prevention and management
3. Document, promote and share models of good practice in data management and clinical quality improvement in an Aboriginal primary health care context

Through its CQI Program, the AH&MRC has been providing support to member ACCHSs on Patient Information Management Systems (PIMS) and the use of data extraction tools, as well as on CQI processes through site visits, up-skilling workshops, the development and dissemination of tools and resources, and a range of other activities.

Quality indicators and data governance in a NSW ACCHS context have been identified as key areas of interest for member ACCHSs, and the AH&MRC is exploring these issues through conducting reviews of relevant literature, and engaging in discussion and information sharing with other affiliates.

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ABBREVIATIONS:

ACCHS	Aboriginal Community Controlled Health Service
AH&MRC	Aboriginal Health and Medical Research Council
AMSANT	Aboriginal Medical Services Alliance Northern Territory
AIHW	Australian Institute of Health and Welfare
CQI	Continuous Quality Improvement
DoHA	Department of Health and Ageing
NACCHO	National Aboriginal Community Controlled Health Organisation
NKPIs	National Key Performance Indicators
NTAH	Northern Territory Aboriginal Health
NT AHKPI	Northern Territory Aboriginal Health Key Performance Indicator
OATSIH	Office of Aboriginal and Torres Strait Islander Health
OCHREStreams	Online Community Health Reporting Environment
OSR	Online Service Report
Pen CAT	Pen Computer Systems, Clinical Audit Tool
PIMS	Patient Information Management System
QAIHC	Queensland Aboriginal and Islander Health Council
RACGP	Royal Australian College of General Practitioners

CONTENTS:

Introduction	4
Background	4
The Workshop- Objectives, structure and evaluation	6
Key Discussion Points:	7
1. Purposes and objectives that could be achieved using ACCHS data	7
2. Advantages of sharing data with other ACCHS	8
3. Indicators for use by NSW ACCHS	8
4. The possibility of having a data repository for NSW ACCHS data	9
5. Data governance and sharing ACCHS data with external organisations	9
6. AH&MRC roles relating to data issues	10
Conclusions	10
Appendix 1: Member ACCHS attending workshop	11
Appendix 2: Workshop Agenda	12
Appendix 3: Supporting Information	13
Appendix 4: Workshop Evaluation Survey	18
References	19

WORKSHOP REPORT

INTRODUCTION:

The Aboriginal Health & Medical Research Council (AH&MRC), through its Continuous Quality Improvement (CQI) Program, has been investigating primary health care indicators and data governance protocols, relevant and appropriate to the needs and interests of NSW Aboriginal Community Controlled Health Services (ACCHSs) and the Aboriginal communities they serve. As part of this work, the AH&MRC convened a workshop – entitled ‘ACCHS Data in ACCHS Hands’ – on 19th February 2013 for member ACCHSs and invited guests. The aim of the workshop was to provide a forum for discussion about the different ways in which ACCHS health data are defined, collated, used and governed, currently and into the future.

This report is a collation of:

- background information, that was provided to workshop participants;
- a report about the workshop; and
- key points from discussions that occurred at the workshop.

The data workshop, and the information contained in this report, will inform the ways in which the AH&MRC will continue to support member services through its CQI program and related data management activities.

BACKGROUND:

All ACCHSs generate and use data in their day-to-day business, including information about individual clients that is entered and stored in various Patient Information Management Systems (PIMS). Tools (such as Pen CAT) that enable data extraction from PIMS to occur easily are now commonplace, and are being used increasingly by ACCHSs. Over recent years, there has been an increasing trend for de-identified ACCHS data from PIMS to be extracted and collated, and used for a range of purposes including reporting to funding agencies, local and regional quality improvement activities, program and service planning and evaluation, and research.

There are a range of indicators available in primary health care that act as monitoring, evaluation and information tools (Kwedza, 2009). However, NSW ACCHSs have not had the opportunity to review, explore and agree on indicators that could be useful for quality improvement in the NSW ACCHSs context or other purposes.

In Queensland and the Northern Territory, ACCHSs and their Affiliates have developed agreed indicator sets, data governance arrangements, and technical and support

infrastructure, to enable member ACCHS data to be collated, shared and used at the State level, thereby enhancing the potential for ACCHS data to be used for quality improvement and other ACCHS-defined purposes.

Nationally, the Department of Health and Aging (DOHA) is currently moving towards requiring all Office for Aboriginal and Torres Strait Islander Health (OATSIH) funded services including ACCHSs to report on a national set of Key Performance Indicators (NKPIs) as a condition of funding. The NKPI data items are extracted by ACCHSs from their PIMS systems, and the OCHREStreams web-based reporting tool has been developed by the Improvement Foundation under contract to DOHA to support the submission of both NKPI and Online Service Report (OSR) data. The Australian Institute for Health and Welfare (AIHW) has been analysing and reporting on OSR data for some years now, and will also be analysing and reporting on NKPI data.

NACCHO and Affiliates have repeatedly expressed concerns to DOHA about the lack of meaningful involvement of the Aboriginal community controlled health sector in the development of the NKPIs, and about the need for adequate governance arrangements for Aboriginal community control of ACCHS data, including the reports arising from them. Advocacy efforts in this area are ongoing.

OCHREStreams has been designed to provide an option for ACCHSs to give permission for NKPI and OSR data reports to be shared with Affiliates; whether and how this approach could work in practice has not yet been explored in a NSW context.

Additionally, NSW Health has previously expressed interest in developing agreed Aboriginal health indicators in specific priority areas such as chronic disease, and in exploring possibilities and issues relating to ACCHS data sharing. ACCHS data could also potentially contribute to the planning and evaluation of NSW Health Aboriginal health programs and policies, and to the population planning and evaluation being conducted by Medicare Locals.

Overall, many ACCHSs currently work collaboratively with research organisations to design and implement research. These collaborations often include agreements to share ACCHS data for defined research objectives. Data governance arrangements are typically the subject of formal agreements between ACCHSs and researchers, and ACCHS ownership and control of ACCHS data is a key criteria used by the AH&MRC Ethics Committee in their review and assessment of Aboriginal health research proposals.

There are well established policies that describe the principles of ACCHS ownership and control of ACCHS data, including the NACCHO Data Protocols (National Aboriginal Community Controlled Health Organisation, 1997), NSW Aboriginal Health Information Guidelines (NSW Aboriginal Health Partnership, 1998), and AH&MRC Ethics Committee Guidelines (Aboriginal Health and Medical Research Council of New South Wales, 2009).

However, establishing and sustaining the structures and processes required to support the recognition and practical application of these principles remains an ongoing challenge.

THE WORKSHOP: OBJECTIVES, STRUCTURE AND EVALUATION

The AH&MRC Health Data Workshop was held in Sydney on 19 February 2013. All AH&MRC member ACCHSs were invited to participate in the workshop: 18 delegates from 14 member services attended (listed in Appendix 1). A further 14 member services signaled interest in attending the workshop during the 'expression of interest' process but were unable to attend on the day.

Workshop objectives were to:

- Identify and discuss current opportunities and challenges for ACCHSs to share ACCHS data within the ACCHS sector, and with external agencies including funding, government and research
- Agree on principles and processes for developing one or more indicator sets for NSW ACCHSs
- Affirm existing ACCHS data governance and ethical principles, and consider how they can best be put into practice when sharing ACCHS data in the current environment
- Explore the option of the AH&MRC hosting a NSW ACCHS data repository in the future, and identify any design and implementation requirements

An information paper was circulated to registrants before the workshop, and included the above background information, the 'Supporting information' in Appendix 3, and an outline of workshop aims and objectives, and planned key discussion points.

Workshop sessions included:

- **Presentations** from the Queensland Aboriginal and Islander Health Council (QAIHC) and the Aboriginal Medical Services Alliance Northern Territory (AMSANT) that enabled delegates to hear at first hand the experiences of indicator and data work in other states. A facilitated **Question and Answer** session followed
- An **Expert Panel** discussion with representatives from organisations and research bodies that have interest in using ACCHS health data for funding, policy and research purposes: The Improvement Foundation; The George Institute for Global Health; and The Kirby Institute. Panel members were asked to consider the interests and challenges that external organisations have in accessing ACCHS data and the opportunities and issues that it creates for the ACCHS sector. This discussion was followed by a facilitated **Question and Answer** session.
- A printed presentation about ethical issues relevant to indicators and data governance from the **AH&MRC Ethics Committee** was distributed to delegates, as a Committee representative was not available to attend the workshop

- An **Afternoon Workshop** exclusively for AH&MRC member service delegates to discuss key opportunities and challenges relating to health indicators, data governance and a data repository within the Aboriginal health sector.

The full workshop program is included in Appendix 2 of this report. Key points of discussion, including views and perspectives of workshop participants were recorded during the workshop by AH&MRC staff and the participants themselves, through large and small group brainstorming and discussions and other workshop activities.

Participants positively evaluated the workshop and details of participant evaluations and feedback is included as Appendix 3 to this report.

KEY DISCUSSION POINTS:

The following summarises the key points of ACCHS delegate views raised at the Health Data Workshop during discussions and workshop activities.

1. Purposes and objectives that could be achieved using ACCHS data

ACCHS delegates were asked to identify different purposes that ACCHS data could be used to achieve. Purposes identified during workshop discussions included:

- increased accountability to the community they represent
- increased ability to understand and respond to the community's needs
- increased ability to monitor, evaluate, manage and improve services
- increased ability to attract funding and quality staff
- increased lobbying power
- to inform internal planning and resource allocation
- to set benchmarks by which to measure achievements

The majority of data uses identified by workshop participants were focused on service and quality improvement. ACCHS participants expressed a higher level of interest in using data for setting service goals and benchmarks to work towards, rather than conducting community based research. However, it was also noted during discussions that many NSW ACCHS were engaged in a range of research projects with external partners, with examples being given of Health Tracker, the Kirby Institute sexual health projects and the Brian Holden Vision Institute eye health projects.

Also regarding research, ACCHS representatives expressed interest in using data for conducting research at the local level, noting that research with a state or national focus was not always useful or applicable at a community level.

2. Advantages of sharing data with other ACCHS

ACCHS delegates clearly described the benefits that could result from ACCHS sharing their data with other ACCHSs. Specific benefits identified by participants included:

- Managing data in-house and sharing and comparing it with other services would provide the potential to identify common issues and develop strategies with other ACCHS
- ACCHS perspectives could be supported by data collated at regional, state and national levels; and
- ACCHS data could significantly improve and inform government's perspectives and decision making about Aboriginal health initiatives.

3. Indicators for use by NSW ACCHS

Workshop attendees heard from QAIHC and AMSANT presenters about the development of indicators for use by the ACCHS sector in Queensland and the Northern Territory. There was support for many of the principles about indicators that had been identified by QAIHC and AMSANT, and for drawing and building on the experiences in these regions for NSW work in this area.

Ethical principles were identified by workshop participants as being critically important to consider when thinking about indicators, as outlined in the AH&MRC Ethics Committee guidelines.

Delegates stressed those indicators for use by NSW ACCHSs should empower Aboriginal communities and reflect their ongoing and emerging health and social needs. The indicators should be easy to understand, and the development process should allow enough time for broad debate, and for fine details to be addressed.

Delegates identified the risk of increasing the ACCHS reporting burden by creating new separate sets of indicators, in addition to those currently being reported against to funding agencies. To avoid this, it was recommended that when developing indicators for use by ACCHSs, existing indicators should be used where possible. It was also stressed that indicators chosen for use by the ACCHS sector need to reflect, and be attributable to, the areas of ACCHS service they are meant to be measuring and improving.

4. The possibility of establishing a data repository for NSW ACCHS data

The idea of an ACCHS-controlled data repository was popular with delegates and seen by them as a 'gold standard' amongst the various ways in which ACCHS could have greater ownership and control of ACCHS data.

Delegates identified that the ACCHS sector being responsible for the analysis and interpretation of ACCHS data would result in all relevant factors, including demographics and social and cultural factors at local and regional levels, being considered and reflected in data interpretations. This was also seen by delegates as having the potential to increase capacity for the ACCHS sector to seek funds, and be accountable for them, as well as to direct those funds and other resources to the most relevant and effective initiatives and programs. Participants were interested in developing a greater understanding of what aggregated ACCHS data looked like, and further exploring the possibilities for its use.

ACCHS delegates expressed the need for funding bodies to provide greater transparency in the intended and actual uses of reported ACCHS data. Concerns were clearly expressed about ACCHS data being held or controlled by Federal or State Governments and related institutions, and about the need for ACCHS control of ACCHS data to be retained.

5. Data governance and sharing ACCHS data with external organisations:

Expert panel speakers from the Improvement Foundation and research organisations, the George Institute for Global Health and the Kirby Institute, provided ACCHS delegates with an external perspective on the ways in which ACCHS health data is, or could be used and the benefits, challenges and risks involved.

During discussions, delegates identified that data governance protocols and data sharing agreements were key factors in ensuring that ACCHSs retain ownership and control over their health data when sharing it with external partners. It was suggested that changes needed to be made to existing partnerships and agreements to ensure that ACCHS objectives are met at all levels of data sharing.

The advantages of appropriately governed, data sharing partnerships with external organisations including researchers were identified as:

- ACCHSs and AH&MRC being able to analyse and interpret ACCHS data while *also* getting an external perspective on it. This could lead to benefits at local/regional levels and drive reforms and agreements at strategic state and national levels.
- ACCHSs working with other organisations could allow greater access to, and expertise in, data management and analysis. This could enhance ACCHS capabilities

by building experience and capacity amongst ACCHS staff in the roles of researchers, data analysts, interpreters etc.

6. AH&MRC roles relating to data issues

Throughout the workshop, ACCHS delegates frequently expressed the needs ACCHSs have for further training, resources and support in the processes of in-house data analysis. It was recognised that some ACCHS are not engaging in data management as much as others. This variance was attributed to a lack of capacity and training in working with their data and, therefore, a limited experience of its potential. Delegates suggested that managing data in-house would help embed this value factor and empower ACCHS to make better decisions and choices for their communities.

Delegates identified several specific functions and support activities for the AH&MRC to support member services in the relevant areas. These included:

- Providing resources, staff support and in-house training to member services in the use of PIMS and data extraction tools (specifically Pen CAT)
- Building skills and capacity for data analysis and quality improvement processes in those services who require it
- Providing support to member services in the process of negotiating data sharing agreements with external organisations requesting access to ACCHS data.

In addition, the AH&MRC was identified as the most suitable host organization for a data repository of NSW ACCHS data. Delegates expressed that the AH&MRC would be best placed to undertake data analyses for member ACCHSs, to provide feed back, and to support quality initiatives based on ACCHSs own data, and it was acknowledged that dedicated staff would be required.

CONCLUSIONS:

The AH&MRC Health Data Workshop provided a forum for AH&MRC and member services, as well as invited guests, to discuss a broad range of issues relating to indicators, data sharing and governance in an ACCHS context. Through its CQI program, the AH&MRC is committed to providing ongoing support to member services in these areas. The key discussion points from the workshop, and the results of future discussions about indicators and data, will inform the ongoing development of the AH&MRC CQI Program and related activities.

APPENDIX 1:

MEMBER ACCHS ATTENDING THE AH&MRC WORKSHOP

Tuesday 19th February 2013, Sydney

1. Biripi Aboriginal Corporation Medical Centre
2. Durri Aboriginal Corporation Medical Service
3. Condolbin Aboriginal Health Service Ltd
4. Albury Wodonga Aboriginal Health Service Ltd
5. Yerin Aboriginal Health Services Incorporation- Eleanor Duncan Aboriginal
6. Riverina Medical & Dental Aboriginal Corporation
7. Armajun Aboriginal Health Service Incorporated
8. Orange Aboriginal Health Service Incorporated
9. Coonamble Aboriginal Health Service Incorporated
10. South Coast Medical Service Aboriginal Corporation
11. Bulgarr Ngaru Medical Aboriginal Corporation
12. Tharawal Aboriginal Corporation
13. Redfern AMS- Aboriginal Medical Service Co-operative Ltd
14. Galambila Aboriginal Health Service Incorporated

APPENDIX 2:

ACCHS DATA IN ACCHS HANDS: WORKSHOP AGENDA

Time	Topic
8.00-9.00	Registrations
9:00 – 9:10am	Welcome to Country
9.10 – 9:20am	Introductions and overview of the day
9:20 – 9:35am	AH&MRC perspective on ACCHS data Ms Sandra Bailey, Chief Executive Officer, AH&MRC
9:35 – 9:45am	AH&MRC Continuous Quality Improvement program and relevant activities Tania Waitokia, Manager, CQI Team, AH&MRC
9:45 – 10:15am	Sharing experiences and stories - Queensland Aboriginal and Islander Health Council: Dr Katie Panaretto, Public Health Medical Officer, Queensland Aboriginal & Islander Health Council
10:15 – 10:45am	Sharing experiences and stories - Aboriginal Medical Services Alliance Northern Territory: Mr Simon Stafford, Manager, eHealth Unit, Aboriginal Medical Services Alliance Northern Territory
10.45pm – 11.00am Morning Tea	
11.00 -12:00 noon	Opportunities and challenges around sharing and accessing data - Panel discussion Mr Colin Frick, Chief Executive Officer, Improvement Foundation Associate Professor David Peiris, Senior Research Fellow Renal & Metabolic The George Institute for Global Health Professor John Kaldor, Epidemiology and NHMRC Senior Principal Research Fellow, Public Health Interventions Research Group, The Kirby Institute
12.00 -12:30 pm	Ethics of data collation, management and sharing Rebecca Hancock, Executive Officer, AH&MRC Ethics Committee
12.30 -12:45 pm	Close of morning workshop and invitation to shared lunch
12:45 – 2:00 Lunch <i>(Please Note: The afternoon workshop is for AH&MRC Member Service Delegates only)</i>	
2.00 -2:30 pm	Highlights and reflection of the morning session
2.30 -3:00 pm	Use of Data
3.00 -3:30 pm	Indicators – Principles and Processes
3.30 -4:00 pm	Data Management
4.00 -4:15 pm	Next Steps
4:15 – 4:30pm Afternoon Tea and Close	

APPENDIX 3:

SUPPORTING INFORMATION

The following information has been sourced from various publications and was provided to workshop participants as background material for the AH&MRC Data Issues workshop. It provides definitions and explanations of the uses and purposes of indicators in primary health care and a summary of data governance principles currently in place in the ACCHS sector across Australia.

Indicators – definitions

Note: The following are definitions of indicators (and sub-categories of indicators such as clinical indicators) that have been sourced from the literature.

- Indicators are succinct measures that aim to describe as much about a system as possible in as few points as possible. Indicators help us understand a system, compare it and improve it (Pencheon D, 2008).
- [About clinical indicators] A measure, process or outcome used to judge a particular clinical situation and indicate whether the care delivered was appropriate (The Royal Australian College of General Practitioners, 2010).
- Clinical indicators are indicators or measures that relate to specific clinical conditions, or measures of function that have particular significance for particular conditions. Clinical indicators are not exact standards; rather, they are designed to be 'flags' which, through the collection and analysis of data, can alert clinicians to possible problems and/or opportunities for improvement in patient care (NSW Health Department, 2001).

Indicators – purpose

Monitoring health care quality is impossible without the use of clinical indicators. They create the basis for quality improvement and prioritization in the health care system. Indicator measurement and monitoring serve many purposes. They make it possible to:

- document the quality of care
- make comparisons (benchmarking) over time between places (e.g. hospitals)
- make judgments and set priorities (e.g. choosing a hospital or surgery, or organizing medical care)
- support accountability, regulation, and accreditation
- support quality improvement
- support patient choice of providers (Mainz, 2003)

Clinical indicators do not 'work' unless used effectively by clinicians and managers to bring about improvements (NSW Health Department, 2001).

NT AHKPI data will contribute to improving Aboriginal health and well being through:

- Increased understanding of Aboriginal health and well-being and services issues amongst communities, providers and government.
- Supporting evidence-based strategic, clinical and operational planning, decision-making and Continual Quality Improvement activities.

Characteristics of a good indicator

There has been no indicator in the history of measurement and improvement is perfect for all purposes (Pencheon D, 2008).

The Queensland Aboriginal and Islander Health Council (QAIHC) put forward the key indicator characteristics that needed to be considered when selecting the indicators as:

- Attributable – critical for both accountability and showing the effectiveness of the services
- Sensitivity – for quality improvement, it is essential that indicators respond fairly rapidly to changes in policy and practice
- Comparability – by being able to compare with other services the effectiveness of the community controlled services can be demonstrated.
- Feasible – indicators that can be reported either with existing systems or with reasonable modifications to existing systems.

The RACGP (The Royal Australian College of General Practitioners, 2012) set of indicators were not designed for performance but chose their initial set of indicators on the basis of:

- Health burdens within Australia
- Health priorities and impact of indicators
- Existing evidence based indicators
- Scope of general practice – recognising the diversity of general practice
- Minimising administrative burdens
- Concordance with current priorities and health burden within Australian primary care
- Equity, evidence, reliability, ease of collection and acceptability
- Taskforce expertise

What makes a strong and measurable indicator?

The NHS Institute for Innovation and Improvement (Pencheon D, 2008) identifies the following as the characteristics that make a strong and measurable indicator.

- Validity - Does the indicator measure what it is supposed to measure?
- Reliability - Does the indicator provide a consistent measure?
- Explicit evidence base – Is the indicator supported by scientific evidence or the consensus of experts?
- Acceptability - Is the indicator acceptable?
- Feasibility - Is it possible to collect the required data and is it worth the resources?
- Sensitivity - Are small changes reflected in the results?
- Specificity - Does the indicator actually capture changes that occur in the service for which the measure is intended?
- Relevance - What useful decisions can be made from the indicator?
- Balance - Do we have a set of indicators that measure different aspects of the service?
- Tested - Have national and international indicators been considered?
- Safe - Will an undue focus on the indicator lead to potential adverse effects on other aspects of quality and safety?
- Avoid duplication - Has consideration been given to other projects or initiatives?
- Timeliness - Is the information available within an acceptable period of time to inform decision-makers?

Table1: Critical questions to ask around data strategy

10 key questions	Answers (examples only)
1. What is being measured?	Levels of diabetes in Aboriginal population
2. Why is it being measured?	It is a serious disease with serious consequences.
3. How is this indicator actually defined?	From recorded levels in general practice
4. Who does it measure?	All persons of Aboriginal background; all ages
5. When does it measure it?	Which day/month/year?
6. Will it measure absolute numbers or proportions?	Proportions: numbers of case per thousand resident population
7. Where does the data actually come from?	Through records of General Practice? PIMS? Other sources depending on the systems reporting capabilities?
8. How accurate and complete will the data be?	Depends on the system's reporting capabilities
9. Are there any warnings or problems?	Potential for errors in collection, collation and interpretation
10. Are particular tests needed such as standardisation, significance tests, or statistical process control to test the meaning of the data and the variation they show?	E.g. when comparing small numbers, in small populations, or to distinguish inherent (common cause) variation,

The following three points are direct excerpts from the organisations policy documents.

1. The Royal Australian College of General Practitioners Key Principles:

- Clinical indicators should be relevant for general practice and the community and should support the enhancement of safety and quality within general practice
- Clinical indicators should relate to processes of care and health outcomes and should be useful in guiding and improving patient care
- Clinical indicators should take account of social variance and social equity
- Clinical indicators should be developed by GPs in order to ensure relevance and application
- Clinical indicators should be evidence based, measurable, reliable, practical to implement, and sensitive to change
- Clinical indicators should provide adequate data to warrant measurement and measure what they purported to measure (RACGP 2010).

2. Northern Territory Aboriginal Health Key Performance Indicator Policy Principles:

NT AHKPI data will contribute to improving Aboriginal health and well being through:

- Increased understanding of Aboriginal health and well-being and services issues amongst communities, providers and government.
- Supporting evidence-based strategic, clinical and operational planning, decision-making and Continual Quality Improvement activities.
- NT AHKPI data will be received, secured, managed and released in strict compliance with national and NT information privacy legislation and standards.
- NT AHKPI data and reports approved for public release, will be aggregated, and will not contain information that will enable the identification of individuals.
- The agreed suite of NT AHKPIs may be expanded or modified to meet emerging information needs, and/or to minimise reporting requirements arising from new national data sets.
- Each service provider has responsibility for ensuring the accuracy, timeliness and integrity of their NT AHKPI data.

- Each service provider, through their designated Community Data Sponsor will be given the opportunity to validate, analyse and comment on draft reports before they are finalised.
- NT AHKPI reports will be prepared in formats that will increase understanding and use by communities, providers and government (NTAH 2010).

3. Queensland Aboriginal and Islander Health Council Guiding Principles:

- Principle 1: The management of health and health-related information about Aboriginal peoples must be ethical, transparent, meaningful and useful to Aboriginal and Torres Strait Islander peoples, based on consistency with the guidelines in the National Aboriginal and Torres Strait Islander Health Strategy (1989), and the NAIHO Report on Aboriginal and Torres Strait Islander Research Ethics (1987). Such determinations may be made at State or local level, as appropriate.
- Principle 2: Information about the health of Aboriginal and Torres Strait Islander peoples and the services they receive must be used to support improved health outcomes for Aboriginal and Torres Strait Islander peoples and better planning and delivery of health services.
- Principle 3: The analysis, interpretation and reporting of Aboriginal and Torres Strait Islander health and health-related information should occur collaboratively between the parties to the QAIHC Data Governance Protocols.
- Principle 4: The privacy and confidentiality of Aboriginal and Torres Strait Islander peoples and health service providers must be protected in accordance with all other legislation or guidelines pertaining to the sector.
- Principle 5: Health service providers should inform Aboriginal and Torres Strait Islander peoples about how and why their health information is collected and used.
- Principle 6: While health service providers have common information needs, there is also diversity among them, which generates unique information requirements.
- Principle 7: The parties should be encouraged to share information that may assist in planning, management and delivery of health services for Aboriginal and Torres Strait Islander peoples.
- Principle 8: Information collections require regular review and refinement by the parties to ensure relevance to service delivery and compliance with agreed information needs (QAIHC 2012).

APPENDIX 4:

WORKSHOP EVALUATION SURVEY

Before the conclusion of the workshop, delegates were asked to complete an evaluation form to provide feedback on the content and conduct of the workshop. The following is a collation of their responses.

Delegates were asked to rate each of the workshop sessions using the following format, circling a number from one, strongly disagree, to five, strongly agree. All responses were rated three and above.

The following is a summary of delegates' responses to each of the eight workshop sessions. The lowest response for any session was 'neither' and as a large majority of responses fell in the 'agree' and 'strongly agree' categories, the results have been simplified into the following table:

Session:	Percentage of respondents who rated the session 'agree' or 'strongly agree'			
The session was:	Easy to understand	Explained concepts clearly	Relevant to your AMS	The right amount of information
1. AH&MRC perspective on ACCHS data	91%	92%	99%	100%
2. CQI Program	94%	92%	99%	100%
3. QAIHC Presentation	100%	100%	92%	92%
4. AMSANT Presentation	100%	100%	92%	92%
5. Panel discussion- Data sharing	92%	75%	75%	66%
7. Use of data	100%	100%	100%	100%
8. Indicators: principles and processes	100%	100%	100%	100%

Summary of feedback comments:

Delegates found it useful to hear about the challenges and successes experienced by QAIHC and AMSANT in developing their own sets of health data indicators. They were also interested to hear more about what happens to ACCHS health data- by whom, and for what purposes it is used.

There were suggestions that greater member services involvement in the workshop would have allowed examples of ACCHS CQI activities and data use to be examined and discussed.

It was also pointed out that there was a lot of material to cover in a one- day workshop and it would have been beneficial to have had more time for discussion of the key topics.

Overall, the workshop rated highly amongst all delegates, particularly in terms of the relevance of the CQI and data governance content to ACCHS, and the way it was presented in an easy to understand manner. Helpful suggestions were also made, and we would like to thank all those who attended for their time and effort.

REFERENCES

- Aboriginal Health and Medical Research Council of New South Wales (2009), AH&MRC Ethics Committee, AH&MRC Guidelines for Research into Aboriginal Health Key Principles, Sydney.
- Kwedza, R. (2009), Creating a framework for key performance indicator use in primary health care, 10th National Rural Health Conference Cairns.
- Mainz, J. (2003), Defining and Classifying Clinical Indicators for Quality Improvement, International Journal for Quality in Health Care, Vol 15 (6), pp 523-530.
- National Aboriginal Community Controlled Health Organisation (NACCHO), (1997), National data protocols for the routine collection of standardised data on Aboriginal and Torres Strait Islander health. Canberra, Australia: National Aboriginal Community Controlled Health Organisation
- Northern Territory Aboriginal Health (2010), Key Performance Indicators, Data Management Policy, (p4).
- NSW Aboriginal Health Partnership. (1998), NSW Aboriginal Health Information Guidelines, Sydney, Australia: NSW Government.
- NSW Health Department. (2001), The Clinician's Toolkit For Improving Patient Care, (First Edition ed.), Sydney, Australia.
- Pencheon D. (2008). The good indicators guide: Understanding how to use and choose indicators. Coventry, UK. NHS Institute for Innovation and Improvement.
- The Royal Australian College of General Practitioners,(2010). Clinical indicators and the RACGP, Policy endorsed by the 51st RACGP Council 5 May 2009. Melbourne, Australia.: The Royal Australian College of General Practitioners.
- Queensland Aboriginal and Islander Health Council, (2012), Data Management Unit, Data Governance Protocols, (p4).