

Access and Flow

Measure - Dimension: Timely

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
90th percentile emergency department length of stay for nonadmitted patients with high acuity	P	Hours / ED patients	CIHI NACRS / December 1, 2024, to November 30, 2025, in alignment with the Pay for Results program	9.10	8.62	Incremental improvement of 5%, towards OH target of 8 hours. Over the last 4 years, we have experienced an average improvement margin of 3.8% year over year, with best improvement between 2022 and 2023 where ED LOS was reduced by 6.7%. Balance between achievable improvement target and unintended consequence of inappropriate admission or premature discharge related to pressure to meet a time target.	

Is this indicator related to:	
Emergency Department Return Visit Audits	No
Executive Compensation	No
Pay-for-Results Action Plan	Yes

Change Ideas

Change Idea #1 Data driven Process Improvement to identify opportunities with biggest impact

Methods	Process measures	Target for process measure	Comments
<ul style="list-style-type: none"> •Continue to collaborate with Analytics Hub and SIMLQ to complete and refine data analysis and modelling •Establish methods and processes to better track consultant response and completion times 	<ul style="list-style-type: none"> •Regular meetings to review insights and develop Improvement Initiatives, with initial PDSA cycle initiated in Q1 •Process measures refined to measure evaluate impact PDSA cycles towards targeted performance 	See process measures above	Linkages to other programs are essential success factors and TBD (potential for DI, DPLM, consult services, outpatient care models)

Change Idea #2 Continue to improve PIA

Methods	Process measures	Target for process measure	Comments
<ul style="list-style-type: none"> •PIA is an existing P4R measure & KPI tracked closely in the ED •Reviewed regularly at ED QP, Management Meetings 	<ul style="list-style-type: none"> •Incremental improvement in PIA year over year Measure: Average and 90th percentile Time to PIA 	2% reduction in 90th percentile Time to PIA	Improvements in PIA can drive reductions in ED LOS for all patient groups, but can be resource-dependent

Measure - Dimension: Timely

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
90th percentile emergency department length of stay for admitted patients	O	Hours / ED patients	CIHI NACRS / December 1, 2024, to November 30, 2025, in alignment with the Pay for Results program	14.80	13.80	<p>Aim for incremental improvement back to pre-pandemic performance over 2 years.</p> <ul style="list-style-type: none"> •Year 1 (CY 2025): 2% reduction to 14.6 hours at the 90th percentile •Year 2 (CY 2026): another 7% reduction to 13.8 hours at the 90th percentile <p>Year 1 will focus on a deeper dive into the factors involved in the interval of time from PIA to Disposition, with support from the Analytics Hub. In addition, we will continue to drive further improvements in the other 2 intervals of Time to PIA and Time to Inpatient Bed. With a better understanding of current and trend performance with TAT for lab test and diagnostic imaging, consult response times and time from initial consult to disposition decision, Year 2 will focus on implementation of improvement initiatives to target this longest time interval to drive greater reductions in overall ED LOS for admitted patients.</p>	

Is this indicator related to:	
Emergency Department Return Visit Audits	No
Executive Compensation	Yes
Pay-for-Results Action Plan	Yes

Change Ideas

Change Idea #1 Continue to reduce time to PIA

Methods	Process measures	Target for process measure	Comments
<ul style="list-style-type: none"> •Continue to build the advanced care provider model of care in the ED (PA & NP) •Continue to employ capacity-demand scheduling •Employ HeroAI for back-up MD deployment, introduce new patient flow flares 	Average and 90th percentile Time to PIA	2% reduction in 90th percentile Time to PIA	N/A

Change Idea #2 Investigate PIA to Disposition Decision time interval factors

Methods	Process measures	Target for process measure	Comments
<ul style="list-style-type: none"> •Collaborate with Analytics Hub to develop a data measurement strategy •Investigate long-stay admissions in the ED to understand root cause •Continue to employ the Escalation Protocol •Consult policy refresh •Continue to leverage the impact of the Emergency DI Service 	Development of KPIs for Disposition Decision factors <ul style="list-style-type: none"> •Consult response times •Time from initial consult response to disposition decision •DI turnaround time o Impact of Emergency DI Service •Lab turnaround time •# of times Escalation Protocol was used •# of long-stay case reviews completed 	See process measures above	Enablers: Engagement with key stakeholders with improvement PDSAs

Change Idea #3 Continue to reduce Time to Inpatient Bed

Methods	Process measures	Target for process measure	Comments
<ul style="list-style-type: none"> •Continue data-driven bed management strategies •SRAT •Patient Flow Escalation status for situation awareness •Nursing Workforce Optimization 	Average and 90th percentile Time to Inpatient Bed	2% reduction in 90th percentile Time to Inpatient Bed	Risk: Physical space challenges through surge, renovation projects

Measure - Dimension: Timely

Indicator #7	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Surgical Waitlist Reduction- Urology Surgery	C	% / Urology waitlist patients	In house data collection / 2026	1958.00	1811.00	<p>This target of a 7.5% reduction in urology waitlist cases represents all cases on the Urology waitlist</p> <ul style="list-style-type: none"> •The urology waitlist has been the most challenging to address post-Covid, accounting for 77% of the waitlist increase above pre-Covid levels. The urology waitlist remains >80% higher than pre-Covid (1964 cases vs 1084 cases) •The urology waitlist only decreased by 5% over the past calendar year vs a decrease of 22.7% for the high-volume services that were focused on for the 2025 QIP. •Additional resources will be available in 2026 to help address the urology waitlist that were not available before <ul style="list-style-type: none"> o Community options for treatment of some procedures in partnership with Trillium, Humber River Health, Scarborough Health Network, North York, Owen Sound and Kingston. o Opportunity to transition some procedures to the 8C Minor Procedure Unit o Expand operating room access in the Main OR at SickKids 	Humber River Health, Trillium Health Partners, North York General Hospital, Scarborough Health Network

Is this indicator related to:	
Emergency Department Return Visit Audits	No
Executive Compensation	No
Pay-for-Results Action Plan	No

Change Ideas

Change Idea #1 Minor Procedure Unit (8C)

Methods	Process measures	Target for process measure	Comments
<ul style="list-style-type: none"> Increased procedure capacity in the Minor Procedure Unit to support urology patients that would otherwise be supported in the operating room. This will increase operating room capacity for children. Patients to be rerouted based on patient and procedure criteria. One urology block per week focusing on cystoscopy and Botox cases, stent removals and adhesions. 	Number of cases removed from the SickKids Waitlist and completed in the Minor Procedure Unit. Start date: June 2026 Number of cases completed. (Aim 5 cases per block for 7 months).	<ul style="list-style-type: none"> Directly reroute cases from the main OR to 8C for a subset of cases. Clinical review of surgical cases on the waitlist to be supported by an Anesthesiologist on 8C. Exclusion criteria to be followed 	Exhaust the pool of minor procedure room-appropriate cases from the surgical waitlist.

Change Idea #2 SickKids Main OR

Methods	Process measures	Target for process measure	Comments
Add one additional block per week, providing access for hypospadias and extreme long waiting cases.	Count of cases completed and removed from the SickKids Waitlist. Start date: June 2026 Aim for 5 cases per week for 7 months.	Targeted block to target hypospadias and extreme long waiters.	N/A

Change Idea #3 Community Surgical Partnership Program

Methods	Process measures	Target for process measure	Comments
<ul style="list-style-type: none"> •Maximize HRH Friday blocks by adding a new Urologist. •Additional access provided at Trillium Health Partners-Credit Valley location supporting hypospadias cases (work in progress) •Reroute lower acuity cases, resulting in capacity-building and the delivery of high-quality care to more children and families. •SickKids has partnered with Humber River Health, Scarborough Health Network, Trillium, North York, Owen Sound, and Kingston to transfer low-acuity urology daycare patients on our existing waitlist. •This will ensure that pediatric surgeries and procedures are done at the right centre, closer to home, and within clinically acceptable access targets. 	<p>Number of cases completed and removed from the SickKids Waitlist Start date April 2026. Aim 3 cases per block for 9 months. Number of cases completed and removed from the SickKids Waitlist Start date April 2026. Aim 2 cases per block for 9 months.</p>	<ul style="list-style-type: none"> •Expand the inclusion criteria and the scope of cases supported by our community partners to drive additional patient referrals. •Directly re-routing cases to community partners before adding patients to the SickKids surgical wait list •SickKids surgeons work at community partnership sites, enabling expanded capacity to treat a higher volume of mid-complexity cases. 	<ul style="list-style-type: none"> •Exhaust pool of low acuity daycare patients from the SickKids waitlist. •Low-acuity patients may be directly rerouted to community partners in the future, reducing the volume referred to SickKids. This is a desirable future state.

Equity

Measure - Dimension: Equitable

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Health Equity Data Initiative (HEDI) completion for all unique SickKids patients seen	C	% / All patients	In house data collection / 2026	26.90	35.00	HEDI collection is integral to advancing the SickKids 2030 strategic goal of “Advance health equity and action on social determinants of health”. HEDI information is immediately viewable to clinical staff within Epic, which means equity considerations can be integrated into care delivery. As more HEDI information is collected, the data can be used to identify opportunities to improve care and to create and improve programs and services.	

Is this indicator related to:	
Emergency Department Return Visit Audits	No
Executive Compensation	No
Pay-for-Results Action Plan	No

Change Ideas

Change Idea #1 HEDI Support drop-in sessions for staff and Search team volunteers

Methods	Process measures	Target for process measure	Comments
HEDI team will offer drop-in sessions for staff and Search team volunteers to visit with questions or concerns. HEDI team will track # of sessions and # of attendees	•# of HEDI Support drop-in sessions •# of total attendees	Minimum of 8 HEDI Support drop-in sessions	Staff awareness of drop-in sessions and ability to attend

Change Idea #2 Distribute “Health Equity Data Initiative – Training” iLearn module to ambulatory areas

Methods	Process measures	Target for process measure	Comments
Completion of this module is tracked on the iLearn platform.	# total iLearn module completions	No target set, as the iLearn will be provided as supplemental support for ambulatory areas	iLearn is available for those who require a refresher on how to facilitate HEDI in Epic and/or new clinical staff who are onboarding

Change Idea #3 Provide targeted support to optimize workflow of ambulatory areas with low HEDI completion

Methods	Process measures	Target for process measure	Comments
The HEDI team will visit ambulatory areas to identify opportunities for targeted support. This will involve identifying primary drivers and specific change ideas. The HEDI team will track the number of areas that are provided with this targeted support.	# individual ambulatory areas that receive targeted support from HEDI team	Minimum 5 ambulatory areas provided with targeted support	N/A

Experience

Measure - Dimension: Patient-centred

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Outpatient experience survey response rate (% returned)	C	% / Ambulatory patients	Qualtrics / 2026	25.00	28.00	25% is the average outpatient experience response rate from September – December 2025. This sample was chosen as it is the time period after changes were made to the field in Epic that is used to distribute surveys via email. We are targeting an increase in overall response rate through the change initiatives described below. 28% is an achievable but significant increase in the overall number of responses. We chose a target that is below our inpatient response rate (32%) as our data suggests that inpatient response rates are consistently higher than outpatient response rates.	

Is this indicator related to:	
Emergency Department Return Visit Audits	No
Executive Compensation	No
Pay-for-Results Action Plan	No

Change Ideas

Change Idea #1 Implement short-form outpatient (ambulatory) experience survey

Methods	Process measures	Target for process measure	Comments
We will continue to collect data through Qualtrics. Data will be reviewed and analyzed by Patient and Family Experience (PFX) and Data & Analytics team members.	Survey response rate as per above.	Survey response rate as per above.	Depends on OHA having the short-form paediatric outpatient survey ready by March 2026 as expected

Change Idea #2 Expand surveys to all outpatient (ambulatory) clinics

Methods	Process measures	Target for process measure	Comments
We will continue to collect data through Qualtrics. Data will be reviewed and analyzed by PFX and Data & Analytics team members.	Survey response rate as per above.	Survey response rate as per above.	Surveys will be rolled out to all ambulatory clinics

Safety

Measure - Dimension: Safe

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Number of patient Serious Safety Events (SSE)/10,000 adjusted patient days	C	Rate / All patients	Hospital collected data / 2026	0.46	0.40	The 2026 SSER target is based on incremental improvement towards a longer-term target aiming to regain some improvement that has been achieved in past years. Our aim this year is to sustain our 2025 target of 0.4 as we implement new Proactive Safety (Safety II) tools in the SSE process. The 0.40/10,000 adjusted patient day target is the average rate of >150 North American paediatric partners who are members of the Solutions for Patient Safety (SPS) Network.	

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Executive Compensation	No
Pay-for-Results Action Plan	No

Change Ideas

Change Idea #1 Focused effort on recognition, escalation, and rescue/resuscitation

Methods	Process measures	Target for process measure	Comments
<ul style="list-style-type: none"> •Environmental scan of best practices •Thematic analysis of Serious Safety Event cases •Gap analysis of SickKids current state against the TAHSN Escalation of Care Framework •Revision of existing sepsis pathways 	Completion of environmental scan, gap analysis, and baseline data collection	Completion by Q3 2026 (September 2026)	Work to establish organizational standards will be based on TAHSN Escalation Framework and benchmarking with similar North American paediatric hospitals

Change Idea #2 Implementation of Proactive Safety (Safety II) tools in SSE review

Methods	Process measures	Target for process measure	Comments
Utilize tools from Solutions for Patient Safety Network (SPS) including Learning Teams, Walk-through-talk-throughs etc. to foster general psychological safety and more robust or timely corrective actions	Number of reviews that use Proactive Safety Tools	In 2026, 25% of SSE reviews utilize at least one Proactive Safety Tool as part of the review process. In 2027 this target will increase to 50%	Ongoing organizational learning and adoption of proactive safety tools over the next year will be vital to success

Measure - Dimension: Safe

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Rate of Central Line Blood Stream Infections (CLABSI) per 1000 line days	C	Rate per 1,000 / All inpatients	In house data collection / 2026	1.05	0.95	In 2015 SickKids joined solutions for patient safety and began benchmarking the organizational CLABSI rate against a network of other paediatric hospitals. Initially SickKids' rate was 2x that of the network rate. Over the last several years through the implementation of standard bundles of care for central line maintenance, process improvements to achieve reliable bundle adherence, and processes for observing and providing feedback, the rate of CLABSI infections has decreased below the network rate. Following several years of sustained performance below network benchmarks, CLABSI rates increased in 2025, indicating a loss of process reliability rather than a lack of evidence-based prevention strategies. A 10% reduction target (0.948/1000 line days) to move towards the SPS network benchmark is achievable within one year by refocusing on high-leverage process measures, specifically bundle adherence, observation with feedback, and leadership accountability. This target also allows for sufficient time for practice stabilization in the context of system pressures and patient complexity.	

Is this indicator related to:	
Emergency Department Return Visit Audits	No
Executive Compensation	No
Pay-for-Results Action Plan	No

Change Ideas

Change Idea #1 Strengthen reliability of central line maintenance through targeted observation and real-time feedback

Methods	Process measures	Target for process measure	Comments
<ul style="list-style-type: none"> Conduct standardized central line maintenance observations using an agreed-upon audit tool Prioritize observations on high-risk units and during high-risk care activities Provide immediate, strengths-based feedback to staff following observations Aggregate and review observation data monthly at unit and corporate forums 	<ul style="list-style-type: none"> Percentage of central line maintenance observations completed as planned Percentage of observations with documented real-time feedback Bundle adherence rate during observed encounters 	<ul style="list-style-type: none"> 85% completion of planned observations per month 90% of observations documented in the audit tracker 80% adherence to central line maintenance bundle elements 	<ul style="list-style-type: none"> Observation capacity may fluctuate with staffing and acuity Aligns with existing infection prevention and nursing practice audit infrastructure Reinforces a coaching culture rather than punitive surveillance

Change Idea #2 Increase leadership accountability and visibility for CLABSI prevention at the unit level

Methods	Process measures	Target for process measure	Comments
<ul style="list-style-type: none"> Embed CLABSI review into routine leadership huddles and quality forums Ensure unit leaders receive and review CLABSI data with clear expectations for follow-up Standardize ACA review and action tracking for CLABSI cases Support leaders with concise data summaries and talking points for proactive safety rounding re: central lines 	<ul style="list-style-type: none"> Percentage of units reviewing CLABSI data monthly Percentage of CLABSI events with completed post-event review and documented action plan Attendance of unit leaders at CLABSI review forums 	<ul style="list-style-type: none"> 100% of in-patient units review CLABSI data monthly 100% of CLABSI cases have a completed ACA within 30 days 80% attendance by identified leaders at CLABSI action group >80% attendance of identified leaders at HAC skill booster sessions 	<ul style="list-style-type: none"> Competing operational priorities may impact consistency Requires alignment between practice, quality, operations, and medical leadership Supports sustainability beyond single interventions and begins to impact safety culture