IN THE MATTER OF THE ROYAL COMMISSION INTO FAMILY VIOLENCE

ATTACHMENT FD-7 TO STATEMENT OF FRANCES MARIE DIVER

Date of document: 3 August 2015
Filed on behalf of: the Applicant
Prepared by:
Victorian Government Solicitor's Office
Level 33
80 Collins Street
Melbourne VIC 3000

[redacted]

This is the attachment marked '**FD-7**' produced and shown to **FRANCES MARIE DIVER** at the time of signing her Statement on 3 August 2015.

[redacted]

Before me: An Aust[redacted] within th[redacted] Legal Pr[redacted] .....

Attachment FD-7

High-performing health services

Victorian health service performance monitoring framework 2014–15

State Government Victoria

High-performing health services

Victorian health service performance monitoring framework 2014–15

To receive this publication in an accessible format phone 9096 7120 using the National Relay Service 13 36 77 if required, or email: mim.biondo@health.vic.gov.au

Authorised and published by the Victorian Government, 1 Treasury Place, Melbourne.

This work is available at: www.health.vic.gov.au/hospital-performance

Printed by Digital House, South Melbourne on sustainable paper (1408007)

Contents

Contents	**1**
Foreword	**3**
Introduction	**5**
Section 1: Strategic directions for performance monitoring	**7**
Driving health outcomes: trends in governance, funding and performance	7
High-performing health services	7
Sustaining performance improvement – implementation approach	13
Section 2: Components of the framework	**19**
Victorian health service governance model	20
Victorian health priorities framework 2012–2022	21
Statement of priorities	21
Victorian health policy and funding guidelines	21
Performance monitoring tools	21
Section 3: Performance assessment and monitoring	**23**
Using the *Statement of priorities* targets to assess performance	23
Performance assessment score	24
Level of monitoring	30
Section 4: Contact details	**33**
References	**35**
Appendix 1: 2014–15 changes	**37**
Appendix 2: Key performance indicators	**41**
Appendix 3: Applicable key performance indicators by health service	**45**
Safety and quality key performance indicators	57
Financial sustainability key performance indicators	60
Governance, leadership and culture key performance indicators	54
Appendix 4: Data requirements	**67**
Appendix 5: Business rules	**71**
Patient experience and outcomes	71
Governance, leadership and culture	93
Ambulance services	101
Financial sustainability	104
Access key performance indicators	109

Foreword

Victoria's devolved system of health service governance leads the way in Australia. Health services operate with a high degree of independence and within a broad set of policy guidelines and strategic directions set by the Victorian Government. The government also sets specific financial and performance targets for each health service through the *Victorian health service performance monitoring framework*. In this way, development of the system is guided while health services are encouraged to use their operational independence to address local needs and circumstances.

Because the healthcare system is constantly changing and evolving, the government's approach to healthcare performance management also needs to evolve. This evolution is driven by changes in thinking about how healthcare system performance should be measured to ensure that Victorians continue to live long and healthy lives.

The government needs to make sure these changes sit within a clear, consistent framework that signals the intent of the changes and directions for the future.

The future directions for performance monitoring are driven by the *Victorian health priorities framework 2012–2022*. This framework sets out the key priorities for planning and delivering an innovative, informed and effective healthcare system that is responsive to people's needs. Within this context, there are four strategic directions that will inform the development of the performance monitoring framework over coming years. They are:

- patient experience and outcomes
- governance, leadership and culture
- safety and quality
- financial sustainability.

These strategic directions for high-performing health services are underpinned by a core set of access and timeliness indicators, which continue to be fundamental to achieving high performance. The strategic directions pick up national and international evidence on high performance in healthcare (including lessons learnt from major failures in performance monitoring). They also acknowledge the importance of contextual factors in monitoring health service performance and helping drive future improvements in performance.

The Hon. David Davis MLC
Minister for Health

Introduction

High-performing health services: Victorian health service performance monitoring framework 2014–15 ('the performance monitoring framework') is the source document for information about the Victorian Government's performance monitoring framework for health services. The services to which this framework applies include metropolitan health services, regional health services, subregional health services, local health services, small rural health services, Ambulance Victoria, Dental Health Services Victoria and the Victorian Institute of Forensic Mental Health (Forensicare).

The document is intended for health service board members and chief executive officers (CEOs) and describes the strategic directions, implementation approach and processes involved in monitoring health service performance by the Department of Health.

The document also provides detailed information about the key performance indicators (KPIs) used to monitor health service performance. This information is provided in appendices to the document and is of particular relevance to health services staff who are responsible for data collection, analysis and reporting to the department.

Section 1: Strategic directions for performance monitoring

Driving health outcomes: trends in governance, funding and performance

The healthcare system exists to improve health outcomes. Whether the healthcare system can do this is driven by three factors: how the system is governed and managed; what services are funded and how they are funded; and how well the system performs in delivering those services. As thinking about healthcare evolves, so does the thinking about how these drivers for delivering healthcare outcomes should work.

There has been an increasing focus in recent years on the role of provider and system governance in delivering healthcare outcomes. This has been expressed in themes relating to: leadership,[1] accountability and responsibility;[2,3] the role of boards;[4] the importance of fostering a culture of safety and quality;[5,6] and the permeation of a patient-centred focus through all levels of healthcare organisations.[7,8] Along with strengthened accountability has come a push for greater transparency, which has led to increased public reporting on healthcare performance.

How healthcare is funded is also in the process of evolving from a focus on activity to a focus on value.[9] In Australia and internationally, the emphasis is gradually shifting from block funding and fee for service to more value-based approaches, such as activity-based funding, pay for performance, capitation and a greater focus on the importance of funding for wellness and population health.

Finally, there have been significant changes in the way we think about healthcare system performance and how to measure it. Stemming in part from more broadly based concepts of performance measurement such as triple-bottom line and balanced scorecard, as well as by the changing understanding of what should be measured, the elements that make up the performance conversation have shifted over time. In parallel, performance monitoring has moved from a pure focus on achieving standards and hitting targets, to a more collaborative, improvement-oriented dialogue, based on a shared conception of value creation and the activities that can support it.[10]

Changes in thinking about performance monitoring have also involved work to broaden the range of metrics for monitoring healthcare performance, including more sophisticated measures of safety and quality, as well as a push to develop better measures for healthcare outcomes, patient experience, sustainability and governance, leadership and culture.[2,5,11]

High-performing health services

The government is committed to driving continuous performance improvement in the healthcare sector as an important contributor to delivering better health outcomes for all Victorians. The goal of continuous performance improvement underpins the performance monitoring framework. In order to support this commitment to performance improvement, the framework needs to do two things:

- minimise the risk of healthcare system failures arising from a framework that is too narrowly focused on targets and indicators
- broaden the framework to include an understanding of, and focus on, contextual factors that drive high performance and lead to excellent healthcare outcomes.

The strategic directions for the performance monitoring framework aim to nurture high performance and support health services as they build the capability to improve performance. Within the devolved governance environment in which health services operate, the department has a responsibility to ensure that performance monitoring is not just based on an assumed correlation between high measured performance and healthcare outcomes but considers the contextual factors that allow health services to reliably deliver high performance and to improve performance over time.

The performance monitoring framework works across a spectrum from education and persuasion through to enforced compliance. This continuum of responses is grounded in the concept of responsive regulation. Towards one end of the spectrum, the department undertakes intensive monitoring to address serious performance issues. At the other end of the spectrum, the focus on performance improvement emphasises a supportive approach that assists health services to maintain and improve performance. It represents a focus on collaboration rather than coercion within an environment of earned autonomy. It also involves a more preventive approach to performance monitoring, which draws on a wider range of information from a variety of sources and uses lead indicators and warning signs to identify potential performance issues before they become performance failures.

The characteristics of high-performing health services

The directions for performance monitoring in Victoria are driven by government priorities and reflect changes in the healthcare system. These same pressures are driving change in health services. It is important for health services to have the right capabilities to ensure they can reliably achieve high performance and maximise healthcare outcomes. While there is substantial debate about the characteristics that can guarantee success, there are some common themes emerging. Recent literature suggests that important characteristics for high-performing health services may include:

- person-centred governance, leadership and culture[1,4,12]
- a strong collaboration and partnership focus[13–15]
- knowledge and innovation proficiency[5,16,17]
- concentrated effort on talent acquisition and cultivation[3,18,19]
- effective, long-term strategies for sustainability.[20,21]

There is not yet a strong body of evidence to demonstrate which health service characteristics are associated with high performance,[22] but this is a growing area of focus that will be an important part of the healthcare performance conversation in the future.

In order to better support health services to achieve and maintain high levels of performance, the department needs to be clear about its strategic directions for performance monitoring and assessment. Victoria's approach has been reframed around the following four strategic directions for the future of health service performance monitoring:

- patient experience and outcomes
- governance, leadership and culture
- safety and quality
- financial sustainability.

Patient experience and outcomes

There is a strong, shared vision across the healthcare system that all aspects of care must be patient-centred. This vision is recognised in the *Victorian health priorities framework 2012–2022*, which includes 'developing a system that is responsive to people's needs' and 'improving every Victorian's health status and health experience' as key priorities.

Over recent years there has been significant convergence in thinking about patient experience and patient outcomes. In particular, there is a view that patient experience needs to be understood across the continuum of care and goes beyond patient satisfaction alone.[23] There is a parallel view that patient outcomes should reflect the full cycle of care and should include those outcomes that are most relevant to patients themselves.[9]

Despite this growing emphasis and convergence of views, the use of outcome measures for gauging healthcare system performance has traditionally been a very underdeveloped area.[24] In part, this is because the outcomes that matter most are often hard to measure or are measured inconsistently. Outcome measures for healthcare can also be difficult to isolate from other determinants of health status and, because of the timeframe over which they need to be measured, they may not be immediately available to support performance monitoring. Finally, individual outcomes are often the result of contextual factors of performance, such as the combined skills of the treating team, the quality of clinical leadership, the effectiveness of care pathways or the efficiency of clinical processes. Recent work on patient-reported outcome measures might help to address some of these challenges, as well as supporting a focus on outcomes most relevant to patients. However, there is significant work yet to be done before such measures can be used confidently to monitor health service and health system performance.[25,26]

This strategic direction involves placing greater weight on qualitative sources of information about patient experience and outcomes, including patient stories, in order to understand what health service performance really means to patients. It also recognises that patient experience is enhanced by involving patients in design and in service development, as well as actively involving them in their care and treatment. Performance monitoring of health services will therefore include more information about how health services ensure the participation of patients from the level of individual care through to planning and development at an organisational level.

Victoria already tracks a number of mortality indicators at the health service level. The introduction of the Victorian Healthcare Experience Survey (VHES) represents a further development of the focus on measuring and monitoring patient experiences and outcomes. The department is also taking a more 'whole of health service' approach, which ensures the framework incorporates monitoring across the full continuum of care provided by health services, including a greater focus on areas such as mental health, maternity, cancer and aged care.

As thinking on, and techniques for, healthcare outcomes measurement mature, there will be considerable scope to enhance the depth and sophistication of experience and outcomes measurement through the performance monitoring framework. The government's approach to this key area of performance will continue to develop over coming years.

Governance, leadership and culture

Achieving improved healthcare outcomes relies on effective governance and leadership, including creating a culture in which clinical staff feel empowered to act in the best interests of patients.[1,3,4]

The government is committed to retaining the clear benefits for the healthcare system in Victoria that are associated with devolved governance and operational independence on the part of health services. Within this environment, the performance monitoring framework has an increased emphasis on the role of effective governance and leadership and a strong patient-centred culture in delivering positive health service performance. Noting that contextual factors such as these are more difficult to measure, a key part of this approach is stronger engagement with health service boards, reflecting their critical role in setting directions and expectations, fostering leadership and shaping organisational culture.

In support of this direction, the department has introduced a new safety culture indicator as part of the calculation of the performance assessment score (PAS), based on safety culture questions from the People Matter survey. The department will also work more closely with other government agencies involved in specific regulation or oversight of health services, such as the Victorian WorkCover Authority, the Victorian Public Sector Commission and the Victorian Managed Insurance Authority, with a view to reflecting the outcomes of their work with health services in the performance conversation.

A stronger focus on governance also serves to better support rural health services, which have smaller pools from which to select board members and may have fewer resources available to achieve performance improvement goals. The department will work with the rural health service sector to identify or develop tools for rural boards to support improved performance and streamline accountability.

Safety and quality

A strong and unwavering commitment by health services to safety and quality results in demonstrable benefits for both patients and the organisation, including fewer complications, lower costs, greater efficiency and improved clinical outcomes. Safety and quality of healthcare is an established part of health service performance management in Victoria and is a key area of focus for the future. This direction recognises that safety and quality is core to every patient's experience and outcomes and needs to be embedded within the culture of healthcare organisations.[5–7]

The department will be expanding performance monitoring of safety and quality across service types to take a whole-of-health-service approach, including greater emphasis on areas such as mental health, aged care, maternity and cancer. This stronger focus on clinical outcomes across a range of service types will align with and support the department's clinical governance policy framework, including concentrating on those areas of performance that are critical to good clinical governance: consumer participation, clinical effectiveness, an effective workforce and risk management.

Importantly, the introduction of pay for performance has initially focused on quality measures, further emphasising the centrality of safety and quality in gauging health service performance. This also acknowledges that there can be a perceived tension between a focus on quality and a focus on quantity, and establishes additional financial incentives that reach beyond type and volume of activity to reward sustained results in healthcare quality.

Zero tolerance for central-line-associated bloodstream infections in Barwon Health intensive care

In 2008–09 Barwon Health was concerned that it had a rate higher than the Victorian average for bloodstream infections as a proportion of the time patients spent in the intensive care unit (ICU) with central lines inserted.

In response, the Barwon Health critical care team embarked on a change initiative, identifying clinical champions, introducing new processes and best practice techniques and establishing practice audits to drive improvement. The health service took a zero tolerance approach to central-line infections in the ICU environment. The introduction of new processes and techniques led by change champions saw a substantial reduction in infection rates between 2008 and 2010.

Auditing of insertion practices began in 2011. Initially, the increased scrutiny of practice led to a sharp increase in reported infection rates. There was an equally dramatic drop the following year as learning from the audits fed back into improved practice. In the period since the start of 2012, the infection rate has dropped from 0.6 to zero. Barwon Hospital has had no central-line-associated bloodstream infections in its ICU since June 2012 (based on data current at the end of quarter three 2013–14).

(Based on information provided by Barwon Health)

The department's recent investment in the Dr Foster Quality Investigator is a further example of the focus on safety and quality, and builds upon the existing suite of safety and quality indicators, including mortality rates, readmissions, cleaning standards and hand hygiene. The introduction of the Quality Investigator also exemplifies the appetite for increasing the breadth and depth of the performance conversation with health services, and drawing on a broader range of indicators and signals of performance.

Targeting safety and quality: healthcare worker immunisation

The annual immunisation of healthcare workers against the influenza virus has significant benefits. It reduces staff absenteeism and operating costs for health services.27,28 But, most importantly, it saves lives.[29]

In 2013–14 healthcare worker immunisation against influenza was included in the *Statement of priorities*, with a target of 75 per cent. For 2014–15 this indicator has been included in calculating the PAS for health services. Alongside the introduction of performance targets, health services have pursued a range of strategies to improve immunisation rates including increasing availability, increasing education, setting up incentives, chief executive endorsement, feedback to staff and mandating vaccinations (with documented grounds for refusal).

For example, in the lead-up to the 2014 influenza season, Monash Health adopted a two-pronged strategy: increasing knowledge and awareness through presentations, a video and other media featuring endorsement from the chief executive and senior clinicians while also requiring that all staff either receive a vaccination or complete a declaration citing the reason they cannot do so. Compliance reports are provided to heads of units and wards. Staff who have been vaccinated have a sticker applied to their staff identification cards, providing a visual marker of those who have received the current year's vaccination and those who have not. The rate of vaccination superseded the vaccination rate for the entire 2013 season after just four weeks.

Across Victoria, there has been significant growth in the percentage of healthcare workers immunised against influenza over the last two years, and the overall rate for 2014 is already higher than predicted.

(Based on information provided by the Department of Health and Monash Health)

Financial sustainability

Financial performance is and will continue to be fundamental to health service performance management. However, financial performance monitoring is about more than operating results and needs to take a wider perspective on financial sustainability. The financial sustainability strategic direction will therefore extend the range of financial performance metrics to incorporate more information about health service liquidity and financial viability (including cash position).

This direction will incorporate the outcomes of work on financial performance between health services and the department, and will bring additional financial metrics into the performance conversation. This means that financial information that is not currently part of the formal performance assessment process can be used to escalate concerns about financial sustainability. It acknowledges the significant financial challenges faced by health services, as exemplified by the concerns raised by the Auditor-General about limited cash holdings and operating margins in a number of health services.[30]

The financial sustainability focus acknowledges that prudent financial management in healthcare is not just about hitting a financial target but about how well health services are positioned to deliver the best healthcare outcomes at the lowest possible cost.[20] Long-term sustainability of health services means achieving sustainable reductions in cost growth – including by managing demand for high-cost care and intervening early to maintain and improve healthcare status and outcomes.

This part of the performance conversation links to existing directions for reducing cost growth such as: developing better clinical pathways and protocols; introducing capitation funding and case management for regular high-needs clients; and controlling costs through process improvement. Recognising its vital contribution to long-term sustainability, the focus on financial sustainability includes closer scrutiny of health service asset management planning and management processes. It also brings in wider aspects of government policy directions for sustainability, including the department's work with health services on sustainable hospitals. The department will look to foster collaborative arrangements between health services that maximise health system performance and long-term sustainability.

Continued focus on access and timeliness

Underpinning these new strategic directions, Victoria's approach retains a core set of indicators for access and timeliness, reflecting the criticality of these aspects of health service performance in delivering the healthcare experience and outcomes most important to the people of Victoria. These indicators will continue to be refined and developed over time in line with developments in the healthcare system and government priorities and policy directions. This will include taking more of a whole of health service approach, encompassing access performance across a wider range of service types.

Sustaining performance improvement – implementation approach

The strategic directions for health service performance monitoring in Victoria support government priorities for the healthcare system and reflect a recent body of evidence on ways to manage and improve healthcare performance. It is vital for success that these strategic directions also sit within the right framework – one that both ensures problems are detected and acted upon quickly, and supports health services to continue improving and innovating to enhance future performance.

The approach to performance management for health services and the government has moved in line with significant sectoral and policy changes over recent years, and will continue to evolve in the future. Alongside these changes, Victoria's public health services have grown their performance management capabilities. They are able to monitor their own performance with increasing sophistication and are in a strong position to embrace contemporary directions in this area. The directions for this framework recognise that, at its core, performance monitoring is a conversation between health services and the department, centred on an agreed vision for healthcare and a shared understanding about what constitutes positive progress towards achieving that vision.

There are well-established healthcare system benefits from performance monitoring, including an increase in quality improvement activities, improved quality of care, improved clinical outcomes and more engaged clinicians.[31] The government's approach to performance monitoring of health services builds upon these benefits while avoiding the pitfalls that can accompany a framework too narrowly focused on targets.

Using performance monitoring to drive quality improvement outcomes

Since 2009 the Victorian Hand Hygiene Program has been integrated within the National Hand Hygiene Initiative. The initiative incorporates the *5-moments* of hand hygiene, developed by the World Health Organization and adapted for the Australian healthcare setting.

Internal audits of hand hygiene practice are conducted by health services to drive improvement. These audits are coupled with education, staff and consumer engagement and other change management activities as part of health service safety and quality improvement initiatives.

Staphylococcus aureus bacteraemia (SAB) associated with healthcare is an important measure of the safety of hospital care and is directly affected by hand hygiene compliance.

Targets for hand hygiene compliance and rate of SAB are now part of the annual *Statement of priorities*, and health service performance against these targets is included in the calculation of the PAS. With these key indicators included in the framework, Victoria has seen sustained improvement in both measures over recent years, making hospitals safer for patients and contributing to improved health outcomes.

(Based on information provided by the Department of Health)

The framework directions ensure the performance conversation is broad-based, encompassing public and confidentially reported performance, targets, non-target indicators and dialogue on performance issues that places performance monitoring in a wider context and focuses on opportunities for improvement. Performance information can come from a number of sources such as regulatory inspections, patient experience surveys, third-party or internal assessments and statistical indicators.[32] In addition there are soft sources of performance information, such as media reports, that can fill in the performance picture. While there are clear risks in placing too much emphasis on such sources, there is value in extending both the breadth and depth of performance information that is available to support the performance conversation. Performance conversations should be informed by a 'culture of curiosity' that aims to continually enhance a joint understanding of high performance.

The department will also continue to make use of a range of qualitative indicators to support the performance conversation with health services. Patient complaints and compliments remain a valuable source of information about the patient experience and patient stories provide a depth of understanding that is not available from survey results alone. The department will work with health services and the Health Services Commissioner to bring this kind of information more formally into the performance conversation.

The performance conversations between the department and health services will:

- be based upon the most recently available information and performance data
- consider factors affecting future performance and performance improvement
- be strategic in nature, considering the healthcare system context and other influences on health service performance, including mitigating factors impacting on performance outcomes.

Monitoring variability in performance: outlier management for unplanned readmissions

Unplanned readmissions are measured as part of the suite of core hospital-based outcome indicators developed by the Australian Commission on Safety and Quality in Health Care. This is a developing area of focus for performance monitoring in Victoria.

In 2013–14 health services were asked to include objectives related to the management of hospital-wide 30-day unplanned readmissions in their *Statement of priorities*. The department is still developing a consistently applicable definition to guide measurement of unplanned readmission rates; however, there is a formal process in place to review outliers.

This process is based on five readmission measures relating to specific types of hospital admissions (for acute myocardial infarction, heart failure, hip replacements, knee replacements and paediatric tonsillectomy and adenoidectomy). When an outlier is identified in the annual rate for one of these readmission measures, the department contacts the health service concerned and provides the data for review. The outcomes of the health service review are then included as a topic for performance meeting discussions, focusing on any identified data issues and any opportunities for clinical, operational or safety and quality improvements.

While there are no formal targets associated with readmission measures, the process for monitoring variability and reviewing outliers means the measures are brought into the performance conversation with the goal of flagging and responding to any potential implications for healthcare outcomes or safety and quality of care.

For example, data for 2012–13 revealed that Ballarat Health Service was an outlier for readmissions following hip replacement. After reviewing the data, Ballarat Health Service indicated that the readmissions had been the result of a combination of patient complexity, surgical practice issues and, in one case, failure of an established protocol. Ballarat Health Service advised that feedback would be provided to surgeons, and that two new surgical practice techniques were being introduced that were expected to result in lower rates of complications.

(Based on information provided by the Department of Health and Ballarat Health Service)

Within a more collaborative, improvement-oriented approach to performance monitoring, which also recognises the growing capabilities of health services to monitor and publicly report on their own performance, it is critical that the roles and responsibilities of the department and health services are clear. The department has a responsibility to set clear guidance and create the conditions within which positive performance can flourish. Health services, as well as responding positively and transparently to performance issues, must develop organisational capacity for reliability, preparedness and learning. Put simply, they must create the environment where the right and safe thing is easy to do.[33]

In implementing the strategic directions for the framework, the department has a responsibility to:

- create a clear, balanced and broad-based performance monitoring framework within a consistent set of directions and priorities
- consider broader implications of changes to the performance monitoring framework before introducing them
- minimise the risk of unintended consequences, including considering the evidence base for using particular measures and continually testing the design, accuracy and relevancy of measures
- ensure performance monitoring is not an end in itself but a driver for systemic improvement (including avoiding burdensome data collection and reporting)
- make comparative performance data available to health services to drive improvement and best practice
- maximise health system performance and sustainability of health services by taking a whole-of-health-service approach and fostering collaboration and shared learning between health services
- engage with health services to continuously develop and improve the framework.

These specific responsibilities for ongoing development of a clear and coherent performance monitoring framework should be read in conjunction with the department's overall performance monitoring role, as described in the *Victorian health services governance handbook*.

On the health service side of the performance monitoring conversation, health services have a responsibility to:

- create a governance environment that drives performance in a way that places patients at the centre of everything the organisation does
- drive improvements to performance within a culture of safety and quality
- measure and monitor their own performance
- respond transparently to performance issues and foster an ethic of learning
- have clear accountabilities and processes for detecting and responding to performance issues when they arise
- optimise and standardise processes to reduce variation in performance and maximise reliability of performance.

These responsibilities are consistent with, and should be read in conjunction with, the description of the role of the board, board chair and CEO outlined in the *Victorian health services governance handbook*.

Within the context of the four strategic directions for performance monitoring outlined above, the department will enhance the framework so the conversation with health services incorporates consideration of contextual factors in achieving healthcare outcomes, as well as measures of the outcomes themselves.

To support the directions of the framework, the department is implementing mechanisms to facilitate shared learning and to support health services to help each other achieve performance improvement goals. One of the ways the department is doing this is by establishing a group of healthcare sector leaders who can help health services to address performance issues. This group will form a panel from which a number of individuals can be selected to provide targeted assistance to health services. Further information about this initiative is contained in Section 3.

To maximise opportunities for shared learning, the department will use the information gained from performance conversations to match high-performing health services with other health services that may need support to address particular performance issues or achieve specific improvement goals. The department will also give special consideration to the unique role of Ambulance Victoria and other specialist health services, ensuring the performance conversation is tailored to their specific activities and expertise. The performance conversation will highlight the leadership role of specialist, quaternary and major regional health services so their capability and experience can benefit the system as a whole.

The department will also take a more whole-of-health-service approach to performance monitoring, bringing in information and indicators of performance relating to the full spectrum of activities in which health services are engaged. This will include increased focus on mental health, aged care, cancer and maternity indicators, among others.

Review of the performance monitoring framework

As part of the annual cycle of performance review, the department will review the strategic directions for performance monitoring to gauge the effectiveness of the performance monitoring framework, ensure its alignment with government policy and directions in the healthcare sector, and measure its impact on Victorian healthcare system performance as a whole.

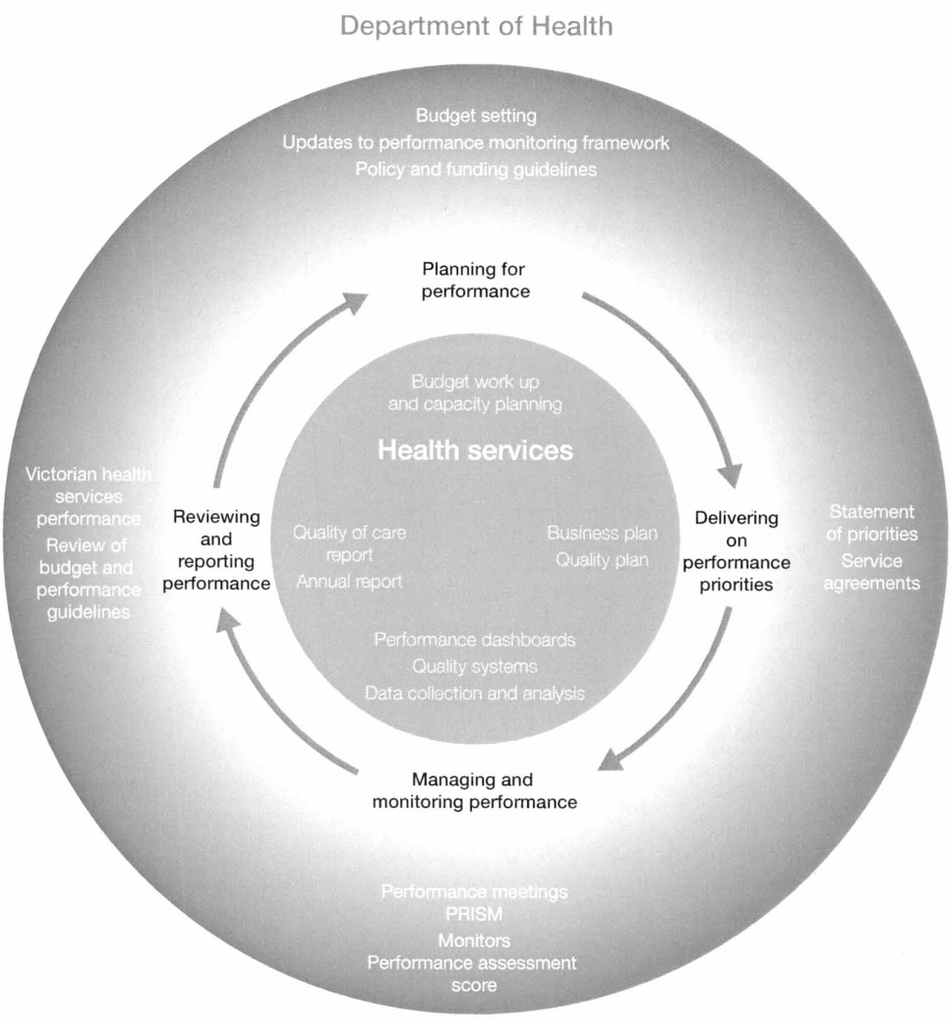
The department will engage health services in this review process, as well as in the ongoing development of the framework, to build on and refine the strategic directions.

Section 2: Components of the framework

The performance monitoring framework encompasses the mechanisms the department uses to formally monitor health service performance. The framework was implemented in public health services in 2004–05 and has been incrementally expanded to cover subregional, local and small rural health services, Ambulance Victoria and Forensicare.

At its heart, the framework is a dialogue between the department and health services aimed at maintaining and improving health service performance. As Figure 1 indicates, this dialogue follows an annual cycle, and the department and health services bring different things to the conversation at each point in the cycle. Particular components of the framework are more relevant to different stages in the cycle.

Figure 1: The performance monitoring cycle



The performance monitoring framework is reviewed annually and provides information on overall directions for performance monitoring, as well as detailing the components of the framework and any changes from previous years.

Victorian health service governance model

The 12 metropolitan health services and six major regional health services are defined under the *Health Services Act 1988* as 'public health services', along with Dental Health Services Victoria, and are governed by boards of directors as set out under s. 65S. The nine subregional health services, 11 local health services and 36 small rural health services are defined as 'public hospitals' and are governed by members who make up boards of management as set out under ss. 115E and 33 (1, 2, 2A). The seven multipurpose services (MPS) are subject to a set of governance provisions similar to public hospitals and are governed by boards of management. Mildura Base Hospital is a privately operated public hospital and the three denominational hospitals are subject to similar performance governance provisions to public hospitals.

Ambulance Victoria was created under s. 23 of the *Ambulance Services Act 1986* on 1 July 2008 and is governed by a board of directors as set out under s. 17 of the Act.

The Victorian Institute of Forensic Mental Health was established under s. 117B of the *Mental Health Act 1986* and is continued under the Mental Health Act 2014, operating under the name Forensicare. Forensicare is governed by a board of directors as set out under s. 67 of the new Mental Health Act.

The devolved governance model in Victoria allows decisions to be made that are most appropriate and effective at a local community level. It recognises that an approach to service delivery in one health service – with a unique combination of patients and service demand, culture and workforce – may not be the most effective solution in a different health service.

This governance model also expects that the board is fully informed to discharge its functions effectively and ensures appropriate action is taken to manage and remedy issues as they arise.

Victorian health priorities framework 2012–2022

The *Victorian health priorities framework 2012–2022* establishes the key outcomes, attributes and improvement priorities for the healthcare system. This framework sets out seven key priorities that address strategic issues facing the health system now and in the future:

- developing a system that is responsive to people's needs
- improving every Victorian's health status and health experience
- expanding service, workforce and system capacity
- increasing the system's financial sustainability and productivity
- implementing continuous improvements and innovation
- increasing accountability and transparency
- using e-health and communications technology.

The first four of these priority areas target specific changes and improvements to the health system; the remaining three are enablers to allow the health system to work more effectively. The health priorities framework provides the overall context and direction for performance monitoring. It also provides the structure for Part A of the *Statement of priorities* (SoP), which outlines the actions health services (including Ambulance Victoria and Forensicare) will undertake in the forthcoming year that contribute to achieving these priorities and the goals set out in health services' multi-year strategic plans. The KPIs outlined in the SoP also contribute to delivering against these priorities.

Statement of priorities

The SoP was introduced in 2004–05 as part of a series of governance reforms enacted through changes to the Health Services Act to improve accountability and transparency between boards of health services and the state government. The SoP is reviewed annually and sets out strategic priorities based on the *Victorian health priorities framework 2012–2022* and agreed objectives for: financial sustainability; service access and performance; safety and quality; and service delivery.

The department is committed to ensuring the suite of performance indicators used to monitor health service performance provide a balanced perspective on service provision. In line with the themes and directions set out in this document, the department will work with health services to develop and refine indicators over time.

Ambulance Victoria, the 12 metropolitan Melbourne health services, the three denominational health services based in Melbourne and the six regional Victorian health services, all have an SoP signed by the Minister for Health and the chair of the health service board. Forensicare has an SoP as the formal funding and priority-setting agreement with the Minister for Mental Health, in accordance with the new Mental Health Act. An SoP is also in place as the formal funding and monitoring agreement between Victorian subregional, local and small rural health services and the Secretary to the Department of Health (with the exception of MPS, which have a separate agreement with the Commonwealth and the State).

Mildura Base Hospital also has an SoP as the formal funding and monitoring agreement with the Secretary to the Department of Health, in accordance with Schedule 1 of the services agreement between Ramsay Health Care and the Victorian Government.

Victorian health policy and funding guidelines

The *Victorian health policy and funding guidelines 2014–15* outline the policy and service delivery objectives, the conditions of funding and key accountability requirements that organisations must comply with in addition to their contractual and statutory obligations. The policy and funding guidelines also provide an overview of the new initiatives and health budget for 2014–15.

In the case of any inconsistencies or ambiguities between these guidelines and any legislation, regulations and contractual obligations with the state of Victoria (acting through the Department of Health or the Secretary to the Department of Health), the legislative, regulatory and contractual obligations will take precedence.

Performance monitoring tools

The **Victorian Health Services Performance Monitor** ('the monitor') reports health service performance against KPIs outlined in the SoP. A similar performance monitoring tool is produced for Ambulance Victoria and Forensicare, as described below. The small rural health services are provided with the Small Rural Health Service Monitor.

Produced monthly, the monitor presents interim results for the access, service and financial aspects of performance for health services with an SoP. Health service performance is assessed quarterly and a PAS and level of monitoring is determined. The monitor is distributed monthly to CEOs and the Minister for Health and is distributed quarterly to board chairs.

The monitor is also produced annually using the consolidated annual activity data and audited financial results. This is distributed to health service CEOs, board chairs, the Minister for Health and the Minister for Mental Health.

The **Ambulance Victoria Monitor** ('AV monitor') reports ambulance service performance against KPIs outlined in the SoP and a broader set of program measures to provide a more balanced perspective of health service activity. Produced monthly, it presents financial and service aspects of performance and activity.

The AV monitor is distributed to the AV CEO and the Minister for Health monthly, and to the board chair quarterly. An annual AV monitor is produced using the consolidated annual activity data and audited financial results. This is distributed to the CEO and board chair.

The **Forensicare Monitor** reports Forensicare performance against KPIs outlined in the SoP and a broader set of program measures. Produced quarterly, it presents financial and service aspects of performance and activity.

The Forensicare Monitor is distributed to the CEO, board chair and the Minister for Mental Health quarterly. An annual Forensicare Monitor is produced using the consolidated annual activity data and audited financial results. This is distributed to the CEO and board chair.

The **Small Rural Health Services Monitor** ('SRHS monitor') reports small rural health service performance against KPIs outlined in the SoP and a broader set of program measures to provide a more balanced perspective of health service activity. Produced monthly, it presents financial and service aspects of performance and activity. The SRHS monitor is also produced for the MPS.

The SRHS monitor is distributed to CEOs and the Minister for Health monthly, and to board chairs quarterly. An annual SRHS Monitor is produced using the consolidated annual activity data and audited financial results. This is distributed to the CEOs and board chairs.

The **Program Report for Integrated Service Monitoring** (PRISM) includes a broader set of measures that provides a balanced perspective of health service activity and system performance. PRISM supports the monitor by providing context and key drivers of performance. For the small rural health services, this information is incorporated in the SRHS monitor.

PRISM monitors a broader range of services provided by health services to the Victorian community and is used by the services to benchmark their performance against similar health services.

The PRISM report is distributed to CEOs and board chairs quarterly. The department encourages health services to disseminate PRISM to relevant staff within the health service.

An annual PRISM is produced using the consolidated annual activity data and audited financial results. This is also distributed to the CEOs and board chairs.

Section 3: Performance assessment and monitoring

This section sets out the approach the department uses to assess and monitor health service performance. As described in Section 1, the performance monitoring framework is centred on a performance conversation between the department and health services. Increasingly, this performance conversation will focus on the strategic directions outlined in Section 1 and will draw on a wide range of information to fill out a comprehensive picture of health service performance. While the department is committed to working with health services to drive high performance, it also has a responsibility to ensure problems are detected and acted upon quickly.

In some cases, performance issues will trigger a higher level of monitoring of health service performance by the department to ensure that appropriate action is being taken to address performance concerns. The PAS is a key mechanism for determining the level of monitoring applied to health services. This score is derived from a subset of the KPIs included in Part B of the SoP. However, in keeping with the broad-based approach to performance monitoring, the PAS is only once factor taken into account when assessing health service performance.

Other factors considered when determining the level of monitoring, include, but are not limited to, the following risk factors:

- accreditation outcomes where core action items are assessed as not met or significant risk of patient harm identified
- persistent and emerging financial risk, including deficit operating result, low liquidity or material budget issues
- demonstrated performance deficits in other critical areas, including: significant unexplained variation in health outcomes or patient experience; indications of pervasive failure in leadership or culture; identified failures in clinical or corporate governance; or unacceptable outcomes in the quality of patient care, occupational health and safety or human resources
- emerging or ongoing significant under performance or deterioration in service access or timeliness indicators
- level of department support required to sustain operations or manage risks.

In the case of those services for which no PAS is generated, these risk factors are the primary means of determining whether a higher level of performance monitoring is required. In 2014–15 this approach applies to small rural health services, Ambulance Victoria and Forensicare.

Using the *Statement of priorities* targets to assess performance

Performance against all KPIs is assessed based on the target agreed in the SoP. The symbols used to assess performance results are:

✓	Target achieved
⊘	Target not achieved
✗	Significant non-achievement

The performance assessment of each KPI is reported in the monitor and performance thresholds are detailed in Appendix 5. Outcomes against these KPIs are a key facet of the performance conversation and inform the assessment of performance against the risk factors outlined above.

Performance assessment score

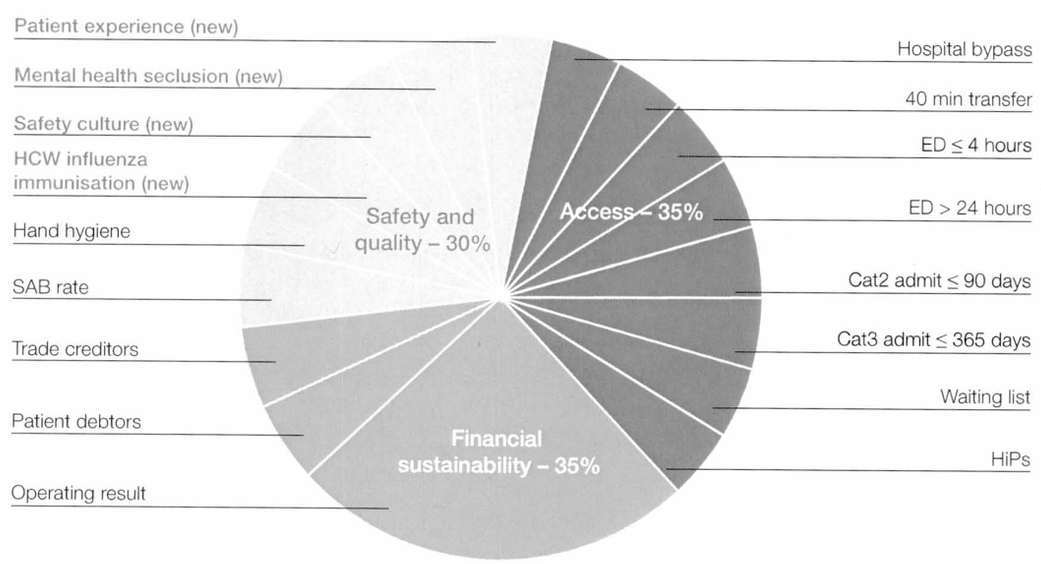
For most health services (aside from the exceptions noted above), a subset of the KPIs is used to generate a PAS, which informs the level of monitoring applicable to individual health services.

The PAS categorises the KPIs into three domains: safety and quality (formerly service), financial sustainability (formerly 'finance') and access. For 2014–15 the PAS has been reframed to align with the strategic directions for performance monitoring as described in Section 1. In particular, the three domains have been rebalanced to give increased weight to the safety and quality domain. The safety and quality domain encompasses the KPIs relating to the strategic directions of: patient experience and outcomes; governance, leadership and culture; and safety and quality. The financial sustainability domain focuses on sustainability and cash management. The access domain continues to focus on timeliness of treatment for emergency care and elective surgery patients.

The relative contribution each KPI makes to the score is dependent on whether the KPI is applicable to the health service. For emergency care KPIs, it is dependent on the number of emergency departments within the health service.

The three domains of the PAS, and the KPIs included in them for 2014–15, are shown in Figure 2. The safety and quality domain has increased from 10 to 30 per cent of the total PAS due to the introduction of the safety culture, patient experience, healthcare worker immunisation and mental health seclusion KPIs. The overall contribution that financial sustainability KPIs make to the PAS has reduced from 45 to 35 per cent due to the removal of the public and private weighted inlier equivalent separations (PP WIES) KPI and the reduction of the operating result KPI from 30 to 25 per cent of the total PAS. The access domain has been reduced from 45 to 35 per cent of the total PAS while retaining the same eight KPIs. As a result, the contribution made by each access KPI to the overall result will be reduced proportionately.

Figure 2: Performance assessment score domains and KPIs



ED = emergency department; HiPs = Hospital-initiated postponements; HCW = healthcare worker; SAB = Staphylococcus aureus bacteraemia

Calculating the performance assessment score

The scoring process occurs in three steps:

1. Allocate points for each KPI based on the performance results and calculate the score for each domain.
2. Apply the conditional KPIs for elective surgery and emergency care, where applicable.
3. Account for accepted force majeure claims that have impacted on performance.

Key performance indicator scores

The performance result of each KPI is assessed based on the corresponding thresholds, then aggregated and weighted for each domain. This means the maximum points score for each domain does not necessarily equate with the weighting that domain receives in the PAS. (For example, the maximum points score that can be achieved in the access domain is 24, but this score is weighted up so that it counts for 35% of the total PAS.) Performance thresholds and points used to calculate the PAS for each KPI are outlined in Tables 1, 2 and 3.

The suites of financial and service KPIs are assessed at the health service level. Consideration will be given to a health service that exceeds WIES activity targets and is able to demonstrate acceptable results for other indicators including the operating result, access and service KPIs.

Depending on the access KPI, performance assessment is either at campus or health service level. For health services with multiple emergency departments, a maximum weighted score is determined across all relevant campuses and the total domain score is calculated by adjusting the relative weighting of the remaining KPIs.

Where a KPI does not apply to a health service (such as bypass), the total domain score is calculated by adjusting the relative weighting of the remaining KPIs.

Where a domain is not applicable, the combined remaining domain scores are factored on a pro-rata basis to calculate a score out of 100.

Table 1: Safety and quality performance thresholds and points

Strategic direction	KPI	Description	Threshold	Points
Patient experience and outcomes	VHES*	Patient experience score based on compliance with use of VHES	Compliance	5
			Noncompliance	0
	SAB rate	Rate of SAB infections per 10,000 occupied bed days	Less than or equal to 2.0	5
			2.1 to 2.5	3
			2.6 to 3.5	1
			Greater than or equal to 3.6	0
	Mental health seclusion	Mental health seclusion rate per 1,000 occupied bed days	Less than or equal to 15	5
			16 to 20	3
			21 to 25	1
			Greater than or equal to 26	0
Governance, leadership and culture	Safety culture	Composite safety culture score based on eight safety culture items in the People Matter survey (percentage agreement)	Equal to or greater than 80%	5
			75% to less than 80%	3
			Less than 75% or response rate for People Matter survey of less than 10%	0
Safety and quality	Hand hygiene**	Hand hygiene compliance – quarter 2	Equal to or greater than 75%	5
			73% to less than 75%	3
			72% to less than 73%	1
			Less than 72%	0
		Hand hygiene compliance – quarter 3	Equal to or greater than 77%	5
			75% to less than 77%	3
			74% to less than 75%	1
			Less than 74%	0
		Hand hygiene compliance – quarter 4	Equal to or greater than 80%	5
			78% to less than 80%	3
			75% to less than 78%	1
			Less than 75%	0
	HCW immunisation	Rate of healthcare worker immunisation – influenza	Equal to or greater than 75%	5
			65% to less than 75%	3
			Less than 65%	0

* Scoring will be based on compliance for the first three quarters of 2014–15 with the target to be established in quarter four.

** Scoring for quarter 1 will be based on 2013–14 results.

Table 2: Financial sustainability performance thresholds and points

KPI	Description	Threshold	Points
Operating result	Operating result as a percentage of total operating revenue	In surplus and achieved or ahead of budget	20
		In surplus but behind budget	17
		In deficit and achieved or ahead of budget	17
		In deficit and within 0.1% to 1.1% unfavourable variance to budget	15
		In deficit and greater than 1.1 to 2.1% unfavourable variance to budget	10
		In deficit and greater than 2.1% to 3.1% unfavourable variance to budget	5
		In deficit and over 3.1% unfavourable variance to budget	0
Creditors	Trade creditors days	Less than or equal to 60 days	5
		61 to 65 days	3
		66 to 70 days	2
		71 days or more	0
Debtors	Patient debtors days	Less than or equal to 60 days	5
		61 to 70 days	3
		71 to 80 days	2
		81 days or more	0

Table 3: Access performance thresholds and points

KPI	Description	Threshold	Points
Bypass	Percentage of ED operating time on ambulance bypass	0.0% to 3.0%	3
		3.1% to 4.0%	2
		4.1% to 5.0%	1
		Greater than or equal to 5.1%	0
40 minute transfer	Percentage of ambulance patients transferred within 40 minutes	Greater than or equal to 90%	3
		85 to 89%	2
		80% to 84%	1
		Less than or equal to 79%	0
Triage1*	Percentage of triage category 1 patients seen immediately	100%	
4 hours	Percentage of all emergency patients with a length of stay in the ED of within four hours	Greater than or equal to 81%	3
		76% to 80%	2
		66% to 75%	1
		Less than or equal to 65%	0
24 hours	Number of patients with a length of stay in the ED greater than 24 hours	0	3
		1 to 15	2
		16 to 30	1
		Greater than or equal to 31	0
Cat 1 admit*	Percentage of urgency category 1 patients admitted within 30 days	100%	
Cat 2 admit	Percentage of urgency category 2 elective surgery patients admitted within 90 days	Greater than or equal to 88%	3
		83% to 87.9%	2
		78 to 82.9%	1
		Less than 78%	0
Cat 3 admit	Percentage of urgency category 3 elective surgery patients admitted within 365 days	Greater than or equal to 97%	3
		92% to 96.9%	2
		87% to 91.9%	1
		Less than or equal to 86.9%	0
ESWL	Number of patients on the elective surgery waiting list – percentage variance to target	Target achieved	3
		Between 0.1% to 2% over target	2
		3% to 5% over target	1
		Greater than or equal to 6% over target	0
HiPs	Number of hospital-initiated postponements per 100 scheduled admissions from the elective surgery waiting list	0 to 8.0	3
		8.1 to 11.0	2
		11.1 to 15.0	1
		Greater than or equal to 15.1	0

* Failure to meet the conditional KPIs will result in a point being deducted from each of the KPIs for the relevant program. Triage category 1 impacts on emergency care, and urgency category 1 impacts on elective surgery, unless the score is already 0.

Conditional key performance indicators

Two of the 10 access KPIs in the performance assessment are conditional, whereby their results only impact on the score when the KPI target is not met. The access score is first calculated for all other KPIs and in the instance where a health service does not achieve the emergency care or elective surgery conditional indicator, points are deducted. In this situation the access score is reduced by one point across each of the corresponding emergency care or elective surgery KPIs in the given quarter. If the score for a KPI is zero, no points are deducted.

The conditional KPIs for 2014–15 are:

- percentage of triage category 1 emergency care patients seen immediately
- percentage of urgency category 1 elective surgery patients admitted within 30 days.

In the event these indicators are not met health services are required to send a letter to the director of Sector Performance, Quality and Rural Health branch within five days of the breach. The letter must:

- advise the department of the breach or expected breach
- explain the circumstances of the breach
- outline the rectification plan and actions to be undertaken by the health service to avoid further breaches.

Following receipt of the letter, the department may follow up with the health service and/or this breach will be an item for discussion at the next health service performance meeting.

For urgency category 1 breaches, the department will continue to monitor overdue patients through the Elective Surgery Information System (ESIS) reporting system and may contact the health service to clarify the status of these patients.

Force majeure

The final step in determining the score is to account for any agreed force majeure claims.

From time to time, unforeseen events may occur that adversely impact on hospital performance and it is critical that the PAS reflects these bona fide concerns.

The intent of the process is to address extraordinary and genuinely unforeseen events beyond the control of the organisation that affect service delivery or reporting requirements. Examples include internal disasters beyond the control of the health service and third-party-related failures leading to interrupted service delivery. Where circumstances have a significant impact on performance, a health service may request that the department consider a claim. The process should not be applied to ad hoc operational difficulties or for planned service interruptions such as capital works.

When a hospital is reliant on services provided by a third party, the hospital is responsible for ensuring that, as far as practicable, the service is of an acceptable quality and delivered in a timely manner. For this reason, the failure of a third party to deliver a product or service is not in itself regarded as acceptable grounds for a force majeure. Difficulties related to software conversion are not a force majeure unless it can be demonstrated that reasonable steps were taken to ensure the continuity of data collection and data recovery.

In applying the force majeure policy, the performance result of a health service will not change, but the department will consider adjusting the assessment, depending on the circumstance.

Submitting a force majeure request

The department will only consider issues of force majeure retrospectively. Health services should not apply for a force majeure in anticipation of poor results.

The department may use its discretion in extraordinary circumstances to apply a force majeure across the system.

Individual health services may make a formal request for a consideration. The request should clearly indicate the event(s) affecting performance against targets and include supporting data and documentation. Formal written requests from the health service CEO should be forwarded to the relevant health service performance lead by the end of the reporting period affected.

Level of monitoring

There are three levels of monitoring applicable to Victorian health services: standard, performance watch and intensive. These levels represent a three-step scale, from lower to higher degrees and frequency for departmental scrutiny and monitoring of health service operations.

Standard monitoring applies to those health services with no significant performance concerns. This is the least intrusive level of monitoring, with meetings occurring on a regular basis (usually quarterly) between the department and the health service to discuss performance.

Performance watch applies to those health services with emerging performance deterioration. Under this level there is scope to intensify monitoring and increase the regularity of performance meetings between the department and the health service, which may include meetings with board chairs.

Intensive monitoring applies to those health services with significant and continuous under performance. Within this level the scope and frequency of monitoring intensifies. Health services are required to meet more regularly with the department and provide detailed performance analysis and risk mitigation strategies at these meetings. The department will also meet with board chairs.

If a health service has been assessed to be on performance watch or intensive monitoring, this may result in the following actions:

- discussions between the department and health service board chairs regarding matters at the strategic level related to governance, leadership or health service culture that may have an impact on performance improvement goals
- monthly meetings between the department and executives of the health service
- development of a financial recovery plan addressing any arising financial concerns
- a requirement to undergo a department-sanctioned cash or financial audit
- develop a service improvement plan addressing drivers of poor performance, including mitigation strategies and implementation actions with timelines
- develop an action plan to address identified issues, such as not met accreditation outcomes and workforce concerns, including mitigation strategies, timelines and available options.

To assist health services to improve performance, the department is establishing a performance improvement panel, with membership drawn from suitably qualified healthcare leaders. In the circumstance where the level of monitoring is performance watch or intensive, the department may, in consultation with the health service concerned, select members of the panel to support health services to achieve their performance improvement goals. In certain circumstances the department may also consider an independent review, the scope of which is determined as appropriate to address the performance concerns.

Regardless of the level of monitoring, the department and individual health services may agree to nominate one or more performance improvement panel members to assist the health service in achieving particular performance improvement goals. The department may also offer other forms of support and guidance to assist health services to develop their performance management, monitoring and improvement capabilities. This could include matching high-performing health services with other health services that may need support to address particular performance issues or achieve specific improvement goals. The department will also give special consideration to the leadership role of specialist, quaternary and major regional health services, so that their capability and experience can benefit the system as a whole. This approach will also extend to the activities of the performance improvement panel, where experience gained and lessons learnt through working with individual health services will be used to catalyse collaborative initiatives and system-wide improvements.

The support offered by the department may be particularly relevant to rural and regional health services where chairs and directors of boards may have fewer resources available to them to drive health service performance improvement goals.

The Minister for Health or Secretary to the Department of Health may also, at any time and regardless of the level of formal monitoring, exercise their powers under the Health Services Act. These include, but are not limited to, appointing delegates to the boards of health services.

Under the Ambulance Services Act, the Minister for Health can appoint delegates to the board of Ambulance Victoria. Under the new Mental Health Act, the Minister for Mental Health can appoint delegates to the board of Forensicare.

In the circumstance where a delegate has been appointed to a health service board, the health service will remain on intensive monitoring until the end of the delegate's appointment.

In the circumstance where accreditation has not been awarded, the risk assessment as per the *Accreditation – performance monitoring and regulatory approach business rules* will determine the monitoring level for the health service.

While performance monitoring forms a central part of the framework, it occurs along a spectrum of activities, and the department will apply specific measures only as required to address the performance concerns. The department will take into account the burden of additional monitoring when scheduling meetings or requesting additional reports. Where possible, existing reports (such as board papers) will be used for monitoring purposes.

Determination of monitoring level

The department uses the PAS as the basis for setting the level of monitoring.

The PAS and its associated levels of monitoring are:

- 70–100 points – standard monitoring
- 50–69 points – performance watch
- 0–49 points – intensive monitoring.

A PAS within the same range for two consecutive quarters will initiate monitoring at that level. However, if a health service has a score of 49 points or fewer in a single quarter, this will automatically trigger intensive monitoring.

As no formal scoring system will be used in 2014–15 for small rural health services, Ambulance Victoria and Forensicare, the level of monitoring will be determined in accordance with assessment against the risk factors outlined at the start of this section.

Section 4: Contact details

Health services with general queries about the information provided in this document may contact either:

The relevant health service performance lead

or

Manager, Performance and Governance / Manager, Rural Health
Sector Performance, Quality and Rural Health
Department of Health
GPO Box 4057
Melbourne 3001
Ph: (03) 9096 1309 / 9096 7711

or (for Ambulance Victoria queries)

Manager, Ambulance Services
Health Service Performance and Programs
Department of Health
GPO Box 4057
Melbourne 3001
Ph: (03) 9096 1302

or (for Forensicare queries)

Manager, Programs and Performance
Mental Health
Department of Health
GPO Box 4057
Melbourne 3001
Ph: (03) 9096 0459

Health services with data submission issues may contact the:

Data Collections Unit
Department of Health
GPO Box 4057
Melbourne 3001
Ph: (03) 9096 8141
Email: hdss.helpdesk@health.vic.gov.au

References

1. The King's Fund 2013, *Patient-centred leadership: rediscovering our purpose*, The King's Fund, London.

2. IBM Corporation 2012, R*edefining value and success in healthcare: charting the path to the future*, IBM Corporation, Armonk.

3. Department of Health (UK) 2013, *Patients first and foremost: the initial government response to the report of the Mid Staffordshire NHS Foundation Trust public inquiry*, Department of Health, London.

4. Millar R, et al. 2013, 'Hospital board oversight of quality and patient safety: a narrative review and synthesis of recent empirical research', *The Millbank Quarterly*, vol. 91, no. 4, pp. 738–770.

5. KPMG International 2013, *Global perspectives on clinical governance*, KPMG International, Amsterdam.

6. Australian Commission on Safety and Quality in Health Care 2011, *Windows into safety and quality in health care 2011*, Commonwealth of Australia, Canberra.

7. Balding C 2013, *Create a great quality system in six months*, Qualityworks P/L, Ashburton.

8. Epstein RE, Street RL 2011, 'The values and value of patient-centred care', *Annals of Family Medicine*, vol. 9, no. 2, pp. 100–103.

9. Porter ME, Teisberg EO 2003, *Redefining health care: creating value-based competition on results,* Harvard Business Press, Boston.

10. Institute of Chartered Accountants Australia 2005, *Extended performance reporting: an overview of techniques*, ICCA, Sydney.

11. National Advisory Group on the Safety of Patients in England 2013, *Improving the safety of patients in England*, National Advisory Group on the Safety of Patients in England, London.

12. Chambers N 2012, 'Healthcare board governance', *Journal of Health Organization and Management*, vol. 26, no. 1, pp. 6–14.

13. Ferlie E, Fitzgerald L, McGivern G, Dopson S, Bennett C 2013, *Making wicked problems governable? The case of managed networks in health care*, Oxford University Press, Oxford.

14. Shih A, et al. 2008, *Organizing the US health care delivery system for high performance*, The Commonwealth Fund, Commission on a High Performance Health System.

15. Moore M 2003, *The public value scorecard: a rejoinder and an alternative to 'Strategic Performance Measurement and Management in Non-Profit Organizations' by Robert Kaplan*, Hauser Center for Nonprofit Organizations, Harvard University, Harvard.

16. Mannion R, Davies HTO, Marshall MN 2005. 'Cultural characteristics of "high" and "low" performing hospitals', *Journal of Health Organization and Management*, vol. 19, no. 6, pp. 431–439.

17. Curry LA, et al. 2011 'What distinguishes top-performing hospitals in acute myocardial infarction mortality rates? A qualitative study', *Annals of Internal Medicine*, vol. 154, no. 6, pp. 384-390.

18. Leggat SG, Bartram T, Stanton P 2005, 'Performance monitoring in the Victorian health care system: an exploratory study', *Australian Health Review*, vol. 29, no. 1, pp. 17–24.

19. Weinberg DB, Avgar AC, Sugrue NM, Cooney Miner D 2013, 'The importance of a high performance work environment in hospitals', *Health Services Research*, vol. 48, no. 1, pp. 319–332.

20. Porter ME, Lee TH 2013, 'The strategy that will fix health care', *Harvard Business Review*, October.

21. Coiera E, Hovenga EJS 2007, *Building a sustainable health system*, IMIA Yearbook of Medical Informatics.

22. Brand CA, et al. 2012, 'A review of hospital characteristics associated with improved performance', *International Journal for Quality in Health Care*, vol. 24, no. 5, pp. 483–494.

23. Wolf J et al. 2014, 'Defining patient experience' *Patient Experience Journal*, vol. 1, no. 1, pp. 7–19.

24. Hurst J, Hughes MJ 2001, 'Performance measurement and performance management in OECD health systems', OECD Labour Market and Social Policy Occasional Papers, No. 47, OECD Publishing, Paris.

25. Appleby J, Devlin N 2004, *Measuring success in the NHS: using patient-assessed health outcomes to manage the performance of healthcare providers*, The King's Fund, London.

26. Basch E, Torda P, Adams K 2013, 'Standards for patient-reported outcome-based performance measures', *Journal of the American Medical Association*, vol. 310, no. 2, pp. 139–140.

27. Wilde JA, McMillan JA, Serwint J, Butta J, O'Riordan MA, Steinhoff MC 1999, 'Effectiveness of influenza vaccine in health care professionals: a randomized trial', *Journal of the American Medical Association*, vol. 281, no. 10, pp. 908–913.

28. Yassi A, Kettner J, Hamond G, Cheang M, McGill M 1991, 'Effectiveness and cost-benefit of an influenza vaccination program for health care workers', *The Canadian Journal of Infectious Diseases*, vol. 2, no. 3, pp. 101–108.

29. Ahmed F, Lindley MC, Allred N, Weinbaum CM, Grohskopf L 2014, 'Effect of influenza vaccination of healthcare personnel on morbidity and mortality among patients: systematic review and grading of evidence', *Clinical Infectious Diseases*, vol. 58, no. 1, pp. 50–57.

30. Government of Victoria 2013, *Public hospitals: results of the 2012–13 audits*, Victorian Auditor-General's report, November.

31. Partel K 2014, *Can we improve the health system with performance reporting?* Deeble Institute, Australian Healthcare and Hospitals Association.

32. Shaw C 2003, *How can hospital performance be measured and monitored?* Copenhagen, World Health Organization Regional Office for Europe.

33. Bilton D, Cayton H 213, *Asymmetry of influence, the role of regulators in patient safety,* The Health Foundation – Thought Paper.

Appendix 1: 2014–15 changes

In keeping with the strategic directions described in Section 1, changes to the performance monitoring framework for 2014–15 are set out below according to the strategic direction to which they are most relevant.

Patient experience and outcomes

- Compliance with the VHES will be included in the PAS. Benchmarks for survey scores will be established during the first two quarters of 2014–15 and shadowed with health services in the second half of the year for introduction into the PAS in 2015–16.
- The previous VICNISS performance composite indicator has been split into two separate KPIs for 2014–15: (i) intensive care unit (ICU) central-line-associated bloodstream infection (CLABSI) and (ii) healthcare-associated infection surgical site infection (SSI) surveillance. Hip and knee SSI surveillance must be undertaken for the July–December period, but health services may substitute another surgical procedure for the January–June period (see business rules at Appendix 5 for more detail).
- Mental health seclusion rate will be included in the PAS.
- Comparative data on whole-of-hospital and four condition-specific mortality measures (pneumonia, stroke, acute myocardial infarction and fractured neck of femur) will be reported in PRISM in 2014–15. Health services should undertake their own investigations of 'outlier' results for their services, commensurate with the degree of variance. These will be reviewed at quarterly performance meetings with the department.
- Health services will be eligible to receive additional funding under the Victorian Government Pricing for Quality initiative where they are able to demonstrate a zero rate of ICU CLABSI over two consecutive quarters.

Governance, leadership and culture

- The current response rate indicator for the People Matter survey will be replaced by a composite indicator based on the eight safety culture items from the survey and the new indicator will be included in the PAS.
- The department will establish a performance improvement panel of suitably experience healthcare leaders to provide support in specific areas to health services where performance could be improved.
- For health services on or at risk of moving to intensive monitoring, stronger action will be taken through the department's engagement with health service board chairs.

Safety and quality

- Hand hygiene compliance will increase incrementally to a new statewide target 80 per cent, with higher thresholds for lower scores being phased in over consecutive quarters of 2014–15.
- Performance reporting to the department against cleaning standards will be increased to three out of four quarters, to align with the current number of cleaning audits undertaken per annum by health services. This replaces the current SoP KPI of a single annual figure based on the mandated external cleaning audit.
- Healthcare worker influenza immunisation will be incorporated into the PAS in 2014–15.
- Health services will be eligible to receive additional funding under the Victorian Government Pricing for Quality initiative where they are able to demonstrate that they are meeting developmental actions with merit in the National Safety and Quality Health Service Standards.

Financial sustainability

- A new traffic light pass/fail indicator will be included in Part B of the SoP based on the submission by health services of basic asset management plans to the department by September 2014.
- Part A of the SoP will include an objective to 'identify and implement practice change to enhance asset management' against the *Victorian health priorities framework 2012–2022* key priority of 'increasing the system's financial sustainability and productivity'.
- The operating result indicator in the PAS will contribute 25 per cent rather than 30 per cent of the total PAS.
- The PP WIES indicator will be removed from the PAS.
- As a result of these two changes, the overall proportion of the PAS relating to financial sustainability will decrease from 45 to 35 per cent.
- The maximum PAS points for the operating result KPI (20 points) will be reserved for health services in surplus and that have achieved or are ahead of budget; health services in deficit while achieving or being ahead of budget will only be eligible to score up to a maximum of 17 points for the operating result KPI.
- A new suite of liquidity measures will be introduced into PRISM including: modification of the Current Asset Ratio (CAR) to include Long-term Investments; introduction of an actual and forecast Cash at Bank indicator; and possible modifications to the Days of Available Cash indicator.

Table 1: Summary of 2014–15 changes indicating how changes will impact on framework components

Domain	Item	SoP Part B – PAS	SoP Part B – monitor	SoP Part A	PRISM
Patient experience and outcomes	VHES	✓	✓		
	SSI		✓		
	ICU CLABSI		✓		
	Mental health seclusion	✓ (composite score)	✓ (individual scores)		
	Mortality measures				✓
	Pricing for quality – ICU CLABSI				
Governance, leadership and culture	People Matter safety score	✓	✓		
	Performance panel				
	Board chair engagement				
Safety and quality	Cleaning standards		✓		
	Hand hygiene	✓	✓		
	Staff influenza immunisation	✓	✓		
	Pricing for quality -National standards				
Financial sustainability	Operating result – overall decrease	✓	✓		
	Operating result – deficit services adjustment	✓	✓		
	PPWIES	removed	✓		
	Asset management plans		✓		
	Enhance asset management			✓	
	Liquidity measures				✓

Appendix 2: Key performance indicators

- The department is committed to ensuring the suite of KPIs used to monitor health services provides a balanced perspective of service provision. The department continues to work with health services and Ambulance Victoria to develop and refine indicators over time.
- Table 1 lists the SoP KPIs for 2014–15 and identifies whether these indicators contribute to the PAS (see Section 4).

Table 2.1: Statement of priorities key performance indicators

Safety and quality performance				
Program	**KPI**	**KPI description**	**Target**	**PAS**
Patient experience and outcomes				
	VHES	Participation in the Victorian healthcare experience survey	Full compliance	✓
	Surgical site infection	Submission of infection surveillance data for nominated surgical procedures.	No outliers	✗
	ICU central-line infection	Submission of infection surveillance data for ICU central lines.	No outliers	✗
	SAB	*Staphylococcus aureus* bacteraemia (SAB) rate per occupied bed day	≤ 2/10,000	✓
Maternity	Postnatal care	% of women who have given birth and on discharge have been offered prearranged postnatal care	100%	✗
Newborns	Newborn screening	% of eligible newborns screened for hearing deficit before one month of age	≥ 97%	✗
Mental health	MH28Day	% of adult general acute psychiatric inpatients readmitted within 28 days of separation	14%	✗
	Post discharge	% of patients with a post-discharge follow-up within seven days (child and adolescent, adult, aged)	75%	✗
	Seclusion	Rate of total seclusions (child and adolescent, adult, aged)	≤ 15/1,000	✓
Ambulance services	Patient satisfaction	% of patients satisfied or very satisfied with quality of care provided by paramedics	95%	✗
	Pain reduction – adult	% of adult patients experiencing severe cardiac and traumatic pain whose level of pain is reduced significantly	90%	✗
	Pain reduction – paediatric	% of paediatric patients experiencing severe traumatic pain whose level of pain is reduced significantly.	90%	✗
	Stroke patients transported	% of adult patients suspected of having a stroke who were transported to a stroke unit with thrombolysis facilities within 60 minutes	80%	✗
	Cardiac survival on hospital discharge	% of adult VF/VT cardiac patients surviving to hospital discharge	20%	✗

Safety and quality performance				
Program	**KPI**	**KPI description**	**Target**	**PAS**
Governance, leadership and culture				
	People Matter patient safety culture	% score on patient safety culture section of People Matter survey	80%	✓
Safety and quality				
	Accreditation	Health service accreditation	Full accreditation	✗
	Resi aged care	Residential aged care compliance with accreditation standards	Full compliance	✗
	Cleaning	Compliance with cleaning audits	Full compliance	✗
	VICNISS data	Submission of infection surveillance data to VICNISS	Full compliance	✗
	Hand hygiene	Hand hygiene compliance	75% Q2 77% Q3 80% Q4	✗
	HCWI – influenza	Healthcare worker immunisation – influenza	75%	✓
Ambulance services	Clinical compliance emergency statewide	% of audited emergency cases statewide meeting clinical practice standards	95%	✗
	Clinical compliance non-emergency statewide	% of audited non-emergency cases statewide meeting clinical practice standards	94%	✗
	Clinical compliance CERT	% of audited cases attended by CERT meeting clinical practice standards	90%	✗

Financial sustainability performance

Program	KPI	KPI description	Target	PAS
Finance	Operating result	Operating result as a % of total operating revenue	Health service specific	✓*
	Creditors	Trade creditor days	60 days	✓*
	Debtors	Patient debtor days	60 days	✓*
	PP WIES	Public and private WIES activity performance to target	100%	✗
Asset management	Basic asset management plan	Submission by health services of a basic asset management plan	Full compliance	✗

Access performance

Program	KPI	KPI description	Target	PAS
Emergency care	Bypass	% of operating time on hospital bypass	3%	✓
	40 min transfers	% of patients transferred from paramedic care to hospital emergency care within 40 minutes of ambulance arrival	90%	✓
	Triage 1	% of triage category 1 patients seen immediately	100%	✓
	Triage 1–5	% of triage category 1–5 patients seen within clinically recommended times	80%	✗
	4 hour	% of patients to physically leave the ED for admission to hospital, be referred to another hospital for treatment, or be discharged within four hours	81%	✓
	24 hours	Number of patients with a length of stay in the ED greater than 24 hours	0	✓
Elective surgery	Cat 1 admit	% of urgency category 1 elective surgery patients admitted within 30 days	100%	✓
	Cat 2 admit	% of urgency category 2 elective surgery patients admitted within 90 days	88%	✓
	Cat 3 admit	% of urgency category 3 elective surgery patients admitted within 365 days	97.0%	✓
	ESWL	Number of patients on the elective surgery waiting list (ESWL)	Health service specific	✓

Access performance

Program	KPI	KPI description	Target	PAS
	HiPS	Number of hospital-initiated postponements (HiPs) per 100 scheduled admissions	8	✓
	Admissions	Number of patients admitted from the elective surgery waiting list	Health service specific	✗
Critical care	ICU	Number of days intensive care unit (ICU) operates below agreed minimum operating capacity	0	✗
	PICU	Number of days paediatric intensive care unit (PICU) operates below agreed minimum operating	0	✗
	NICU	Number of days neonatal intensive care unit (NICU) operates below agreed minimum standard and flex operating capacity	0	✗
Timely response	Response times statewide	% of emergency (code 1) incidents responded to within 15 minutes	85%	✗
	Response times urban	% of emergency (code 1) incidents responded to within 15 minutes in centres with a population greater than 7,500	90%	✗
	Response times CERT	% CERT arrival occurs prior to ambulance arrival where CERT is dispatched	85%	✗
	Call Referral	% of 000 events where the caller receives advice or service from another health provider as an alternative to emergency ambulance response in the metropolitan area.	10%	✗

*excludes Ambulance Victoria

Appendix 3: Applicable key performance indicators by health service

The following tables set out KPIs applicable to individual health services and hospitals. The key below outlines the symbols used in each of the tables.

- ✗ KPI not applicable
- ▣ Performance monitored against SoP for this KPI but no performance score generated
- ✓ Performance score generated
- ✧ Non-achievement of the statewide target will result in the reduction of one point for each emergency care and elective surgery KPI

Safety and quality key performance indicators

Patient experience and outcomes

Table 3.1: Patient experience and outcomes key performance indicators

Health service	VHES	HAI SSI	HAI ICU CLABSI	SAB
Metropolitan				
Austin Health	✓	▣	▣	✓
Alfred Health	✓	▣	▣	✓
Calvary Health	✓	✗	✗	✓
Eastern Health	✓	▣	▣	✓
Melbourne Health	✓	▣	▣	✓
Mercy Public Hospitals Inc.	✓	▣	✗	✓
Monash Health	✓	▣	▣	✓
Northern Health	✓	▣	▣	✓
Peninsula Health	✓	▣	▣	✓
Peter MacCallum Cancer Centre	✓	✗	▣	✓
St Vincent's Hospital (Melbourne) Ltd	✓	▣	▣	✓
The Royal Victorian Eye and Ear Hospital	✓	✗	✗	✓
The Royal Children's Hospital	✓	✗	▣	✓
The Royal Women's Hospital	✓	▣	✗	✓
Western Health	✓	▣	▣	✓
Regional				
Albury Wodonga Health	✓	▣	▣	✓
Ballarat Health Services	✓	▣	▣	✓
Barwon Health	✓	▣	▣	✓
Bendigo Health Care Group	✓	▣	▣	✓
Goulburn Valley Health	✓	▣	▣	✓
Latrobe Regional Hospital	✓	▣	▣	✓

Health service	VHES	HAI SSI	HAI ICU CLABSI	SAB
Subregional				
Bairnsdale Regional Health Service	✓	✗	✗	✗
Central Gippsland Health Service	✓	✗	✗	✗
Echuca Regional Health Service	✓	✗	▣	✗
Mildura Base Hospital	✓	✗	▣	✗
Northeast Health Wangaratta	✓	✗	▣	✗
South West Healthcare	✓	✗	▣	✗
Swan Hill District Health	✓	✗	✗	✗
West Gippsland Healthcare Group	✓	✗	✗	✗
Western District Health Service	✓	✗	▣	✗
Wimmera Health Care Group	✓	✗	▣	✗
Local				
Bass Coast Regional Health	✓	✗	✗	✗
Benalla Health	✓	✗	✗	✗
Colac Area Health	✓	✗	✗	✗
Djerriwarrh Health Services	✓	✗	✗	✗
East Grampians Health Service	✓	✗	✗	✗
Gippsland Southern Health Service	✓	✗	✗	✗
Kyabram and District Health Service	✓	✗	✗	✗
Maryborough and District Health Service	✓	✗	✗	✗
Castlemaine Health	✓	✗	✗	✗
Portland District Health	✓	✗	✗	✗
Stawell Regional Health	✓	✗	✗	✗
Small rural health services				
Alexandra District Hospital	▣	✗	✗	✗
Alpine Health	▣	✗	✗	✗
Beaufort and Skipton Health Service	▣	✗	✗	✗
Beechworth Health Service	▣	✗	✗	✗
Boort District Health	▣	✗	✗	✗
Casterton Memorial Hospital	▣	✗	✗	✗
Cobram District Health	▣	✗	✗	✗
Cohuna District Health	▣	✗	✗	✗
Dunmunkle Health Services	▣	✗	✗	✗
East Wimmera Health Service	▣	✗	✗	✗
Edenhope and District Hospital	▣	✗	✗	✗
Hepburn Health Service	▣	✗	✗	✗
Hesse Rural Health Service	▣	✗	✗	✗
Heywood Rural Health	▣	✗	✗	✗
Inglewood and District Health Service	▣	✗	✗	✗

Health service	VHES	HAI SSI	HAI ICU CLABSI	SAB
Kerang District Health	▣	✗	✗	✗
Kilmore and District Hospital	▣	✗	✗	✗
Kooweerup Regional Health Service	▣	✗	✗	✗
Kyneton District Health Service	▣	✗	✗	✗
Lorne Community Hospital	▣	✗	✗	✗
Maldon Hospital	▣	✗	✗	✗
Mallee Track Health and Community Service	▣	✗	✗	✗
Mansfield District Hospital	▣	✗	✗	✗
McIvor Health and Community Services	▣	✗	✗	✗
Moyne Health Services	▣	✗	✗	✗
Nathalia District Hospital	▣	✗	✗	✗
Numurkah District Health Service	▣	✗	✗	✗
Omeo District Health	▣	✗	✗	✗
Orbost Regional Health	▣	✗	✗	✗
Otway Health and Community Services	▣	✗	✗	✗
Robinvale District Health Services	▣	✗	✗	✗
Rochester and Elmore District Health Service	▣	✗	✗	✗
Rural Northwest Health	▣	✗	✗	✗
Seymour Health	▣	✗	✗	✗
South Gippsland Hospital	▣	✗	✗	✗
Tallangatta Health Service	▣	✗	✗	✗
Terang and Mortlake Health Service	▣	✗	✗	✗
Timboon and District Healthcare Service	▣	✗	✗	✗
Upper Murray Health and Community Services	▣	✗	✗	✗
West Wimmera Health Service	▣	✗	✗	✗
Yarram and District Health Service	▣	✗	✗	✗
Yarrawonga District Health Service	▣	✗	✗	✗
Yea and District Memorial Hospital	▣	✗	✗	✗

Table 3.2: Maternity and neonatal patient experience and outcomes key performance indicators, by health service

Campus	Postnatal	Newborn screening
Metropolitan		
Angliss Hospital	▣	✗
Austin Hospital	✗	✗
Box Hill Hospital	▣	✗
Casey Hospital	▣	✗
Dandenong Hospital	▣	✗
Frankston Hospital	▣	✗
Maroondah Hospital*	✗	✗
Mercy Hospital for Women	▣	✗
Monash Medical Centre – Clayton	▣	✗
Peter MacCallum Cancer Centre	✗	✗
Rosebud Hospital	✗	✗
Sandringham and District Hospital	▣	✗
St Vincent's Hospital	✗	✗
Sunshine Hospital	▣	✗
The Alfred	✗	✗
The Northern Hospital	▣	✗
The Royal Melbourne Hospital	✗	✗
The Royal Children's Hospital	✗	✗
The Royal Victorian Eye and Ear Hospital	✗	✗
The Royal Women's Hospital	▣	✗
Werribee Mercy Hospital	▣	✗
Western Hospital	✗	✗
Williamstown Hospital	✗	✗
Regional		
Albury Hospital	✗	✗
Ballarat Base Hospital	▣	✗
Geelong Hospital	▣	✗
Bendigo Hospital	▣	✗
Shepparton Hospital	▣	✗
Latrobe Regional Hospital	▣	✗
Subregional		
Bairnsdale Regional Hospital	▣	✗
Hamilton Base Hospital	▣	✗
Wangaratta Hospital	▣	✗
Swan Hill Hospital	▣	✗
West Gippsland Hospital	▣	✗

Campus	Postnatal	Newborn screening
Sale Hospital	▣	✗
Warrnambool Hospital	▣	✗
Horsham Hospital	▣	✗
Echuca Regional Hospital	▣	✗
Mildura Base Hospital	▣	✗
Camperdown Hospital	▣	✗
Local		
Bass Coast Regional Hospital	▣	✗
Benalla Health	▣	✗
Colac Area Health	▣	✗
Djerriwarrh Health Services	▣	✗
Bacchus Marsh Hospital	▣	✗
East Grampians Health (Ararat)	▣	✗
Gippsland Southern Health (Leongatha)	▣	✗
Kyabram and District Hospital	▣	✗
Maryborough and District Hospital	▣	✗
Castlemaine Health	▣	✗
Portland District Health	▣	✗
Small rural health services		
Cohuna District Health	▣	✗
East Wimmera Health Service	▣	✗
Kerang District Health	▣	✗
Kilmore District Hospital	▣	✗
Kyneton District Health Service	▣	✗
Mansfield District Hospital	▣	✗
Orbost Regional Health	▣	✗
South Gippsland Hospital	▣	✗
Terang and Mortlake Health Service	▣	✗
Yarrawonga District Health Service	▣	✗

Table 3.3: Mental health composite patient experience and outcomes key performance indicator, by health service

Health service	Seclusion composite score
Metropolitan	
Alfred Health	✓
Austin Health	✓
Eastern Health	✓
Melbourne Health	✓
Monash Health	✓
Peninsula Health	✓
St Vincent's Hospital	✓
Werribee Mercy Hospital	✓
Forensicare	✓
The Royal Children's Hospital	✓
Regional	
Albury Wodonga Health	✓
Ballarat Health Services	✓
Barwon Health	✓
Bendigo Health	✓
Goulburn Valley Health	✓
Latrobe Regional Hospital	✓
Subregional	
Mildura Base Hospital	✓
South West Healthcare	✓

Table 3.4: Adult mental health patient experience and outcomes key performance indicators, by mental health team

Area mental health service	Adult MH 28 day	Adult post discharge	Adult seclusion
Metropolitan			
Alfred Health – Inner South East	▣	▣	▣
Austin Health – North East	▣	▣	▣
Eastern Health – Central East	▣	▣	▣
Eastern Health – Outer East	▣	▣	▣
Melbourne Health – Inner West	▣	▣	▣
Melbourne Health – Mid West	▣	▣	▣
Melbourne Health – North West	▣	▣	▣
Melbourne Health – Northern	▣	▣	▣
Melbourne Health (ORYGEN Youth Health)	✗	▣	▣
Monash Health – Casey	▣	▣	▣
Monash Health – Dandenong	▣	▣	▣
Monash Health – Middle South	▣	▣	▣
Peninsula Health – Peninsula	▣	▣	▣
St Vincent's Hospital – Inner Urban East	▣	▣	▣
Werribee Mercy Hospital – South West	▣	▣	▣
Forensicare	✗	✗	▣
Regional			
Albury Wodonga Health – North East and Border	▣	▣	▣
Ballarat Health Services – Grampians	▣	▣	▣
Barwon Health – Barwon	▣	▣	▣
Bendigo Health – Loddon Campaspe/ Southern Mallee	▣	▣	▣
Goulburn Valley Health – Goulburn and Southern	▣	▣	▣
Latrobe Regional Hospital – Gippsland	▣	▣	▣
Subregional			
Mildura Base Hospital – Northern Mallee	▣	▣	▣
South West Healthcare – Glenelg (South Western)	▣	▣	▣

Table 3.5: CAMHS mental health patient experience and outcomes key performance indicators, by mental health team

Area mental health service	CAMHS post discharge	CAMHS seclusion
Metropolitan		
Alfred Health – Inner South East	▣	✗
Austin Health – North East	▣	✗
Austin Health – Statewide Eagle Unit (Child)	✗	▣
Austin Health – Marion Drummond Unit (Adolescent)	✗	▣
Eastern Health – Eastern	▣	▣
Monash Health – South Eastern	▣	▣
The Royal Children's Hospital – North Western	▣	▣
Regional		
Albury Wodonga Health – North East and Border	▣	✗
Ballarat Health Services – Grampians	▣	✗
Barwon Health – Barwon	▣	✗
Bendigo Health – Loddon Campaspe / Southern Mallee	▣	✗
Goulburn Valley Health – Goulburn and Southern	▣	✗
Latrobe Regional Hospital – Gippsland	▣	✗
Subregional		
Mildura Base Hospital – Northern Mallee	▣	✗
South West Healthcare – Glenelg (South Western)	▣	✗

Table 3.6: Aged mental health patient experience and outcomes key performance indicators, by mental health team

Area mental health service	Aged post discharge	Aged seclusion
Metropolitan		
Alfred Health – Caulfield (Inner South East)	▣	▣
Eastern Health – Peter James Centre (Central / Outer East)	▣	▣
Melbourne Health – Broadmeadows (North West / Inner West)	▣	▣
Melbourne Health – Sunshine (Mid West / South West)	▣	▣
Melbourne Health – Bundoora (North East)	▣	▣
Monash Health – Monash Aged (Middle South)	▣	▣
Monash Health – Dandenong	▣	▣
Peninsula Health – Peninsula	▣	▣
St Vincent's – St Georges (Inner and North West)	▣	▣
Regional		
Albury Wodonga Health – North East and Border	▣	▣
Ballarat Health Services – Grampians	▣	▣
Barwon Health – Barwon	▣	▣
Bendigo Health – Loddon Campaspe / Southern Mallee	▣	▣
Goulburn Valley Health – Goulburn and Southern	▣	▣
Latrobe Regional Hospital – Gippsland	▣	▣
Subregional		
Mildura Base Hospital – Northern Mallee	▣	▣
South West Healthcare – Glenelg (South Western)	▣	▣

Table 3.7: Ambulance Victoria patient experience and outcomes indicators

Health service	Patient satisfaction	Pain reduction – adult	Pain r eduction – paed	Stroke patients transported	Cardiac survival to hospital	Cardiac survival to hospital discharge
Ambulance Victoria	▣	▣	▣	▣	▣	▣

Governance, leadership and culture key performance indicators

Table 3.8: People Matter patient safety culture key performance indicator

Health service	Safety culture
Metropolitan	
Austin Health	✓
Alfred Health	✓
Calvary Health	✓
Eastern Health	✓
Melbourne Health	✓
Mercy Public Hospitals Inc.	✓
Monash Health	✓
Northern Health	✓
Peninsula Health	✓
Peter MacCallum Cancer Centre	✓
St Vincent's Hospital (Melbourne) Ltd	✓
The Royal Children's Hospital	✓
The Royal Victorian Eye and Ear Hospital	✓
The Royal Women's Hospital	✓
Western Health	✓
Regional	
Albury Wodonga Health	✓
Ballarat Health Services	✓
Barwon Health	✓
Bendigo Health Care Group	✓
Goulburn Valley Health	✓
Latrobe Regional Hospital	✓
Subregional	
Bairnsdale Regional Health Service	✓
Central Gippsland Health Service	✓
Echuca Regional Health Service	✓
Mildura Base Hospital	✓
Northeast Health Wangaratta	✓
South West Healthcare	✓
Swan Hill District Health	✓
West Gippsland Healthcare Group	✓
Western District Health Service	✓
Wimmera Health Care Group	✓
Local	
Bass Coast Regional Health	✓
Benalla Health	✓

Health service	Safety culture
Colac Area Health	✓
Djerriwarrh Health Services	✓
East Grampians Health Service	✓
Gippsland Southern Health Service	✓
Kyabram and District Health Service	✓
Maryborough and District Health Service	✓
Castlemaine Health	✓
Portland District Health	✓
Stawell Regional Health	✓
Small rural health services	
Alexandra District Hospital	▣
Alpine Health	▣
Beaufort and Skipton Health Service	▣
Beechworth Health Service	▣
Boort District Health	▣
Casterton Memorial Hospital	▣
Cobram District Health	▣
Cohuna District Health	▣
Dunmunkle Health Services	▣
East Wimmera Health Service	▣
Edenhope and District Hospital	▣
Hepburn Health Service	▣
Hesse Rural Health Service	▣
Heywood Rural Health	▣
Inglewood and District Health Service	▣
Kerang District Health	▣
Kilmore and District Hospital	▣
Kooweerup Regional Health Service	▣
Kyneton District Health Service	▣
Lorne Community Hospital	▣
Maldon Hospital	▣
Mallee Track Health and Community Service	▣
Mansfield District Hospital	▣
McIvor Health and Community Services	▣
Moyne Health Services	▣
Nathalia District Hospital	▣
Numurkah District Health Service	▣
Omeo District Health	▣
Orbost Regional Health	▣
Otway Health and Community Services	▣

Health service	Safety culture
Robinvale District Health Services	▣
Rochester and Elmore District Health Service	▣
Rural Northwest Health	▣
Seymour Health	▣
South Gippsland Hospital	▣
Tallangatta Health Service	▣
Terang and Mortlake Health Service	▣
Timboon and District Healthcare Service	▣
Upper Murray Health and Community Services	▣
West Wimmera Health Service	▣
Yarram and District Health Service	▣
Yarrawonga District Health Service	▣
Yea and District Memorial Hospital	▣

Safety and quality key performance indicators

Table 3.9: Safety and quality key performance indicators, by health service

Health service	Accred	Resi	Clean	VICNISS part	Hand hygiene	HCWI flu
Metropolitan						
Austin Health	▣	▣	▣	✗	✓	✓
Alfred Health	▣	▣	▣	✗	✓	✓
Calvary Health	▣	✗	▣	✗	✓	✓
Eastern Health	▣	▣	▣	✗	✓	✓
Melbourne Health	▣	▣	▣	✗	✓	✓
Mercy Public Hospitals Inc.	▣	✗	▣	✗	✓	✓
Monash Health	▣	▣	▣	✗	✓	✓
Northern Health	▣	▣	▣	✗	✓	✓
Peninsula Health	▣	▣	▣	✗	✓	✓
Peter MacCallum Cancer Centre	▣	✗	▣	✗	✓	✓
St Vincent's Hospital (Melbourne) Ltd	▣	▣	▣	✗	✓	✓
The Royal Children's Hospital	▣	✗	▣	✗	✓	✓
The Royal Victorian Eye and Ear Hospital	▣	✗	▣	✗	✓	✓
The Royal Women's Hospital	▣	✗	▣	✗	✓	✓
Western Health	▣	▣	▣	✗	✓	✓
Regional						
Albury Wodonga Health	▣	✗	▣	✗	✓	✓
Ballarat Health Services	▣	▣	▣	✗	✓	✓
Barwon Health	▣	▣	▣	✗	✓	✓
Bendigo Health Care Group	▣	▣	▣	✗	✓	✓
Goulburn Valley Health	▣	▣	▣	✗	✓	✓
Latrobe Regional Hospital	▣	▣	▣	✗	✓	✓
Subregional						
Bairnsdale Regional Health Service	▣	▣	▣	▣	✓	✓
Central Gippsland Health Service	▣	▣	▣	▣	✓	✓
Echuca Regional Health Service	▣	▣	▣	▣	✓	✓
Mildura Base Hospital	▣	✗	▣	▣	✓	✓
Northeast Health Wangaratta	▣	▣	▣	▣	✓	✓
South West Healthcare	▣	▣	▣	▣	✓	✓
Swan Hill District Health	▣	▣	▣	▣	✓	✓
West Gippsland Healthcare Group	▣	▣	▣	▣	✓	✓
Western District Health Service	▣	▣	▣	▣	✓	✓
Wimmera Health Care Group	▣	▣	▣	▣	✓	✓

Health service	Accred	Resi	Clean	VICNISS part	Hand hygiene	HCWI flu
Local						
Bass Coast Regional Health	☐	☐	☐	☐	✓	✓
Benalla Health	☐	☐	☐	☐	✓	✓
Colac Area Health	☐	☐	☐	☐	✓	✓
Djerriwarrh Health Services	☐	☐	☐	☐	✓	✓
East Grampians Health Service	☐	☐	☐	☐	✓	✓
Gippsland Southern Health Service	☐	☐	☐	☐	✓	✓
Kyabram and District Health Service	☐	☐	☐	☐	✓	✓
Maryborough and District Health Service	☐	☐	☐	☐	✓	✓
Castlemaine Health	☐	☐	☐	☐	✓	✓
Portland District Health	☐	☐	☐	☐	✓	✓
Stawell Regional Health	☐	☐	☐	☐	✓	✓
Small rural health services						
Alexandra District Hospital	☐	☐	☐	☐	☐	☐
Alpine Health	☐	☐	☐	☐	☐	☐
Beaufort and Skipton Health Service	☐	☐	☐	☐	☐	☐
Beechworth Health Service	☐	☐	☐	☐	☐	☐
Boort District Health	☐	☐	☐	☐	☐	☐
Casterton Memorial Hospital	☐	☐	☐	☐	☐	☐
Cobram District Health	☐	☐	☐	☐	☐	☐
Cohuna District Health	☐	☐	☐	☐	☐	☐
Dunmunkle Health Services	☐	☐	☐	☐	☐	☐
East Wimmera Health Service	☐	☐	☐	☐	☐	☐
Edenhope and District Hospital	☐	☐	☐	☐	☐	☐
Hepburn Health Service	☐	☐	☐	☐	☐	☐
Hesse Rural Health Service	☐	☐	☐	☐	☐	☐
Heywood Rural Health	☐	☐	☐	☐	☐	☐
Inglewood and District Health Service	☐	☐	☐	☐	☐	☐
Kerang District Health	☐	☐	☐	☐	☐	☐
Kilmore and District Hospital	☐	☐	☐	☐	☐	☐
Kooweerup Regional Health Service	☐	☐	☐	☐	☐	☐
Kyneton District Health Service	☐	☐	☐	☐	☐	☐
Lorne Community Hospital	☐	☐	☐	☐	☐	☐
Maldon Hospital	☐	☐	☐	☐	☐	☐
Mallee Track Health and Community Service	☐	☐	☐	☐	☐	☐
Mansfield District Hospital	☐	☐	☐	☐	☐	☐
McIvor Health and Community Services	☐	☐	☐	☐	☐	☐

Health service	Accred	Resi	Clean	VICNISS part	Hand hygiene	HCWI flu
Moyne Health Services	▣	▣	▣	▣	▣	▣
Nathalia District Hospital	▣	▣	▣	▣	▣	▣
Numurkah District Health Service	▣	▣	▣	▣	▣	▣
Omeo District Health	▣	▣	▣	▣	▣	▣
Orbost Regional Health	▣	▣	▣	▣	▣	▣
Otway Health and Community Services	▣	▣	▣	▣	▣	▣
Robinvale District Health Services	▣	▣	▣	▣	▣	▣
Rochester and Elmore District Health Service	▣	▣	▣	▣	▣	▣
Rural Northwest Health	▣	▣	▣	▣	▣	▣
Seymour Health	▣	▣	▣	▣	▣	▣
South Gippsland Hospital	▣	▣	▣	▣	▣	▣
Tallangatta Health Service	▣	▣	▣	▣	▣	▣
Terang and Mortlake Health Service	▣	▣	▣	▣	▣	▣
Timboon and District Healthcare Service	▣	▣	▣	▣	▣	▣
Upper Murray Health and Community Services	▣	▣	▣	▣	▣	▣
West Wimmera Health Service	▣	▣	▣	▣	▣	▣
Yarram and District Health Service	▣	▣	▣	▣	▣	▣
Yarrawonga District Health Service	▣	▣	▣	▣	▣	▣
Yea and District Memorial Hospital	▣	▣	▣	▣	▣	▣

Table 3.10: Ambulance Victoria safety and quality key performance indicators

Health Service	Clinical compliance – emerg	Clinical compliance – non-emerg	Clinical compliance – CERT
Ambulance Victoria	▣	▣	▣

Financial sustainability key performance indicators

Table 3.11: Financial sustainability key performance indicators, by health service

Health service	Operating result	Creditors	Debtors	PP WIES	Asset management
Ambulance Victoria	◙	◙	◙	✗	✗
Forensicare	◙	◙	◙	✗	✗
Metropolitan					
Austin Health	✓	✓	✓	◙	◙
Alfred Health	✓	✓	✓	◙	◙
Calvary Health	✓	✓	✓	✗	✗
Eastern Health	✓	✓	✓	◙	◙
Melbourne Health	✓	✓	✓	◙	◙
Mercy Public Hospitals Inc.	✓	✓	✓	◙	◙
Monash Health	✓	✓	✓	◙	◙
Northern Health	✓	✓	✓	◙	◙
Peninsula Health	✓	✓	✓	◙	◙
Peter MacCallum Cancer Centre	✓	✓	✓	◙	◙
St Vincent's Hospital (Melbourne) Ltd	✓	✓	✓	◙	✗
The Royal Children's Hospital	✓	✓	✓	◙	◙
The Royal Victorian Eye and Ear Hospital	✓	✓	✓	◙	◙
The Royal Women's Hospital	✓	✓	✓	◙	◙
Western Health	✓	✓	✓	◙	◙
Regional					
Albury Wodonga Health	✓	✓	✓	◙	◙
Ballarat Health Services	✓	✓	✓	◙	◙
Barwon Health	✓	✓	✓	◙	◙
Bendigo Health Care Group	✓	✓	✓	◙	◙
Goulburn Valley Health	✓	✓	✓	◙	◙
Latrobe Regional Hospital	✓	✓	✓	◙	◙
Subregional					
Bairnsdale Regional Health Service	✓	✓	✓	◙	◙
Central Gippsland Health Service	✓	✓	✓	◙	◙
Echuca Regional Health Service	✓	✓	✓	◙	◙
Mildura Base Hospital	✓	✓	✓	◙	◙
Northeast Health Wangaratta	✓	✓	✓	◙	◙
South West Healthcare	✓	✓	✓	◙	◙
Swan Hill District Health	✓	✓	✓	◙	◙
West Gippsland Healthcare Group	✓	✓	✓	◙	◙
Western District Health Service	✓	✓	✓	◙	◙
Wimmera Health Care Group	✓	✓	✓	◙	◙

Health service	Operating result	Creditors	Debtors	PP WIES	Asset management
Local					
Bass Coast Regional Health	✓	✓	✓	▣	▣
Benalla Health	✓	✓	✓	▣	▣
Colac Area Health	✓	✓	✓	▣	▣
Djerriwarrh Health Services	✓	✓	✓	▣	▣
East Grampians Health Service	✓	✓	✓	▣	▣
Gippsland Southern Health Service	✓	✓	✓	▣	▣
Kyabram and District Health Service	✓	✓	✓	▣	▣
Maryborough and District Health Service	✓	✓	✓	▣	▣
Castlemaine Health	✓	✓	✓	▣	▣
Portland District Health	✓	✓	✓	▣	▣
Stawell Regional Health	✓	✓	✓	▣	▣
Small rural health services					
Alexandra District Hospital	▣	▣	▣	✗	v
Alpine Health	▣	▣	▣	✗	▣
Beaufort and Skipton Health Service	▣	▣	▣	✗	▣
Beechworth Health Service	▣	▣	▣	✗	▣
Boort District Health	▣	▣	▣	✗	▣
Casterton Memorial Hospital	▣	▣	▣	✗	▣
Cobram District Health	▣	▣	▣	✗	▣
Cohuna District Health	▣	▣	▣	✗	▣
Dunmunkle Health Service	▣	▣	▣	✗	▣
East Wimmera Health Service	▣	▣	▣	✗	▣
Edenhope and District Hospital	▣	▣	▣	✗	▣
Hepburn Health Service	▣	▣	▣	✗	▣
Hesse Rural Health Service	▣	▣	▣	✗	▣
Heywood Rural Health	▣	▣	▣	✗	▣
Inglewood and District Health Service	▣	▣	▣	✗	▣
Kerang District Health	▣	▣	▣	✗	▣
Kilmore and District Hospital	▣	▣	▣	✗	▣
Kooweerup Regional Health Service	▣	▣	▣	✗	▣
Kyneton District Health Service	▣	▣	▣	✗	▣
Lorne Community Hospital	▣	▣	▣	✗	▣
Maldon Hospital	▣	▣	▣	✗	▣
Mallee Track Health and Community Service	▣	▣	▣	✗	▣
Mansfield District Hospital	▣	▣	▣	✗	▣
McIvor Health and Community Services	▣	▣	▣	✗	▣
Moyne Health Services	▣	▣	▣	✗	▣
Nathalia District Hospital	▣	▣	▣	✗	▣

Health service	Operating result	Creditors	Debtors	PP WIES	Asset management
Numurkah District Health Service	▣	▣	▣	✗	▣
Omeo District Health	▣	▣	▣	✗	▣
Orbost Regional Health	▣	▣	▣	✗	▣
Otway Health and Community Services	▣	▣	▣	✗	▣
Robinvale District Health Services	▣	▣	▣	✗	▣
Rochester and Elmore District Health Service	▣	▣	▣	✗	▣
Rural Northwest Health	▣	▣	▣	✗	▣
Seymour Health	▣	▣	▣	✗	▣
South Gippsland Hospital	▣	▣	▣	✗	▣
Tallangatta Health Service	▣	▣	▣	✗	▣
Terang and Mortlake Health Service	▣	▣	▣	✗	▣
Timboon and District Healthcare Service	▣	▣	▣	✗	▣
Upper Murray Health and Community Services	▣	▣	▣	✗	▣
West Wimmera Health Service	▣	▣	▣	✗	▣
Yarram and District Health Service	▣	▣	▣	✗	▣
Yarrawonga District Health Service	▣	▣	▣	✗	▣
Yea and District Memorial Hospital	▣	▣	▣	✗	▣

Access key performance indicators

Table 3.12: Timely response key performance indicators

Health service	Response time – statewide	Response time – urban	Response time – CERT	Call referral
Ambulance Victoria	▣	▣	▣	▣

Table 3.13: Emergency care key performance indicators, by campus

Campus	Bypass	40min tfrs	Triage1	Triage1–5	4hours	24hrs
Metropolitan						
Angliss Hospital	✓	✓	✧	▣	✓	✓
Austin Hospital	✓	✓	✧	▣	✓	✓
Box Hill Hospital	✓	✓	✧	▣	✓	✓
Casey Hospital	✗	✓	✧	▣	✓	✓
Dandenong Hospital	✓	✓	✧	▣	✓	✓
Frankston Hospital	✓	✓	✧	▣	✓	✓
Maroondah Hospital	✓	✓	✧	▣	✓	✓
Mercy Hospital for Women	✗	✓	✧	▣	✓	✓
Monash Medical Centre – Clayton	✓	✓	✧	▣	✓	✓
Rosebud Hospital	✗	✓	✧	▣	✓	✓
Sandringham and District Hospital	✗	✓	✧	▣	✓	✓
St Vincent's Hospital	✓	✓	✧	▣	✓	✓
Sunshine Hospital	✓	✓	✧	▣	✓	✓
The Alfred	✓	✓	✧	▣	✓	✓
The Northern Hospital	✓	✓	✧	▣	✓	✓
The Royal Children's Hospital	✗	✓	✧	▣	✓	✓
The Royal Melbourne Hospital	✓	✓	✧	▣	✓	✓
The Royal Victorian Eye and Ear Hospital	✗	✓	✧	▣	✓	✓
The Royal Women's Hospital	✗	✓	✧	▣	✓	✓
Werribee Mercy Hospital	✗	✓	✧	▣	✓	✓
Western Hospital	✓	✓	✧	▣	✓	✓
Williamstown Hospital	✗	✓	✧	▣	✓	✗
Regional						
Albury Hospital	✗	✓	✧	▣	✓	✓
Ballarat Base Hospital	✗	✓	✧	▣	✓	✓
Geelong Hospital	✗	✓	✧	▣	✓	✓
Bendigo Hospital	✗	✓	✧	▣	✓	✓
Shepparton Hospital	✗	✓	✧	▣	✓	✓
Latrobe Regional Hospital	✗	✓	✧	▣	✓	✓
Wodonga Hospital	✗	✓	✧	▣	✓	✓
Subregional						
Bairnsdale Regional Hospital	✗	✓	✧	▣	✓	✓
Hamilton Base Hospital	✗	✓	✧	▣	✓	✓
Wangaratta Hospital	✗	✓	✧	▣	✓	✓
Swan Hill Hospital	✗	✓	✧	▣	✓	✓
Warragul Hospital	✗	✓	✧	▣	✓	✓
Sale Hospital	✗	✓	✧	▣	✓	✓

Campus	Bypass	40min tfrs	Triage1	Triage1–5	4hours	24hrs
Metropolitan						
Warrnambool Hospital	✗	✓	✧	▣	✓	✓
Horsham Hospital	✗	✓	✧	▣	✓	✓
Echuca Regional Hospital	✗	✓	✧	▣	✓	✓
Mildura Base Hospital	✗	✓	✧	▣	✓	✓
Local						
Bass Coast Regional Hospital	✗	✓	✧	▣	✓	✓

Table 3.14: Elective surgery key performance indicators, by health service

Health service	Cat1 admit	Cat2 admit	Cat3 admit	ESWL	HiPs	Admissions
Metropolitan						
Austin Health	✧	✓	✓	✓	✓	▣
Alfred Health	✧	✓	✓	✓	✓	▣
Eastern Health	✧	✓	✓	✓	✓	▣
Melbourne Health	✧	✓	✓	✓	✓	▣
Mercy Public Hospitals Inc.	✧	✓	✓	✓	✓	▣
Monash Health	✧	✓	✓	✓	✓	▣
Northern Health	✧	✓	✓	✓	✓	▣
Peninsula Health	✧	✓	✓	✓	✓	▣
Peter MacCallum Cancer Centre	✧	✓	✓	✓	✓	▣
St Vincent's Hospital (Melbourne) Ltd	✧	✓	✓	✓	✓	▣
The Royal Children's Hospital	✧	✓	✓	✓	✓	▣
The Royal Victorian Eye and Ear Hospital	✧	✓	✓	✓	✓	▣
The Royal Women's Hospital	✧	✓	✓	✓	✓	▣
Western Health	✧	✓	✓	✓	✓	▣
Regional						
Ballarat Health Services	✧	✓	✓	✓	✓	▣
Barwon Health	✧	✓	✓	✓	✓	▣
Bendigo Health Care Group	✧	✓	✓	✓	✓	▣
Goulburn Valley Health	✧	✓	✓	✓	✓	▣
Latrobe Regional Hospital	✧	✓	✓	✓	✓	▣
Subregional		✓	✓	✓	✓	
West Gippsland Healthcare Group	✧	✓	✓	✓	✓	▣
Northeast Health Wangaratta	✧	✓	✓	✓	✓	▣

Table 3.15: Critical care key performance indicators, by campus

Campus	ICU	NICU
Metropolitan		
Angliss Hospital	✗	✗
Austin Hospital	◙	✗
Box Hill Hospital	◙	✗
Casey Hospital	✗	✗
Dandenong Hospital	◙	✗
Frankston Hospital	◙	✗
Maroondah Hospital*	◙	✗
Mercy Hospital for Women	✗	◙
Monash Medical Centre – Clayton	◙	◙
Peter MacCallum Cancer Centre	◙	✗
Rosebud Hospital	✗	✗
Sandringham and District Hospital	✗	✗
St Vincent's Hospital	◙	✗
Sunshine Hospital	✗	✗
The Alfred	◙	✗
The Northern Hospital	◙	✗
The Royal Melbourne Hospital	◙	✗
The Royal Children's Hospital	◙	◙
The Royal Victorian Eye and Ear Hospital	✗	✗
The Royal Women's Hospital	✗	◙
Werribee Mercy Hospital	✗	✗
Western Hospital	◙	✗
Williamstown Hospital	✗	✗
Regional		
Albury Hospital*	◙	✗
Ballarat Base Hospital*	◙	✗
Geelong Hospital	◙	✗
Bendigo Hospital*	◙	✗
Shepparton Hospital*	◙	✗
Latrobe Regional Hospital*	◙	✗

* Campus with a combined critical care unit service mix where they operate ICU and CCU beds within one unit.

Appendix 4: Data requirements

The data sources and data submission timeframes for KPIs are presented in Table 4.1. More comprehensive information about data submission and reporting requirements is provided in the *Victorian health policy and funding guidelines 2014–15* (see <www.health.vic.gov.au/pfg>). Information on health service data collections is contained in their respective data collection manuals and can be viewed at <www.health.vic.gov.au/hdss>.

Where a health service or hospital is unable to submit completed electronic ESIS, VEMD, Victorian Admitted Episode Data (VAED), or Agency Information Management System (AIMS) data, the department (via the Data Collection Unit) must be notified in writing before the submission date of the month following the affected data collection. More information on this process can be found at <www.health.vic.gov.au/hdss>.

For the purposes of the Victorian Health Services Performance Monitor and PRISM, a snapshot of the data is taken at a point in time after the published submission dates. This is a year-to-date snapshot of the current financial year data.

Table 4.1: Data submission requirements for key performance indicators

Program	KPI	Data source	Data submission timeframes
Patient experience and outcomes			
	VHES	Survey	Submitted by health services to survey contractor by the 10th day of the following month
	VICNISS SSI VICNISS ICU CLABSI SAB rate	VICNISS Coordinating Centre	Submitted to VICNISS by: 1 August 2014, 7 November 2014, 6 Feb 2015, 1 May 2015
Maternity	Postnatal home care	VAED	Submitted to the department on the 10th day of the following month Annual – submitted to the department by 10 September 2014
Newborns	Newborn hearing screening	VIHSP	Submitted to the department by the 12th day after the end of the quarter Annual – submitted to the department by 12 September 2015
Mental health	MH 28 days	CMI/ODS	Twice a day 7 days a week
	Post discharge	CMI/ODS	Submitted to the department on the 10th day of the following month Annual – final consolidated data 31 August 2015
	Seclusion	CMI/ODS	Submitted to the department on the 10th day of the following month
Ambulance services	Patient satisfaction	Ambulance Victoria	Submitted to the department annually Annual – final consolidated data 31 August 2015
	Pain reduction – adult	Ambulance Victoria	Submitted to the department monthly
	Pain reduction – paed Stroke patients transported Cardiac survival	Ambulance Victoria	Submitted to the department quarterly

Program	KPI	Data source	Data submission timeframes
Governance, leadership and culture			
	People Matter safety culture	Victorian Public Sector Commission	Submission to the department by 31 August 2014
Safety and quality			
	Accreditation	Health service accrediting agency	Accreditation survey or summary report from accrediting agency being submitted to the department
		Residential aged care accreditation	Accreditation survey or summary report from accrediting body submitted to Aged Care branch
	Cleaning Standards	Health service	Submitted to the department by 1 August 2014, 7 November 2014, 6 March 2015
	VICNISS compliance Hand hygiene rate	VICNISS Coordinating Centre	Submitted to VICNISS by: 1 August 2014, 7 November 2014, 6 Feb 2015, 1 May 2015
	Healthcare Worker Immunisation – influenza	VICNISS Coordinating Centre	Submitted to VICNISS by 15 August 2014
Ambulance services	Clinical compliance – emergency Clinical compliance – non emergency Clinical compliance – CERT	Ambulance Victoria	Submitted to the department monthly
Financial sustainability			
Finance	Operating result Creditors Creditors Debtors PP WIES	AIMS F1	Submitted 12 days after the end of the month or earlier if the date falls on a weekend or public holiday Annual – audited financial data by 12 September 2015
Asset management	Basic asset management plan	Health service	Submitted to the department annually
Access			
Emergency care	Bypass	Ambulance Victoria	Submitted to the department daily
	40 min transfers	Ambulance Victoria	Submitted to the department every Monday
	Triage 1 Triage 1 to 5 4 hours 24 hours	VEMD	Submitted to the department by the third working day of the following month Annual – submitted to the department by 20 August 2015

Program	KPI	Data source	Data submission timeframes
Elective surgery	Cat 1 admit Cat 2 admit Cat 3 admit ESWL HiPs Admissions	ESIS	Submitted to the department by the third working day of the following month Annual – submitted to the department by 20 August 2015
Critical care	ICU	Retrieval and critical health website	Extracted by the department first week following the end of each month
	NICU	Victorian Perinatal Information Centre (VicPIC) website	Extracted by the department first week following the end of each month
Timely response	Response – statewide Response– urban Call referral	Ambulance Victoria	Submitted to the department monthly
	Response – CERT	Ambulance Victoria	Submitted to the department quarterly

Appendix 5: Business rules

A detailed description of each indicator in the SoP is outlined in the following section including the methodology for calculating performance, the numerator, denominator and statewide target. In addition the thresholds and points used to assess performance are also presented where applicable.

Patient experience and outcomes

Victorian Healthcare Experience Survey			
Description	A new patient experience survey has replaced the VPSM in Victorian public hospitals. The survey measures patient experience rather than patient satisfaction. The new survey has undergone cognitive testing with consumers and was piloted through selected health services during Q3 of 2013–14. The surveying of all health services commenced in Q4 2014 and includes adult and paediatric in-patients, emergency department consumers and maternity clients. Results from the new surveys will be provided quarterly commencing with Q4's results in September 2014. This indicator is measured at the campus level.		
Calculating performance	Health service participation will be analysed quarterly from 1 April to 30 June 2014 and a report provided to the department's Sector Performance, Quality and Rural Health branch regarding the participation of each health service and relevant campuses. Participation is based on health service's providing patient data to the contractor to enable surveying. New performance targets for health services to replace the existing VPSM scores will be identified after the results from Q4 2013–14 and Q1 in 2014–15 have been collated. Once established results will be provided quarterly.		
Statewide target	**Full compliance with surveying from 1 July 2014**		
Thresholds	Achieved	5 points	✓
	Not achieved	0 points	✗
Frequency of reporting and data collection	Health services are required to submit details of eligible patients to the survey contractor each month. Performance is monitored and assessed quarterly. Data reported is lagged by one quarter. This means that any changes to business rules, from one financial year to the next, will also be lagged by one quarter. For example, business rule changes that come into effect from 1 July will be reported from quarter 2 onwards. The performance reported in quarter 1 will reflect the business rules of the previous financial year.		

Healthcare-associated infection surveillance surgical site infection		
Description	Healthcare-associated infection (HAI) surveillance surgical site (SSI) infection focuses on reducing the incidence of HAIs among nominated surgical procedures. In Victoria data about these infections are managed by the VICNISS Coordinating Centre on behalf of the department. VICNISS collates and analyses data from health services and reports quarterly to participants and the department on aggregate, risk-adjusted, procedure-specific infection rates. This indicator is measured at the health service level. Where a health service has multiple campuses, an aggregate for the health service result is produced.	
Calculating performance	This indicator refers to a set of specific types of procedures: • hip arthroplasty • knee arthroplasty • coronary artery bypass grafts • caesarean section for nominated health services. Campuses performing cardiac bypass surgery and ≥ 50 hip and knee prosthesis surgical procedures per annum are required to conduct continuous surveillance. Health services may substitute another surgical procedure for hip and knee surveillance between January and June of the reporting year based on the following criteria: • The health service has not reported a statistically significantly high rate compared with statewide data at the campus for at least two years for all risk indices of the procedure chosen (hips or knees). • The health service must demonstrate the alternative SSI surveillance meets epidemiological surveillance criteria – that is, there is an identified problem related to frequency or severity of infections which can be addressed by surveillance. Hip and knee SSI surveillance must be undertaken for the July–December period. The four surgery procedures are expressed as a rate per 100 procedures. For each procedure type, where a health service is found to have a statistically significantly higher infection rate than the state aggregate rate, they are deemed an outlier. Further information can be found at <www.vicniss.org.au>. If a health service does not submit infection surveillance data this will also be deemed as not meeting the target.	
Numerator	The number of infections for each procedure	
Denominator	The total number of procedures in each category of surgery or for patients with a central line, the total number of central line days	
Statewide target	**No outliers**	
Thresholds	Achieved	✓
	Not achieved	✗

Healthcare-associated infection surveillance surgical site infection	
Frequency of reporting and data collection	Performance is monitored and assessed quarterly. Data reported is lagged by one quarter. This means that any changes to business rules, from one financial year to the next, will also be lagged by one quarter. For example, business rule changes that come into effect from 1 July will be reported from quarter 2 onwards. The performance reported in quarter 1 will reflect the business rules of the previous financial year. The data are submitted to the VICNISS Coordinating Centre and performance reported for the periods: • 1 April to 30 June 2014 in quarter 1 • 1 July to 30 September 2014 in quarter 2 • 1 October to 31 December 2014 in quarter 3 • 1 January to 30 March 2015 in quarter 4. A performance result is generated annually using lagged data. Where a health service does not achieve the KPI in any quarter the annual result is not achieved.

Healthcare-associated infection surveillance ICU central-line-associated bloodstream infection	
Description	Healthcare-associated infection surveillance ICU focuses on reducing the incidence of HAIs among laboratory confirmed central-line-associated bloodstream infections (CLABSI) in ICUs. In Victoria data about these infections are managed by the VICNISS Coordinating Centre on behalf of the department. VICNISS collates and analyses data from health services and reports quarterly to participants and the department on aggregate, risk-adjusted infection rates. This indicator is measured at the hospital level, although is only relevant to those with an ICU. NICU is excluded.
Calculating performance	Results are presented as rates calculated by the VICNISS Coordinating Centre on behalf of the department using the data collected from participating ICUs. Rates = numerator/denominator × 1,000 The aggregate mean rates for Victoria, detailed below, have been calculated from the most recent five calendar years of data. These will be reviewed on an annual basis. The aggregate mean rate for major teaching hospitals (The Alfred, Austin Hospital, Monash Medical Centre Clayton, The Royal Melbourne Hospital, The Royal Children's Hospital, St Vincent's Hospital and Geelong Hospital) is 1.5 infections per 1,000 central line days. The aggregate mean rate for all other hospitals with ICU beds is 1.0 per 1,000 central line days. Note that health services achieving zero infections over two consecutive quarters will be eligible for additional funding under the Pricing for Quality initiative.
Numerator	The number of infections
Denominator	The total number of central line days for the total number of procedures in each category of ICU patient with a central line insertion.
Statewide target	**No outliers**
Thresholds	Less than or equal to 1.5/1,000 (major teaching hospitals) Less than or equal to 1.0/1,000 (other hospitals) Greater than 1.5/1,000 (major teaching hospitals) Greater than 1.0/1,000 (others hospitals)
Frequency of reporting and data collection	Performance is monitored and assessed quarterly. Data reported is lagged by one quarter. This means that any changes to business rules, from one financial year to the next, will also be lagged by one quarter. The data are submitted to the VICNISS Coordinating Centre and performance reported for the periods: • 1 April to 30 June 2014 in quarter 1 • 1 July to 30 September 2014 in quarter 2 • 1 October to 31 December 2014 in quarter 3 • 1 January to 30 March 2015 in quarter 4. A performance result is generated annually using lagged data. Where a health service does not achieve the KPI in any quarter the annual result is not achieved.

Staphylococcus aureus bacteraemia rate			
Description	The Staphylococcus aureus bacteraemia (SAB) indicator aims to reduce the rate of SAB. In Victoria SAB data is managed by the VICNISS Coordinating Centre on behalf of the department. VICNISS collects and analyses data from health services and reports quarterly to participants and the department. This indicator is measured at the health service level. Where a health service has multiple campuses, an aggregate for the health service result is produced.		
Definition	A patient episode of bacteraemia is defined as a positive blood culture for Staphylococcus aureus. For surveillance purposes, only the first isolate per patient is counted, unless at least 14 days has passed without a positive blood culture, after which an additional episode is recorded. A SAB will be considered to be healthcare-associated either if: • the patient's first SAB blood culture was collected more than 48 hours after hospital admission or less than 48 hours after discharge, or • the patient's first SAB blood culture was collected less than or equal to 48 hours after hospital admission and one or more of the defined clinical criteria was met for the patient episode of SAB. Occupied bed days are defined as the total number of days for all patients who were admitted for an episode of care in the acute health facility, including psychiatric bed days. Further information on the SAB definition can be found at <www.vicniss.org.au>.		
Calculating performance	This indicator is expressed as the rate of infections per 10,000 occupied bed days. This indicator is measured at the health service level. Where a health service has multiple campuses, an aggregate for the health service result is produced. This indicator is expressed as a rate and rounded to one decimal place (0.05 is rounded down).		
Numerator	SAB patient episodes		
Denominator	Number of patient days for health services		
Statewide target	**Less than or equal to 2.0 episodes per 10,000 occupied bed days**		
Thresholds	Less than or equal to 2.0	5 points	✓
	2.1 to 2.5	3 points	⊘
	2.6 to 3.5	1 point	⊘
	Greater than or equal to 3.6	0 points	✗

Staphylococcus aureus bacteraemia rate	
Frequency of reporting and data collection	Performance is monitored and assessed quarterly. A performance assessment score is generated quarterly. Data reported is lagged by one quarter. This means that any changes to business rules, from one financial year to the next, will also be lagged by one quarter. For example, business rule changes that come into effect from 1 July will be reported from quarter 2 onwards. The performance reported in quarter 1 will reflect the business rules of the previous financial year. The data are submitted to the VICNISS Coordinating Centre and performance reported for the periods: • 1 April to 30 June 2014 in quarter 1 • 1 July to 30 September 2014 in quarter 2 • 1 October to 31 December 2014 in quarter 3 • 1 January to 31 March 2015 in quarter 4. A performance result is generated annually based on the full year lagged data.

Maternity

Percentage of women with prearranged postnatal care	
Description	Postnatal care primarily aims to provide: recuperation from the birthing process; breastfeeding education and support; parenting education and support; clinical care to promote the physical and psychological health and wellbeing of the woman and her baby. The Postnatal care program guidelines for Victorian health services (2012) outlines the Victorian Government's expectations of public health services in the delivery of the postnatal period of care. Prior to discharge home, hospitals are required to offer all women one or more postnatal domiciliary visits (depending on need) by a suitably qualified health professional. Hospitals should also work collaboratively with other hospital and community-based service providers to facilitate timely access to care that meet individual needs and expectations during the postnatal period.
Calculating performance	This indicator is measured at the campus level. This indicator applies to all maternity hospitals and only includes birth separations where the mother is discharged to a private residence. To be counted as a birth separation, each record must meet each of the following criteria: • a diagnosis code commencing with 'O' (for obstetric) must appear within the string of ICD–10-AM diagnosis codes • the birth indicator is derived from Z37 (the outcome of the birth must be present on the mother's record) • excludes VicDRG in – O03B Ectopic Pregnancy W/O CC – O04A Postpartum and Post Abortion W or Procedure W Catastrophic or Severe CC – O04B Postpartum and Post Abortion W or Procedure W/O Catastrophic or Severe CC – O05Z Abortion with operating room procedure – O64Z False Labour – O66Z Antenatal and Other Obstetric Admission • excludes women transferred to another hospital • separation mode must be 'H' defined as separation to private residence/ accommodation. The separation referral codes are listed in the VAED user manual. This indicator is expressed as a percentage and rounded to the nearest whole number (0.5 is rounded up).
Numerator	Number of women who have given birth and been offered appropriate postnatal care prior to discharge from hospital.
Denominator	Number of women who have given birth
Statewide target	**100%**
Thresholds	Achieved target ✓ Between 96% and 99% ⊘ Less than or equal to 95% ✗
Frequency of reporting and data collection	Performance is monitored and assessed monthly. Data is lagged by one month. A performance result is generated annually based on the full year data. Data is submitted by health services monthly via the VAED. Please refer to the Victorian health policy and funding guidelines 2014–15 for further information on VAED data submission timelines.

Newborns

Eligible newborns screened for hearing deficit		
Description	The Royal Children's Hospital is responsible for the Victorian Infant Hearing Screening Program (VIHSP) which screens the hearing of newborn babies at all hospitals providing maternity services. The objectives of infant hearing screening are to maximise early detection of permanent childhood hearing impairment (PCHI), ensure timely follow-up care, and achieve consistent standards of screening management. It also aims to improve the quality of life for Australian children with PCHI in terms of their communication and language skills, subsequent education and employment prospects, and psychological wellbeing.	
Calculating performance	This KPI reports the number of completed hearing screenings as a percentage of eligible infants notified to the VIHSP. While some infants may be deemed ineligible for a variety of reasons at the preferred time of screening, all infants should be eventually screened. To be counted as an eligible newborn, each record must meet the following criteria: • term, healthy infants between 34 weeks' gestation and six months of age • ready or planning for discharge within a few days • newborns with normal outer ear anatomy and no obvious deformities of the head or neck. To calculate performance the number of eligible newborns includes both in-hospital newborns and those seen in outpatient settings. This indicator is expressed as a percentage and the variance is rounded to the nearest whole number (0.5 is rounded up).	
Numerator	Number of completed hearing screenings within 44 weeks of corrected gestational age (CGA). This takes into account level of prematurity during an assessment of babies' growth and development.	
Denominator	Total number of eligible infants notified to VIHSP	
Statewide target	**97%**	
Thresholds	Greater than or equal to 97%	✓
	92% to 96%	⊘
	Less than or equal to 91%	✗
Frequency of reporting and data collection	Performance is monitored and assessed quarterly. Data reported is lagged by two months. A performance result is generated annually based on the full year lagged data. The data is submitted by The Royal Children's Hospital monthly to the department and reported for the periods: • 1 May to 31 July in quarter 1 • 1 August to 31 October in quarter 2 • 1 November to 31 January in quarter 3 • 1 February to 30 April in quarter 4.	

Mental health

Composite seclusion rate			
Description	Reducing restraint and seclusion is a national safety priority and incorporating this indicator ensures appropriate monitoring of seclusion use in adult acute inpatient units in Victoria.		
Calculating performance	This indicator is a composite comprising adult, CAMHS and aged acute inpatient services provided by public mental health services and includes adult, CAMHS and aged acute admissions as well as patients at ORYGEN Youth Health Melbourne Clinic campus. Occupied bed days are calculated where the admission event type is one of the following: • **SA** (statistical admission) • **R** (return from leave) • **A** (admission – formal) • **T** (ward transfer). Leave events within an admission are excluded. Admission events that do not have any temporal overlap with the reporting period are excluded. Only the minutes of the admission events that overlap with the reporting period are counted. The minutes for each adult acute admission event are then summed and divided by 1,440 to give the total occupied bed days for the campus for the reporting period. Any period of seclusion relating to an adult acute admission ending in the reporting period is counted. The number of seclusions is divided by the number of occupied bed days. The quotient is then multiplied by 1,000. This indicator is expressed as a percentage and rounded to the nearest whole number.		
Numerator	Adult, CAMHS and aged acute seclusion events during the reference period		
Denominator	Total adult, CAMHS and aged acute occupied bed days during the reference period		
Statewide target	**15%**		
Thresholds	Less than or equal to 15	5	✓
	Between 16 and 20	3	⊘
	Between 21 and 25	1	⊘
	Greater than or equal to 26	0	✗
Frequency of reporting and data collection	Performance is monitored quarterly for the periods: • 1 July to 30 September 2014 in quarter 1 • 1 October to 31 December 2014 in quarter 2 • 1 January to 31 March 2015 in quarter 3 • 1 April to 30 June 2015 in quarter 4. The data source for this KPI is the Client Management Interface (CMI), which is the local client information system used by each public mental health service. It also uses the Operational Data Store (ODS), which manages a set of select data items from each CMI. The initialism used for this data source is CMI/ODS. A performance result is generated annually based on the full year data.		

Adult 28-day readmission rate		
Description	Adult specialist mental health services are aimed primarily at people with a serious mental illness or mental disorder who have associated significant levels of disturbance and psychosocial disability due to their illness or disorder. Readmission rates for adult mental health patients can reflect the quality of care, effectiveness of discharge planning, level of support provided to patients after discharge, as well as other factors.	
Calculating performance	This indicator includes adult mental health patients who are admitted overnight or longer in hospital. Exclusions are overnight separations for electroconvulsive therapy (ECT), transfers to other acute hospitals or to residential aged care, and patients who leave against medical advice or abscond. This indicator is expressed as a percentage and rounded to the nearest whole number.	
Numerator	Non-sameday separations from adult general acute psychiatric inpatient units that result in a non-sameday readmission to the same or to another public sector acute psychiatric inpatient unit within 28 days of discharge	
Denominator	Number of non-sameday separations from adult general acute psychiatric inpatient units	
Statewide target	**14%**	
Thresholds	Less than or equal to 14%	✓
	Between 15% and 17%	⊘
	Between 18% and 20%	⊘
	Greater than or equal to 21%	✗
Frequency of reporting and data collection	Performance is monitored and assessed quarterly. The 28-day lag inherent in the KPI means that reporting for this KPI is lagged by one month. For example, quarter 2 will report the mental health results for separations occurring in the period September to November 2014. Performance is reported for the periods: • 1 June to 30 September 2014 in quarter 1 • 1 September to 30 November 2014 in quarter 2 • 31 December to 28 February 2015 in quarter 3 • 1 March to 31 May 2015 in quarter 4. The data source for this KPI is the Client Management Interface (CMI), which is the local client information system used by each public mental health service. It also uses the Operational Data Store (ODS), which manages a set of select data items from each CMI. The initialism used for this data source is CMI/ODS. A performance result is generated annually based on the full year data.	

Adult post-discharge follow-up rate		
Description	Timely post-discharge follow-up is an important component of client care. Monitoring the proportion of discharges that are followed up within seven days is a good measure of the timeliness of this care. This indicator reflects the effectiveness of the interface between admitted care and non-admitted care. It is also monitored at the Commonwealth level.	
Calculating performance	Where one or more contacts fall in the seven days after the separation date, the separation is considered to have received post-discharge community care. The separation type is home or residential aged care and patients must be admitted overnight or longer in hospital. Contacts on the day of separation are excluded. Contacts can be of any duration, in any location for any type of recipient, whether by the local mental health service or another mental health service. This KPI is expressed as a percentage of post-discharge follow-ups on the total number of non-sameday acute adult separations. This indicator is expressed as a percentage and rounded to the nearest whole number.	
Numerator	Number of post-discharge follow-ups within seven days	
Denominator	Total non-sameday acute mental health adult separation to a private residence or accommodation.	
Statewide target	**75%**	
Thresholds	Greater than or equal to 75%	✓
	Between 71% and 74%	⊘
	Between 60% and 70%	⊘
	Less than or equal to 59%	✗
Frequency of reporting and data collection	Performance is monitored and assessed quarterly. The separation date is between the start of the reporting period (minus seven days) and the end of the reporting period (minus seven days). Separations are lagged by seven days to allow all post-discharge follow-up in the reporting period to be captured. For example, if the reporting period is from 1 July 2014 to 30 September 2014, then separations from 24 June 2014 to 24 September 2014 are included. Performance is reported for the periods: • 1 July to 30 September 2014 in quarter 1 • 1 October to 31 December 2014 in quarter 2 • 1 January to 31 March 2015 in quarter 3 • 1 April to 30 June 2015 in quarter 4. The data source for this KPI is the Client Management Interface (CMI), which is the local client information system used by each public mental health service. It also uses the Operational Data Store (ODS), which manages a set of select data items from each CMI. The initialism used for this data source is CMI/ODS. A performance result is generated annually based on the full year data.	

Adult seclusion rate		
Description	Reducing restraint and seclusion is a national safety priority and incorporating this indicator ensures appropriate monitoring of seclusion use in adult acute inpatient units in Victoria.	
Calculating performance	This indicator comprises adult acute inpatient services provided by public mental health services and includes adult acute admissions as well as patients at ORYGEN Youth Health Melbourne Clinic campus. Occupied bed days are calculated where the admission event type is one of the following: • **SA** (statistical admission) • **R** (return from leave) • **A** (admission – formal) • **T** (ward transfer). Leave events within an admission are excluded. Admission events that do not have any temporal overlap with the reporting period are excluded. Only the minutes of the admission events that overlap with the reporting period are counted. The minutes for each adult acute admission event are then summed and divided by 1,440 to give the total occupied bed days for the campus for the reporting period. Any period of seclusion relating to an adult acute admission ending in the reporting period is counted. The number of seclusions is divided by the number of occupied bed days. The quotient is then multiplied by 1,000. This indicator is expressed as a percentage and rounded to the nearest whole number.	
Numerator	Adult acute seclusion events during the reference period	
Denominator	Total adult acute occupied bed days during the reference period	
Statewide target	**Less than or equal to 15 seclusions per 1,000 bed days**	
Thresholds	Less than or equal to 15	✓
	Between 16 and 20	⊘
	Between 21 and 25	⊘
	Greater than or equal to 26	✗
Frequency of reporting and data collection	Performance is monitored and assessed quarterly for the periods: • 1 July to 30 September 2014 in quarter 1 • 1 October to 31 December 2014 in quarter 2 • 1 January to 31 March 2015 in quarter 31 April to 30 June 2015 in quarter 4. The data source for this KPI is the Client Management Interface (CMI), which is the local client information system used by each public mental health service. It also uses the Operational Data Store (ODS), which manages a set of select data items from each CMI. The initialism used for this data source is CMI/ODS. A performance result is generated annually based on the full year data.	

Child and adolescent mental health service post-discharge follow-up rate		
Description	Timely post-discharge follow-up is an important component of client care. Monitoring the proportion of discharges that are followed up within seven days is a good measure of the timeliness of this care. This indicator reflects the effectiveness of the interface between admitted care and non-admitted care. It is also monitored at a national level.	
Calculating performance	Where one or more contacts fall in the seven days after the separation date, the separation is considered to have received post-discharge community care. Separations are counted against the mental health area (catchment campus) of the client, rather than the campus of separation. The separation type is 'home' and patients must be admitted overnight or longer in hospital. Contacts on the day of separation are excluded. Contacts can be of any duration, in any location for any type of recipient, whether by the local mental health service or another mental health service. Child and adolescent mental health service (CAMHS) clients are identified by admission type in the Client Management Interface (CMI) system. This indicator is expressed as a percentage and rounded to the nearest whole number.	
Numerator	Number of post-discharge follow-ups within seven days	
Denominator	Total non-sameday acute mental health CAMHS separations to a private residence.	
Statewide target	**75%**	
Thresholds	Greater than or equal to 75%	✓
	Between 71% and 74%	⊘
	Between 60% and 70%	⊘
	Less than or equal to 59%	✗
Frequency of reporting and data collection	Performance is monitored and assessed quarterly. The separation date is between the start of the reporting period (minus seven days) and the end of the reporting period (minus seven days). Separations are lagged by seven days to allow all post-discharge follow-up in the reporting period to be captured. For example, if the reporting period is from 1 July 2014 to 30 September 2014, then separations from 24 June 2014 to 24 September 2014 are included. Results are reported for the periods: • 1 July to 30 September 2014 in quarter 1 • 1 October to 31 December 2014 in quarter 2 • 1 January to 31 March 2015 in quarter 3 • 1 April to 30 June 2015 in quarter 4. The data source for this KPI is the CMI, which is the local client information system used by each public mental health service. It also uses the Operational Data Store (ODS), which manages a set of select data items from each CMI. The initialism used for this data source is CMI/ODS. A performance result is generated annually based on the full year data.	

Child and adolescent mental health seclusion rate		
Description	Reducing restraint and seclusion is a national safety priority and incorporating this indicator ensures appropriate monitoring of seclusion use in CAMHS acute inpatient units in Victoria.	
Calculating performance	This indicator comprises CAMHS acute inpatient services provided by public mental health services and includes all CAMHS acute admissions. Occupied bed days are calculated where the admission event type is one of the following: • **SA** (statistical admission) • **R** (return from leave) • **A** (admission – formal) • **T** (ward transfer). Leave events within an admission are excluded. Admission events that do not have any temporal overlap with the reporting period are excluded. Only the minutes of the admission events that overlap with the reporting period are counted. The minutes for each CAMHS acute admission event are then summed and divided by 1,440 to give the total occupied bed days for the campus for the reporting period. Any period of seclusion relating to a CAMHS acute admission ending in the reporting period is counted. The number of seclusions is divided by the number of occupied bed days. The quotient is then multiplied by 1,000. CAMHS clients are identified by program type. This indicator is expressed as a percentage and rounded to the nearest whole number.	
Numerator	CAMHS acute seclusion events during the reference period	
Denominator	Total CAMHS acute occupied bed days during the reference period	
Statewide target	**Less than or equal to 15 seclusions per 1,000 bed days**	
Thresholds	Less than or equal to 15	✓
	Between 16 and 20	⊘
	Between 21 and 25	⊘
	Greater than or equal to 26	✗
Frequency of reporting and data collection	Performance is monitored and assessed quarterly for the periods: • 1 July to 30 September 2014 in quarter 1 • 1 October to 31 December 2014 in quarter 2 • 1 January to 31 March 2015 in quarter 3 • 1 April to 30 June 2015 in quarter 4. The data source for this KPI is the Client Management Interface (CMI), which is the local client information system used by each public mental health service. It also uses the Operational Data Store (ODS), which manages a set of select data items from each CMI. The initialism used for this data source is CMI/ODS. A performance result is generated annually based on the full year data.	

Aged post-discharge follow-up rate		
Description	Timely post-discharge follow-up is an important component of client care. Monitoring the proportion of discharges that are followed up within seven days is a good measure of the timeliness of this care. This indicator reflects the effectiveness of the interface between admitted care and non-admitted care. It is also monitored at the Commonwealth level.	
Calculating performance	Where one or more contacts fall in the seven days after the separation date, the separation is considered to have received post-discharge community care. The separation type is home and patients must be admitted overnight or longer in hospital. Contacts on the day of separation are excluded. Contacts can be of any duration, in any location for any type of recipient, whether by the local mental health service or another mental health service. This KPI is expressed as a percentage of post-discharge follow-ups on the total number of non-sameday acute aged separations. Aged clients are identified by the type of admission. This indicator is expressed as a percentage and rounded to the nearest whole number.	
Numerator	Number of post-discharge follow-ups within seven days	
Denominator	Total non-sameday acute mental health aged separations to a private residence or accommodation	
Statewide target	**75%**	
Thresholds	Greater than or equal to 75%	✓
	Between 71% and 74%	⊘
	Between 60% and 70%	⊘
	Less than or equal to 59%	✗
Frequency of reporting and data collection	Performance is monitored and assessed quarterly. The separation date is between the start of the reporting period (minus seven days) and the end of the reporting period (minus seven days). Separations are lagged by seven days to allow all post-discharge follow-up in the reporting period to be captured. For example, if the reporting period is from 1 July 2014 to 30 September 2014, then separations from 24 June 2014 to 24 September 2015 are included. Performance is reported for the periods: • 1 July to 30 September 2014 in quarter 1 • 1 October to 31 December 2014 in quarter 2 • 1 January to 31 March 2015 in quarter 3 • 1 April to 30 June 2015 in quarter 4. The data source for this KPI is the Client Management Interface (CMI), which is the local client information system used by each public mental health service. It also uses the Operational Data Store (ODS), which manages a set of select data items from each CMI. The initialism used for this data source is CMI/ODS. A performance result is generated annually based on the full year data.	

Aged seclusion rate		
Description	Reducing restraint and seclusion is a national safety priority and incorporating this indicator ensures appropriate monitoring of seclusion use in aged acute inpatient units in Victoria.	
Calculating performance	This indicator comprises aged acute inpatient services provided by public mental health services and includes all aged acute admissions. Occupied bed days are calculated where the admission event type is one of the following: • SA (statistical admission) • R (return from leave) • A (admission – formal) • T (ward transfer). Leave events within an admission are excluded. Admission events that do not have any temporal overlap with the reporting period are excluded. Only the minutes of the admission events that overlap with the reporting period are counted. The minutes for each aged acute admission event are then summed and divided by 1,440 to give the total occupied bed days for the campus for the reporting period. Any period of seclusion relating to an aged acute admission ending in the reporting period is counted. The number of seclusions is divided by the number of occupied bed days. The quotient is then multiplied by 1,000. Aged clients are identified by the type of admission. This indicator is expressed as a percentage and rounded to the nearest whole number.	
Numerator	Aged acute seclusion events during the reference period	
Denominator	Total aged acute occupied bed days during the reference period	
Statewide target	**Less than or equal to 15 seclusions per 1,000 bed days**	
Thresholds	Less than or equal to 15	✓
	Between 16 and 20	⊘
	Between 21 and 25	⊘
	Greater than or equal 26	✗
Frequency of reporting and data collection	Performance is monitored and assessed quarterly for the periods: • 1 July to 30 September 2014 in quarter 1 • 1 October to 31 December 2014 in quarter 2 • 1 January to 31 March 2015 in quarter 3 • 1 April to 30 June 2015 in quarter 4. The data source for this KPI is the Client Management Interface (CMI), which is the local client information system used by each public mental health service. It also uses the Operational Data Store (ODS), which manages a set of select data items from each CMI. The initialism used for this data source is CMI/ODS. A performance result is generated annually based on the full year data.	

Ambulance services

Patient satisfaction	
Description	The Council of Ambulance Authorities (CAA) is the peak body representing the principal statutory and other providers of member ambulance services of Australia, New Zealand and Papua New Guinea. The CAA conducts an annual survey to measure the service quality and satisfaction ratings of ambulance services. The patient satisfaction measure is reported annually in the Report on government services. This indicator measures the proportion of patients satisfied or very satisfied with the quality of care provided by the attending paramedics.
Calculating performance	This indicator is measured by randomly selecting a sample of 1,300 (code 1 and 2) patients transported within two months of the sampling date. A review is performed to ensure that the % of samples in each Victorian region is similar to the % of transports performed in each region. To avoid the risk of distressing family members or carers, known deceased patients, cardiac patients and children aged under five years are excluded from the random selection process. Data is collected by AV and submitted to the CAA. Performance results are based on the findings of the CAA annual survey and exclude nil/don't know responses. This indicator is expressed as a percentage to one decimal place.
Numerator	Number of completed surveys from code 1 and 2 patients who were satisfied or very satisfied when answering the question: 'How satisfied were you overall with your last experience using the Ambulance service?'
Denominator	Total number of completed surveys excluding nil/don't know responses
Statewide target	**95%**
Frequency of reporting and data collection	Performance is monitored annually. Data is submitted to the department annually.

Pain reduction – adult	
Description	Providing adequate relief of pain is one of a series of key measures of the clinical effectiveness of interventions by paramedics. The KPI of the proportion of patients experiencing severe cardiac or traumatic pain, whose level of pain is significantly reduced, focuses the attention of the organisation on the effectiveness of clinical interventions in two common areas of service provision – cardiac care and trauma care. Assessment of pain severity and the extent of relief that paramedics can provide is central to the provision of appropriate care. This indicator applies to adult patients (15 years or older) experiencing severe cardiac or traumatic pain.
Calculating performance	This indicator measures the difference between the initial pain score and the final pain score according to AV clinical practice guidelines. Patients experiencing severe pain are defined as those having an initial pain score of 8 or more, with pain measured out of 10. A patient is deemed to have had a significant reduction in pain if the difference between their initial and final pain score is 2 or more. This indicator excludes patients with a Glasgow Coma Score < 9; intubated patients; patients unable to rate pain; or patients that have one or more missing pain scores. This indicator is expressed as a percentage to one decimal place.
Numerator	Total number of adult patients with an initial pain score assessed as 8 or more experiencing a reduction in score of 2 or more
Denominator	Total number of adult patients with severe cardiac or traumatic pain
Statewide target	**90%**
Frequency of reporting and data collection	Performance is monitored monthly. Data is submitted to the department monthly.

Pain reduction – paediatric	
Description	Providing early and effective relief of pain is one of a series of key measures of the clinical effectiveness of interventions by paramedics. The KPI of the proportion of paediatric patients experiencing severe traumatic pain, whose level of pain is significantly reduced, focuses the attention of the organisation on the effectiveness of clinical interventions in the provision of service for trauma care. Assessment of pain severity and the extent of relief that paramedics can provide is central to the provision of appropriate care. This indicator applies to paediatric patients (14 years or younger) experiencing severe traumatic pain.
Calculating performance	This indicator measures the difference between the initial pain score and the final pain score according to AV clinical practice guidelines. Patients experiencing severe pain are defined as those having an initial pain score of 8 or more, with pain measured out of 10. A patient is deemed to have had a significant reduction in pain if the difference between their initial and final pain score is 2 or more. This indicator excludes patients with a Glasgow Coma Score < 9; intubated patients; patients unable to rate pain; or patients that have one or more missing pain scores. This indicator is expressed as a percentage to one decimal place.
Numerator	Total number of paediatric patients with an initial pain score assessed as 8 or more experiencing a reduction in score of 2 or more
Denominator	Total number of paediatric patients with severe traumatic pain
Statewide target	**90%**
Frequency of reporting and data collection	Performance is monitored quarterly. Data reported is lagged by one quarter. Data is submitted to the department quarterly.

Stroke patients transported	
Description	The Report on government services states that 'clinical interventions and treatments' have been identified as an indicator of delivery of quality ambulance services. The early recognition of stroke symptoms and the timing and the destination to which patients are transported are critical to ensuring optimal outcomes for stroke patients. This indicator is a measure of ambulance response to adult patients (15 years or older) suspected of having a stroke who are transported to a stroke unit with thrombolysis facilities within 60 minutes.
Calculating performance	This indicator is expressed as a percentage to one decimal place.
Numerator	Total number of paramedic-identified stroke patients transported to a stroke unit with thrombolysis facilities within 60 minutes
Denominator	Total number of adult patients whose final paramedic assessment was stroke
Statewide target	**80%**
Frequency of reporting and data collection	Performance is monitored quarterly. Data reported is lagged by one quarter. Data is submitted to the department quarterly.

Percentage of adult cardiac arrest patients surviving to hospital	
Description	Cardiac arrest survival has strong links to clinical interventions and treatments. This is a measure of the ability to meet clients' needs through delivery of quality ambulance services (Report on government services). The cardiac arrest survival to hospital rate describes the percentage of adult patients who out-of-hospital cardiac arrest, where any chest compressions and/or defibrillation was undertaken by ambulance / emergency medical services (EMS) (fire brigade first responders, community emergency response teams or ambulance) and who have a return to spontaneous circulation (palpable pulse) on arrival at hospital. Data is collected and reported according to the internationally recognised Utstein template and definitions. The Victorian Ambulance Cardiac Arrest Registry captures data on all out-of-hospital cardiac arrest patients attended by EMS in Victoria. This indicator applies to adult patients (16 years or over) who are in ventricular fibrillation or pulseless ventricular tachycardia (VF/VT) on EMS arrival for whom resuscitation is commenced (minimum is cardiopulmonary resuscitation) by EMS.
Calculating performance	This indicator applies to adult patients who are in VF/VT on EMS arrival for whom resuscitation is commenced by EMS. Excludes cardiac arrests witnessed by EMS and patients where vital signs at hospital are unknown. This indicator is expressed as a percentage to one decimal place.
Numerator	The number of adult VF/VT cardiac arrest patients with a palpable pulse on arrival at hospital
Denominator	The total number of adult VF/VT cardiac arrest patients meeting the criteria
Statewide target	**45%**
Frequency of reporting and data collection	Performance is monitored quarterly using 12-month rolling percentages. Data is submitted to the department quarterly.

Percentage of adult cardiac arrest patients surviving to hospital discharge	
Description	Cardiac arrest survival has strong links to clinical interventions and treatments. This is a measure of the ability to meet clients' needs through delivery of quality ambulance services (Report on government services). Data is collected and reported according to the internationally recognised Utstein template. The Victorian Ambulance Cardiac Arrest Registry captures data on all out-of-hospital cardiac arrest patients attended by EMS in Victoria. This indicator applies to adult patients (16 years or over) who were in ventricular fibrillation or pulseless ventricular tachycardia (VF/VT) on EMS arrival for whom resuscitation was commenced by EMS.
Calculating performance	This indicator applies to adult patients who were in VF/VT on EMS arrival for whom resuscitation was commenced by EMS. Excludes cardiac arrests witnessed by EMS and patients where discharge status is unknown. This indicator is expressed as a percentage to one decimal place.
Numerator	The number of adult VF/VT cardiac arrest patients discharged alive from hospital
Denominator	The total number of adult VF/VT cardiac arrest patients meeting the criteria
Statewide target	**20%**
Frequency of reporting and data collection	Performance is monitored quarterly using 12-month rolling percentages. Data is submitted to the department quarterly.

Governance, leadership and culture

People Matter survey patient safety culture			
Description	The health service People Matter survey includes eight questions that specifically assess health service staff perspectives around the safety culture of the organisation. Organisations participating in the survey receive a report on their results, and are also benchmarked against other like healthcare organisations.		
Calculating performance	All Victorian public healthcare organisations must participate at least once every two years in the People Matter survey. Performance is measured based on a composite score of the eight safety culture agreement questions, and expressed as the percentage of staff responses which either 'agreed' or 'strongly agreed' with each question. For those health services that participated in the survey in 2012–13 and are not required to participate in 2013–14, their results from 2012–13 will be used. Where health services participate in the survey annually, their most recent score will be used This indicator measures performance at the health service level.		
Numerator	The number of 'agreed' or 'strongly agreed' responses to each of the eight safety culture questions in the health service People Matter survey.		
Denominator	The total number of responses to each of the eight safety culture questions in the health service People Matter survey.		
Statewide target	**80%**		
Thresholds	Equal to or greater than 80%	5 points	✓
	70% to less than 80%	3 points	⊘
	Less than 70% and/or response rate for People Matter survey of less than 10%	0 points	✗
Frequency of reporting and data collection	Performance is monitored and assessed annually. Data is submitted to the department by 31 August 2014 and 2015 and reported in quarter 4. The data source for this is the Victorian Public Sector Commission.		

Safety and quality

Health service accreditation	
Description	Effective from 1 January 2013 accreditation of health services falls under the Australian Health Service Safety and Quality Accreditation Scheme. Under this scheme health services are required to be accredited against the National Safety and Quality Health Service Standards (NSQHS standards). This scheme applies to all health services, including small rural health services, and clinical mental health services. It includes contracted/outsourced services as if they are being provided by the health service. All eligible Victorian health services will be assessed against the NSQHS standards at their next accreditation assessment. Under the scheme the department, as the jurisdictional regulator, has responsibility for verifying the accreditation status of Victorian public health services. Performance monitoring of accreditation by the department in 2014–15 will be undertaken as per the Accreditation – Performance monitoring and regulatory approach business rules 2013. In the event of an identified significant patient risk or 'not met' core action item, health services are required to immediately notify the Sector Performance, Quality and Rural Health branch and the regional office (where applicable) and submit an action plan to the department addressing the issues. Further details on accreditation requirements can be found at: www.health.vic.gov.au/accreditation This KPI is assessed at the health service level.
Calculating performance	Note that health services achieving development actions under the national standards will be eligible for additional funding under the Pricing for Quality initiative. Full compliance with accreditation standards will be referred to as 'achieved'. Health services that have appointed an accrediting body and have commenced accreditation processes will be referred to as 'enrolled'. Where a health service has not met accreditation standards they will be referred to as 'not achieved'.
Statewide target	**Full compliance**
Thresholds	Achieved ✓ Enrolled ⊘ Not achieved ✗
Frequency of reporting and data collection	Performance is monitored and assessed quarterly. The accreditation status as at the end of the quarter for each health service is reported for the periods: • 1 July to 30 September 2014 in quarter 1 • 1 October to 31 December 2014 in quarter 2 • 1 January to 31 March 2015 in quarter 3 • 1 April to 30 June 2015 in quarter 4. A performance result is generated annually. Where a health service does not achieve the KPI in any quarter the annual result is not achieved.

Residential aged care accreditation	
Description	It is a requirement that all residential aged care facilities are accredited and maintain full compliance with the relevant accreditation standards. The Commonwealth Government has primary responsibility for funding and regulating the residential aged care sector. In Victoria, a number of residential aged care services are provided by public health services and are subject to the Commonwealth's Aged Care Accreditation Standards.
Calculating performance	To achieve this KPI all residential aged care services must be fully compliant with all 44 expected outcomes of the Aged Care Accreditation Standards, at all times. All episodes where expected outcomes are not met during the reporting period will be assessed as not achieved. Any breaches require health services to meet a timetable for improvements set by the Aged Care Standards and Accreditation Agency (ACSAA), usually within a three-month period, which includes submitting action plans and follow-up visits during and after this period. Where applicable, each health service is also required to notify the department's Aged Care branch of any instances of noncompliance as soon as the ACSAA have identified them. This KPI is assessed at the health service level. Where a health service has multiple facilities, all facilities are required to meet the expected outcomes.
Numerator	Number of expected outcomes achieved
Denominator	Total number of outcomes
Statewide target	**Full compliance**
Thresholds	Achieved ✓ Not achieved ✗
Frequency of reporting and data collection	Performance is monitored and assessed quarterly. The accreditation status as at the end of the quarter for the health service is to be reported for the periods: • 1 July to 30 September 2014 in quarter 1 • 1 October to 31 December 2014 in quarter 2 • 1 January to 31 March 2015 in quarter 3 • 1 April to 30 June 2015 in quarter 4. For each quarter, a list of residential aged care services that have failed to comply with the Aged Care Accreditation Standards during the relevant quarter will be obtained. A performance result is generated annually. Where a health service does not achieve the KPI in any quarter the annual result is not achieved.

Cleaning standards		
Description	Cleaning standards for Victorian health services aim to improve the quality of healthcare provision by ensuring that all risks involving cleaning are identified and managed in an appropriate manner, irrespective of cleaning service provider arrangements. The standards are outcome focused. The acceptable quality level (AQL) required is a score of 90 for category A (very high risk) and 85 for category B (high risk) and category C (moderate risk) functional areas. Cleaning audits are conducted three times per financial year – two internal and one external audit. All audits are to be undertaken by qualified auditors. The external audit is to be conducted by an independent external auditor (not an employee of the health service). Qualified means having successfully passed the accredited 21909VIC Course in Cleaning Standards Auditing. Reporting of the external cleaning standards audit is mandatory for all health services. If the AQL is not achieved a repeat external audit is required within 60 days.	
Calculating performance	The principle behind the audit scoring is a demerit-based system. A campus is given 100 points when the audit begins. Points are deducted on areas that do not meet the standard. The cleaning standards are assessed as achieved if: • the audits are conducted by a qualified Victorian cleaning standards auditor • the overall score for the health service meet the AQL required for all functional areas • all elements of the internal auditing program, as prescribed in the Cleaning standards for Victorian public hospitals 2011, have been met. The KPI is assessed as not achieved if any of the above mentioned criteria have not been met. This indicator is assessed at the health service level. Where a health service has multiple campuses, all campuses are required to achieve the cleaning standards.	
Statewide target	**High-risk and moderate-risk functional areas: AQL 85 points** **Very high risk functional areas: AQL 90 points**	
Thresholds	Achieved	✓
	Not achieved	✗
Frequency of reporting and data collection	This KPI is monitored and assessed quarterly. Audit results should be submitted to the department by: • quarter 1 – Friday 1 August 2014 • quarter 2 – Friday 7 November 2014 • quarter 3 – Friday 6 March 2015.	

Submission of infection surveillance data	
Description	Submitting infection surveillance data aims to improve the quality of infection control by requiring health services to be fully compliant in their data submission to the Victorian Healthcare-associated Infection Surveillance System (VICNISS) Coordinating Centre. This indicator is measured at the health service level. Where a health service has multiple campuses, the compliance is aggregated to produce an overall health service result
Calculating performance	The VICNISS performance indicators are set out on the VICNISS website (see <www.vicniss.org.au>) and outline the defined set of surveillance activities that hospitals are required to perform and achieve. Health service participation and performance will be analysed quarterly by the VICNISS Coordinating Centre and a report provided to the department's Sector Performance, Quality and Rural Health branch regarding the participation of each health service and relevant campuses.
Statewide target	**Full compliance**
Thresholds	Achieved ✓ Not achieved ✗
Frequency of reporting and data collection	This KPI is monitored and assessed quarterly. Data reported is lagged by one quarter. This means that any changes to business rules, from one financial year to the next, will also be lagged by one quarter. For example, business rule changes that come into effect from 1 July will be reported from quarter 2 onwards. The performance reported in quarter 1 will reflect the business rules of the previous financial year. The data are submitted to the VICNISS Coordinating Centre and performance reported for the periods: • 1 April to 30 June 2014 in quarter 1 • 1 July to 30 September 2014 in quarter 2 • 1 October to 31 December 2014 in quarter 3 • 1 January to 30 March 2015 in quarter 4. A performance result is generated annually. Where a health service does not achieve the KPI in any quarter the annual result is not achieved.

Hand hygiene program			
Description	The hand hygiene program aims to improve compliance with best practice hand hygiene processes so that healthcare-associated infections are reduced. The KPI encourages health services to achieve a high standard of hand hygiene, be fully compliant in their data submission to the VICNISS Coordinating Centre, and improve on their hand hygiene rates where necessary.		
Calculating performance	This indicator is expressed as a percentage of hand hygiene compliance achieved. This percentage is obtained by using the '5 moments' methodology for hand hygiene rules, as well as the auditing requirements detailed by Hand Hygiene Australia (HHA) at <www.hha.org.au>. HHA specifies the required number of: • audits per year • areas per audit • observations per area. Data are reported to VICNISS, which analyses the data and reports results to the department and HHA. This indicator is assessed at the health service level. Where a health service has multiple campuses, the compliance is aggregated to produce an average health service result. Hand hygiene compliance will increase incrementally to a new statewide target of 80%, with higher thresholds for lower scores being phased in over consecutive quarters of 2014–15. The national hand hygiene benchmark of 70% is considered a minimum standard for health services to achieve. As further encouragement to health services to improve and achieve a higher standard of hand hygiene, health services will be awarded additional points for higher performance.		
Statewide target – Q2	**75%**		
Thresholds	Equal to or greater than 75%	5 points	✓
	73% to less than 75%	3 points	⊘
	72% to less than to 73%	1 point	⊘
	Less than 72%	0 points	✗
Statewide target – Q3	**77%**		
Thresholds	Equal to or greater than 77%	5 points	✓
	75% to less than to 77%	3 points	⊘
	74% to less than to 75%	1 point	⊘
	Less than 74%	0 points	✗
Statewide target – Q4	**80%**		
Thresholds	Equal to or greater than 80%	5 points	✓
	78% to less than to 80%	3 points	⊘
	75% to less than to 78%	1 point	⊘
	Less than 75%	0 points	✗

Hand hygiene program	
Frequency of reporting and data collection	Performance is monitored and assessed quarterly. Data reported is lagged by one quarter. This means that any changes to business rules, from one financial year to the next, will also be lagged by one quarter. For example, business rule changes that come into effect from 1 July will be reported from quarter 2 onwards. The performance reported in quarter 1 will reflect the business rules of the previous financial year. The data is submitted to the VICNISS Coordinating Centre and performance reported for the periods: • 1 July to 31 October 2014 in quarter 2 • 1 November 2014 to 18 March 2015 in quarter 3 • 19 March 2015 to 30 June 2015 in quarter 4. A performance result is generated annually. Where a health service does not achieve the KPI in any quarter the annual result is not achieved.

Healthcare worker immunisation – influenza			
Description	High coverage rates for immunisation in healthcare workers (HCW) are essential to reduce the risk of transmission in healthcare settings. The target will require 75 per cent of health service Category A, B and C HCW (as outlined in Table C2.1 of the Australian guidelines for the prevention and control of infection in health care) who are permanently, temporarily or casually (bank staff) employed by the health service through the influenza period (March to July) to be immunised.		
Calculating performance	The VICNISS performance indicators are set out in the type 1 and type 2 surveillance manuals (see <www.vicniss.org.au>) and outline the defined set of surveillance activities that hospitals are required to perform and achieve. Health service participation and performance will be analysed annually by the VICNISS Coordinating Centre and a report provided to the department's Sector Performance, Quality and Rural Health branch.		
Numerator	Number of Cat A, B and C healthcare workers vaccinated as at 31 July		
Denominator	Number of Cat A, B and C healthcare workers employed as at 31 July who worked one or more shifts during the influenza vaccination campaign (March to July)		
Statewide target	**75%**		
Thresholds	Equal to or greater than 75%	5 points	✓
	Less than 75% and greater or equal to 65%	3 points	⊘
	Less than 65%	0 points	✗
Frequency of reporting and data collection	Performance is monitored and assessed annually. Data reported for the influenza immunisation period is lagged. This means that any changes to business rules, from one financial year to the next, will also be lagged. The performance reported annually in quarter 1 will reflect the business rules of the previous financial year. The data are submitted to the VICNISS Coordinating Centre and performance reported for the following periods: • 1 March 2014 to 31 July 2014 in quarter 1.		

Ambulance services

Clinical compliance emergency – statewide	
Description	This indicator aims to encourage improved performance in managing emergency patient care by paramedics. This indicator applies to all audited emergency cases statewide.
Calculating performance	This indicator is measured by randomly selecting at least one patient care record per paramedic per month for an emergency case and auditing for compliance against AV clinical practice guidelines. Compliant cases are recorded as a percentage of audited cases. This indicator is expressed as a percentage to one decimal place.
Numerator	Number of emergency cases audited meeting AV clinical practice guidelines
Denominator	Total number of emergency cases audited
Statewide target	**95%**
Frequency of reporting and data collection	Performance is monitored and assessed monthly. Data reported is lagged by one month. Data is submitted to the department monthly.

Clinical compliance non-emergency – statewide	
Description	This indicator aims to encourage improved performance in managing non-emergency patient care by paramedics. Non-emergency patient transports (NEPT) must be medically assessed and authorised and are covered by NEPT regulations. Transport and care may be provided by AV emergency or non-emergency crews or AV contracted private providers. This indicator applies to all audited non-emergency cases statewide.
Calculating performance	This indicator is measured by randomly selecting at least one in 100 patient care records statewide per month for non-emergency cases and auditing for compliance against AV clinical practice guidelines. Compliant cases are recorded as a percentage of selected cases. Non-stretcher transports (involving clinic cars) are excluded. This indicator is expressed as a percentage to one decimal place.
Numerator	Number of non-emergency cases audited meeting AV clinical practice guidelines
Denominator	Total number of non-emergency cases audited
Statewide target	**94%**
Frequency of reporting and data collection	Performance is monitored and assessed monthly. Data reported is lagged by one month. Data is submitted to the department monthly.

Clinical compliance – community emergency response teams	
Description	This indicator aims to encourage improved performance in managing emergency patient care by volunteers until an ambulance arrives. Community emergency response teams (CERTs) are units without transport capability that are crewed by trained AV volunteers to provide an on-call response to code 1 incidents. CERTs are located throughout Victoria, in areas within communities where the nearest ambulance branch is at a distance. A team is dispatched simultaneously with an ambulance to initiate and provide treatment until an ambulance arrives. CERTs are always backed up by a transport-capable unit. This indicator applies to all audited cases attended by CERTs statewide.
Calculating performance	This indicator is measured by randomly selecting at least one in every three patient care records per month for emergency cases attended by a CERT and auditing for compliance against AV clinical practice guidelines. Compliant cases are recorded as a percentage of selected cases. This indicator is expressed as a percentage to one decimal place.
Numerator	Number of cases audited attended by CERTs meeting AV clinical practice guidelines
Denominator	Total number of audited cases attended by CERTs
Statewide target	**90%**
Frequency of reporting and data collection	Performance is monitored monthly. Data reported is lagged by two months. Data is submitted to the department monthly.

Financial sustainability

Finance

Operating result as a percentage of revenue			
Description	This indicator is a measure of financial sustainability. The agreed SoP target should achieve an operating surplus necessary to maintain or, where necessary, improve the current operating cash position. This requirement aligns with the reform priority of the department to increase the financial sustainability and productivity of the health system.		
Calculating performance	This indicator is predicated on the year-to-date (YTD) operating result in the SoP. The variance between the actual result and the target is the measured outcome, and is expressed as a percentage and rounded to two decimal places. The indicator excludes consolidated entities (with the exception of Monash Health, which includes Jessie McPherson Private Hospital). The thresholds have tolerances in recognition of the difficulty in achieving absolute precision relative to budget targets. Phased monthly targets are based on the September AIMS F1 submission for the financial year. Changes thereafter are only reported on agreement between the department and the health service regardless of the data submitted in the AIMS F1. The opportunity to prospectively re-phase monthly targets tracking to the agreed annual operating result should be negotiated with the department. Should the phasings require adjusting, these changes will be considered on a quarterly basis and, where agreed, submitted in the F1 by the health service. Please note that the department does not support retrospective changes to phased targets.		
Numerator	YTD operating result before capital and depreciation		
Denominator	YTD total revenue		
Specific health service target	**As agreed in the SoP**		
Thresholds	In surplus and achieved or ahead of budget	20 points	✓
	In surplus but behind budget	17 points	⊘
	In deficit and achieved or ahead of budget	17 points	✓
	In deficit and within 0.1% to 1.1% unfavourable variance budget	15 points	⊘
	In deficit and greater than 1.1% to 2.1% unfavourable variance to budget	10 points	⊘
	In deficit and greater than 2.1% to 3.1% unfavourable variance to budget	5 points	✗
	In deficit and greater than 3.1% unfavourable variance to budget	0 points	✗
Frequency of reporting and data collection	Performance is monitored and assessed monthly. A performance assessment score is generated quarterly. The annual result is generated on receipt of audited financial data submitted in the AIMS F1. Data is submitted by health services monthly via AIMS F1. Please refer to the Guidelines for completing the F1 (finance return) 2014–15 for further information on completing the F1. Please refer to the Victorian health policy and funding guidelines 2014–15 for further information about funding policy changes.		

Trade creditors			
Description	This KPI is a short-term liquidity indicator. It represents the average number of days a health service takes to pay creditors. Increasing days beyond the 60-day target may indicate significant cash liquidity issues. In response to feedback from health services and consistent with outcomes from the benchmarking group an adjustment to the calculation of this indicator has been made to include account codes related to inter hospital and accrual expenses.		
Calculating performance	Average trade creditors divided by the average daily non-salary operating costs. Trade creditors are defined as account codes between: 80101 to 80149: Trade creditors – system generated 80600 to 80649: Creditors – Inter hospital 81001 to 81099: Accrual expenses Non-salary operating costs are defined as account codes in the ranges: 20001 to 38999 *(exclude accounts 37036 – 37040: PPP interest expense)* 12500 to 13099 This indicator is calculated at a health service level and calculation of the indicator does not include controlled entities cost range Z9002–Z9100 and Z9502–Z9900 (with the exception of Monash Health, which includes Jessie McPherson Private Hospital). The indicator is expressed as a number of whole days, therefore rounded to the nearest whole number (0.5 is rounded up).		
Numerator	The sum of trade creditors at the end of previous financial year and trade creditors at end of the reporting month divided by two		
Denominator	YTD non-salary operating costs divided by the YTD number of days		
Statewide target	**60 days**		
Thresholds	Less than or equal to 60 days	5 points	✓
	61 to 65 days	3 points	⦸
	66 to 70 days	2 points	⦸
	71 days or more	0 points	✗
Frequency of reporting and data collection	Performance is monitored and assessed monthly. A performance assessment score is generated quarterly. The annual result is generated on receipt of audited financial data submitted in the AIMS F1. Data is expected to be submitted by health services monthly via AIMS F1. Please refer to the *Guidelines for completing the F1 (finance return) 2014–15* for further information on completing the F1.		

Patient fee debtors			
Description	This KPI is a short-term liquidity indicator. It represents the average number of days a health service takes to collect debts in relation to patient fees. The length of time it takes for private health funds and statutory bodies (such as TAC) to settle their accounts will influence the result. A fall in days indicates more effective collection. In 2013–14 uninsured overseas debtors have been included in the calculation of this KPI.		
Calculating performance	Average patient fees receivable divided by the average daily patient fee revenue. Debts subject to debt recovery plans in relation to receivables/fees for uninsured or under insured overseas visitors are excluded (account codes 71071–71080 for numerator and 50041–50043 for denominator). Patient fees receivable are defined as the following account codes: 71001 to 71049 Debtors – Private Inpatients 71071 to 71086: Debtors – Private Inpatients (Uninsured O'S Visitors) 71100 to 71149: Debtors – Private Outpatients 71200 to 71249: Admitted Patient Fees – Residential Aged Care 71300 to 71349: Debtors Diagnostic Billing 71401 to 71449 Other Patient Debtors – e.g. Day hospital Patient fees revenue are defined as the following account codes: 50001 to 50040: Admitted Patient fees – Acute 50041 to 50043: Admitted Patient fees uninsured debtors 50051 to 50399: Admitted Patient fees – other 50400 to 50749: Non-admitted Patient fees 50901 to 50999: Private Practise fees 59111 to 59499: Private Practise fees This indicator is calculated at a health service level and calculation of the indicator does not include controlled entities cost range Z9002–Z9100 and Z9502–Z9900 (with the exception of Monash Health, which includes Jessie McPherson Private Hospital). The indicator is expressed as a number of whole days, therefore rounded to the nearest whole number (0.5 is rounded up).		
Numerator	The sum of patient fees receivable at the end of the previous financial year and the patient fees receivable at the end of the reporting month divided by two		
Denominator	YTD patient fee revenue divided by the YTD number of days		
Statewide target	**60 days**		
Thresholds	Less than or equal to 60 days	5 points	✓
	61 to 70 days	3 points	⊘
	71 to 80 days	2 points	⊘
	81 days or more	0 points	✗
Frequency of reporting and data collection	Performance is monitored and assessed monthly. A performance assessment score is generated quarterly. The annual result is generated on receipt of audited financial data submitted in the AIMS F1. Data is expected to be submitted by health services monthly via AIMS F1. Please refer to the *Guidelines for completing the F1 (finance return) 2014–15* for further information on completing the F1.		

Public and private WIES		
Description	The year-to-date public and private (PP) WIES KPI aims to reinforce the need for health services to manage their activity to within the two per cent tolerance level, in line with current policy.	
Calculating performance	In 2014–15 PP WIES includes renal WIES and competitive public WIES. Phased monthly targets are based on the September F1 submission for the financial year. Changes thereafter are only reported on agreement between the department and the health service regardless of data submitted in the AIMS F1. The phased end-of-year targets (as reported for the F1 activity budget) should reflect the agreed activity targets. Year-to-date (YTD) activity performance against target is expressed as a percentage and rounded to two decimal places (0.055 is rounded up).	
Numerator	YTD actual PP WIES	
Denominator	YTD PP WIES target	
Statewide target	**100%**	
Thresholds	0 to 2.00% variance to target	✓
	2.01% to 3.00% variance to target	⊘
	Greater than or equal to 3.01% variance to target	✗
Frequency of reporting and data collection	Performance is monitored and assessed monthly. A performance assessment score is generated quarterly. An annual result is generated based on year to date result at 30 June 2015 (following final consolidation of VAED). In assessing performance, the department recognises that there may be exceptional circumstances whereby a health service exceeds the 103% tolerance level without adversely impacting financial viability. These cases are assessed by the department on a case-by-case basis and in conjunction with performance against other KPIs. Data is submitted by health services monthly via the AIMS F1. Please refer to the *Guidelines for completing the F1 (finance return) 2014–15* for further information on completing the F1. Please refer to the *Victorian health policy and funding guidelines 2014–15* for further information on the funding policy changes and recall policy.	

Asset management

Asset management plans		
Description	All health services providing acute services are required to have in place their own medical equipment and engineering infrastructure basic asset management plans (BAMPS), based on the principles of the Victorian Department of Health Medical equipment asset management framework (MEAMF). BAMPs should be updated and submitted to the department annually.	
Calculating performance	Achievement of this KPI is based on annual lodgement to the department of an acceptable BAMP. For 2014–15 (plans submitted by end of September 2014) performance will be judged on lodgement of medical equipment and engineering infrastructure BAMPS. For 2015–16 (plans submitted by end September 2015) BAMPs will be assessed against criteria made available to health services in late 2014. Further details on the Medical Equipment and Engineering Replacement Program can be found at <www.health.vic.gov.au/med-equip>. This KPI is assessed at the health service level. Where a health service has multiple facilities on campuses with acute services, all facilities are expected to be covered in the basic asset management plan. Health service participation will be analysed annually from 1 July 2014 to 30 June 2015.	
Statewide target	**Compliance**	
Thresholds	Achieved	✓
	Not achieved	⊘
Frequency of reporting and data collection	Performance is monitored and assessed annually and reported at the end of quarter 4. A performance result is generated annually. Where a health service does not achieve the KPI the annual result is not achieved.	

Access key performance indicators

Emergency care

The emergency care indicators have been reviewed to reflect departmental policy whereby all EDs (inclusive of VEMD reporting health services) are required to manage demand and patient cohorts to ensure high-quality patient outcomes.

Percentage of operating time on hospital bypass			
Description	This indicator aims to ensure the safety and quality of care of patients in EDs. During periods of high demand, hospitals may request the ambulance service to take non-urgent patients to another hospital ED. The benchmark requires hospitals to spend no more than three per cent of operating time on bypass.		
Calculating performance	This indicator is measured at the campus level. For the purpose of this indicator, occasions of bypass that exceed 30 minutes and the reported reason is the ED is currently at capacity ('A & E Full') are counted. This indicator is expressed as a percentage and rounded to one decimal place (0.05 is rounded up).		
Numerator	Actual time on bypass		
Denominator	Actual operating time in the reporting period		
Statewide target	**3%**		
Thresholds	Less than or equal to 3.0%	3 points	✓
	3.1% to 4.0%	2 points	⊘
	4.1% to 5.0%	1 point	⊘
	Greater than or equal to 5.1%	0 points	✗
Frequency of reporting and data collection	Performance is monitored and assessed monthly. A performance assessment score is generated quarterly. A performance result is generated annually based on the full year data. Data is reported via the hospital bypass notification provided to the department by Ambulance Victoria daily.		

Percentage of ambulance patients transferred within 40 minutes			
Description	Timely reception of ambulance patients in EDs is essential to delivering responsive and safe emergency care. Timely reception and handover impacts positively on patient outcomes, patient flow in the ED and ambulance response times. This indicator monitors the percentage of patients who were transferred from paramedic care to the hospital emergency care within 40 minutes of ambulance arrival.		
Calculating performance	This indicator is measured at the campus level. Ambulance patient transfer time is the total time from ambulance arrival at the hospital ('at destination time') to the physical transfer of the patient and handover of care to hospital staff ('off-stretcher time'). This indicator captures the percentage of cases where ambulance patient transfer time is less than or equal to 40 minutes. This indicator includes all patients who arrive by ambulance to the ED. This indicator is expressed as a percentage and rounded to the nearest whole number (0.5 is rounded up).		
Numerator	Patients arriving by emergency ambulance transferred within 40 minutes to the ED		
Denominator	All patients arriving by emergency ambulance transferred to the ED.		
Statewide target	**90%**		
Thresholds	Greater than or equal to 90%	3 points	✓
	85% to 89%	2 points	⊘
	80% to 84%	1 point	⊘
	Less than or equal to 79%	0 points	✗
	Performance is monitored and assessed monthly. Frequency of reporting and data collection A performance assessment score is generated quarterly. A performance result is generated annually based on the full year data. Data is submitted by Ambulance Victoria weekly to the department.		

Percentage of triage category 1 emergency patients seen immediately			
Description	All patients attending EDs are triaged or assessed for urgency. The Australasian College of Emergency Medicine has identified five triage categories and defines the desirable time by when treatment should commence for patients in each category. Triage category 1 patients have a condition that is clinically assessed as immediately life threatening and requires immediate intervention. The aim of this KPI is to drive improvement in patient care and to increase the proportion of patients receiving treatment within appropriate clinical benchmark times.		
Calculating performance	This indicator is measured at the campus level. A patient is categorised as having been seen immediately if the time to treatment, as defined in the VEMD manual, is less than or equal to one minute. Time to treatment equals b – a, where: • a is arrival date and time • b is the date and time of the initiation of patient management (either by a doctor, a mental health practitioner or a nurse, whichever is earliest). This KPI excludes those presentations with a departure status code of: • 10 – Left after advice regarding treatment options • 11 – Left at own risk without treatment • 30 – Referred to collocated clinic. If a hospital reports that a category 1 patient was not seen immediately, this must be confirmed or, if incorrect, amended by the health service. If this is not done, the patient will be regarded as a breach for the purposes of performance measurement. Please refer to Section 4 regarding the process for notifying the department of triage category 1 patients not seen immediately. This indicator is expressed as a percentage and rounded to the nearest whole number (0.5 is rounded up).		
Numerator	Number of triage category 1 emergency patients seen immediately		
Denominator	Total number of triage category 1 emergency patients		
Statewide target	**100%**		
Thresholds	100%	No loss of points	✓
	Less than 100%	Loss of one point from each emergency care KPI	⊘
Frequency of reporting and data collection	Performance is monitored and assessed monthly. A performance assessment score is generated quarterly. A performance result is generated annually based on the full year data. Data is submitted by health services fortnightly via the VEMD. Please refer to the *Victorian health policy and funding guidelines 2014–15* for further information on VEMD data submission timelines.		

Percentage of triage category 1 to 5 emergency patients seen within clinically recommended timelines		
Description	All patients attending EDs are triaged or assessed for urgency. The Australasian College of Emergency Medicine has identified five triage categories and defines the desirable time by when treatment should commence for patients in each category. The aim of this KPI is to drive improvement in patient care and to increase the proportion of patients receiving treatment within appropriate clinical benchmark times.	
Calculating performance	This indicator is measured at the campus level. A patient is categorised as having been seen within clinically appropriate timelines where the time to treatment is as defined in the VEMD manual. Time to treatment equals b – a, where: • a is arrival date and time • b is the date and time of the initiation of patient management (either by a doctor, a mental health practitioner or a nurse, whichever is earliest). This KPI excludes those presentations with a departure status code of: • 10 – Left after advice regarding treatment options • 11 – Left at own risk without treatment • 30 – Referred to collocated clinic. This indicator is expressed as a percentage and rounded to the nearest whole number (0.5 is rounded up).	
Numerator	Number of triage category 1 to 5 emergency patients seen within desirable times	
Denominator	Total number of triage category 1 to 5 emergency patients	
Statewide target	**80%**	
Thresholds	Greater than or equal to 80%	✓
	75% to 79%	⊘
	Less than or equal to 74%	✗
Frequency of reporting and data collection	Performance is monitored and assessed monthly. A performance result is generated annually based on full year data. Data is expected to be submitted by health services fortnightly via the VEMD. Please refer to the Victorian health policy and funding guidelines 2014–15 for further information on VEMD data submission timelines.	

Percentage of emergency patients with a length of stay less than four hours			
Description	This KPI measures the effectiveness of hospital processes and patient flow. The measure aims to encourage more timely management of ED patients who are admitted to the hospital, referred to another hospital or treated wholly within the ED. This indicator also aligns with national health reform and is identified by the National Partnership Agreement as the National Emergency Access Target (NEAT).		
Calculating performance	This indicator is measured at the campus level. This KPI excludes patients referred to a collocated clinic. This indicator is expressed as a percentage and rounded to the nearest whole number (0.5 is rounded up).		
Numerator	Number of patients with an ED length of stay of less than or equal to four hours (240 minutes).		
Denominator	Total number of patients presenting to the ED		
Statewide target	**81%**		
Thresholds	Greater than or equal to 81%	3 points	✓
	76% to 80%	2 points	⊘
	66% to 75%	1 point	⊘
	Less than or equal to 65%	0 points	✗
Frequency of reporting and data collection	Performance is monitored and assessed monthly. A performance assessment score is generated quarterly. A performance result is generated annually based on full year data. Data is submitted by health services fortnightly via the VEMD. Please refer to the *Victorian health policy and funding guidelines 2014–15* for further information on VEMD data submission timelines.		

Number of patients with a length of stay in the emergency department greater than 24 hours			
Description	This KPI measures the timely transfer of emergency patients to an inpatient bed or discharged home. It reflects the effectiveness of hospital patient flow processes and discharge planning.		
Calculating performance	This indicator is measured at the campus level. This KPI excludes patients whose status is dead on arrival.		
Numerator	Number of patients with an ED length of stay of greater than 24 hours (1,440 minutes), regardless of departure status code		
Statewide target	**0 patients**		
Thresholds	0 patients	3 points	✓
	Between 1 and 15 patients	2 points	⊘
	Between 16 and 30 patients	1 point	⊘
	31 or more patients	0 points	✗
Frequency of reporting and data collection	Performance is monitored and assessed monthly. A performance assessment score is generated quarterly. A performance result is generated annually based on full year data. Data is submitted by health services fortnightly via the VEMD. Please refer to the *Victorian health policy and funding guidelines 2014–15* for further information on VEMD data submission timelines.		

Elective surgery

Elective surgery performance indicators aim to encourage improved performance in managing healthcare for elective surgery patients. Elective surgery services should be provided in accordance with the Elective surgery access policy (2009). See <www.health.vic.gov.au/surgery/policies>.

Percentage of urgency category 1 elective patients admitted within 30 days			
Description	Urgency category 1 elective surgery patients are patients whose condition has the potential to deteriorate quickly to the point that it may become an emergency and whose admission within 30 days is clinically desirable. This indicator is measured at the health service level. Where a health service has multiple campuses, the aggregate for all campuses is used.		
Calculating performance	Only records assigned a principal prescribed procedure code of less than 500 and with a readiness status of R (ready for care) are used to assess this KPI. A removal in ESIS is counted as an admission when the reason for removal is either: • **W** – Admitted to this hospital • **S** – Treated for awaited procedure arranged by ESAS • **X** – This hospital arranged admission to another hospital • **Y** – Procedure received – at the same time as another procedure • **M** – Admitted for awaited procedure as an emergency patient. If a hospital reports that a category 1 patient is overdue this must be confirmed or, if incorrect, amended by the health service. If this is not done, the patient will be regarded as overdue for the purposes of performance measurement. Please refer to Section 4 regarding the process for notifying the department about overdue patients. This indicator is expressed as a percentage and rounded to one decimal place (0.05 is rounded up).		
Numerator	Number of urgency category 1 patients admitted within 30 days		
Denominator	Total urgency category 1 patients admitted		
Statewide target	**100%**		
Thresholds	100%	No loss of points	✓
	Less than 100%	Loss of one point from each elective surgery KPI	⊘
Frequency of reporting and data collection	Performance is monitored and assessed monthly. A performance assessment score is generated quarterly. A performance result is generated annually based on full year data. Data is submitted by health services fortnightly via ESIS. Please refer to the *Victorian health policy and funding guidelines 2014–15* for further information on ESIS data submission timelines.		

Percentage of urgency category 2 elective patients admitted within 90 days			
Description	This indicator aligns with national health reform and is identified by the National Partnership Agreement as part of the National Elective Surgery Targets (NEST). Elective surgery urgency category 2 patients have a condition causing some pain, dysfunction or disability that is not likely to deteriorate quickly or become an emergency. It is desirable that these patients be admitted within 90 days. This KPI is measured at the health service level. Where a health service has multiple campuses, the aggregate for all campuses is used.		
Calculating performance	Only records assigned a principal prescribed procedure code of less than 500 and with a readiness status of R (ready for care) are used to assess this KPI. A removal in ESIS is counted as an admission when the reason for removal is either: • W – Admitted to this hospital • S – Treated for awaited procedure arranged by ESAS • X – This hospital arranged admission to another hospital • Y – Procedure received – at the same time as another procedure • M – Admitted for awaited procedure as an emergency patient. This indicator is expressed as a percentage and rounded to one decimal place (0.05 is rounded up).		
Numerator	Number of urgency category 2 patients admitted within 90 days		
Denominator	Total number of urgency category 2 patients admitted		
Statewide target	**88%**		
Thresholds	Greater than or equal to 88.0%	3 points	✓
	83.0% to 87.9%	2 points	⦸
	78.0% to 82.9%	1 point	⦸
	Less than 78.0%	0 points	✗
Frequency of reporting and data collection	Performance is monitored and assessed monthly. A performance assessment score is generated quarterly. A performance result is generated annually based on full year data. Data is submitted by health services fortnightly via ESIS. Please refer to the *Victorian health policy and funding guidelines 2014–15* for further information on ESIS data submission timelines.		

Percentage of urgency category 3 elective patients admitted within 365 days			
Description	This indicator aligns with national health reform and is identified by the National Partnership Agreement as part of the National Elective Surgery Targets (NEST). Elective surgery urgency category 3 patients have a condition causing minimal or no pain, dysfunction or disability that is unlikely to deteriorate quickly or become an emergency. It is desirable that these patients be admitted within 365 days. This KPI is measured at the health service level. Where a health service has multiple campuses, the aggregate for all campuses is used.		
Calculating performance	Only records assigned a principal prescribed procedure code of less than 500 and with a readiness status of R (ready for care) are used to assess this KPI. A removal in ESIS is counted as an admission when the reason for removal is either: • W – Admitted to this hospital • S – Treated for awaited procedure arranged by ESAS • X – This hospital arranged admission to another hospital • Y – Procedure received – at the same time as another procedure • M – Admitted for awaited procedure as an emergency patient. This indicator is expressed as a percentage and rounded to one decimal place (0.05 is rounded up).		
Numerator	Number of urgency category 3 patients admitted within 365 days		
Denominator	Total number of urgency category 3 patients admitted		
Statewide target	**97.0%**		
Thresholds	Greater than or equal to 97.0%	3 points	✓
	92.0% to 96.9%	2 points	⦸
	87.0% to 91.9%	1 point	⦸
	Less than or equal to 86.9%	0 points	✗
Frequency of reporting and data collection	Performance is monitored and assessed monthly. A performance assessment score is generated quarterly. A performance result is generated annually based on full year data. Data is submitted by health services fortnightly via ESIS. Please refer to the *Victorian health policy and funding guidelines 2014–15* for further information on ESIS data submission timelines.		

Number of patients on the elective surgery waiting list			
Description	Elective surgery performance indicators aim to encourage improved performance in managing healthcare for elective surgery patients. Elective surgery services should be provided in accordance with the Elective surgery access policy (2009). See <www.health.vic.gov.au/surgery/policies>. This indicator measures the number of patients waiting for elective surgery as at the end of the reporting period and is measured at health service level. Where health services have multiple campuses, the aggregate for all campuses is used. Agreed individual health service quarterly targets take into account external factors impacting on service capacity such as peaks in emergency demand and seasonal fluctuations. Notional monthly targets are used to assist with monitoring performance.		
Calculating performance	Only records assigned a principal prescribed procedure code of less than 500 and with a readiness status of R (ready for care) are used to assess this KPI. This indicator is expressed as a percentage and the variance is rounded to the nearest whole number (0.5 is rounded up).		
Numerator	Number of patients, for all urgency categories, waiting for elective surgery as at the end of the reporting period		
Specific health service target	**As agreed in the SoP**		
Thresholds	Target achieved	3 points	✓
	Between 0.1% and 2% over target	2 points	⊘
	Between 3% and 5% over target	1 point	⊘
	Greater than or equal to 6% over target	0 points	✗
Frequency of reporting and data collection	Performance is monitored and assessed monthly. A performance assessment score is generated quarterly. An annual result is generated based on year to date result at 30 June 2015 (following final consolidation of data). Data is submitted by health services fortnightly via ESIS. Please refer to the *Victorian health policy and funding guidelines 2014–15* for further information on ESIS data submission timelines.		

Number of hospital-initiated postponements per 100 scheduled admissions			
Description	Elective surgery performance indicators aim to encourage improved performance in managing healthcare for elective surgery patients. Elective surgery services should be provided in accordance with the Elective surgery access policy (2009). See <www.health.vic.gov.au/surgery/policies>. This indicator measures the number of hospital-initiated postponements (HiPs) experienced by elective surgery patients during a quarter. This indicator is measured at the health service level. Where a health service has multiple campuses, the aggregate for all campuses is used.		
Calculating performance	Only records assigned a principal prescribed procedure code of less than 500 are used to assess this indicator. All HiPs occurring within the quarter will impact on performance regardless of whether the patient is 'ready for care', 'not ready for care' or has been removed from the waiting list. HiPs are counted for the quarter in which they actually occur, even if the procedure being postponed was scheduled for a different quarter. A postponement is hospital initiated if the reason for the scheduled admission date change in ESIS is recorded as: • 100 – Surgeon unavailable • 101 – Surgical unit initiated • 102 – Hospital staff unavailable • 103 – Ward bed unavailable • 104 – Critical care bed unavailable • 105 – Equipment unavailable • 106 – Theatre overbooked • 108 – Emergency priority • 109 – Elective priority • 110 – Hospital or surgeon has not prepared patient • 111 – Clerical or booking error. This indicator is rounded to one decimal place (0.05 is rounded up).		
Numerator	Number of HiPs within the quarter		
Denominator	Number of procedures scheduled to occur in the quarter, regardless of whether the procedure actually takes place		
Statewide target	**Eight per 100 scheduled admissions**		
Thresholds	0 to 8.0	3 points	✓
	8.1 to 11.0	2 points	⊘
	11.1 to 15.0	1 point	⊘
	Greater than or equal to 15.1	0 points	✗
Frequency of reporting and data collection	Performance is monitored and assessed quarterly. A performance assessment score is generated quarterly. A performance result is generated annually based on the full year data. Data is submitted by health services fortnightly via ESIS. Please refer to the *Victorian health policy and funding guidelines 2014–15* for further information on ESIS data submission timelines.		

Number of patients admitted from the elective surgery waiting list		
Description	Elective surgery performance indicators aim to encourage improved performance in managing healthcare for elective surgery patients. Elective surgery services should be provided in accordance with the *Elective surgery access policy (2009)*. See <www.health.vic.gov.au/surgery/policies>. Individual targets are negotiated with each health service. Targets for the number of patients admitted from the waiting list during each quarter have been set at the health service, rather than individual hospital level. The quarterly targets set for individual health services reflect peaks in emergency demand and seasonal capacity limitations. To enable this KPI to be monitored on a monthly basis health services provide the department with notional monthly targets.	
Calculating performance	The Number of patients during the reporting period who have been admitted for the awaited procedure, or related procedure, that addresses the clinical condition for which they were added to the elective surgery waiting list. Only records assigned an ESIS principal prescribed procedure code of less than 500 are used to assess this KPI. Within ESIS data, a removal is counted as a planned admission if the removal date falls within the quarter being reported and the reason for removal is either: • W – Admitted to this hospital • S – Treated for awaited procedure arranged by ESAS, or • X – This hospital arranged admission to another hospital. This indicator is expressed as a percentage and rounded to the nearest whole number (0.5 is rounded up).	
Numerator	Number of admitted patients	
Specific health service target	**As agreed in the SoP**	
Thresholds	Achieved target	✓
	Between 0% and 5% below target	⊘
	Greater than or equal to 6% below target	✗
Frequency of reporting and data collection	Performance is monitored and assessed monthly. A performance result is generated annually based on the full year data. Data is submitted by health services fortnightly via ESIS. Please refer to the *Victorian health policy and funding guidelines 2014–15* for further information on ESIS data submission timelines.	

Critical care

Adult and paediatric intensive care unit operate to their agreed minimum operating capacity	
Description	Victoria's adult and paediatric intensive care units (ICU) provide a critical statewide resource. By agreeing to provide a minimum level of service capacity, it is possible to monitor and respond to ICU demand and access pressures at a local and system level. This KPI is intended to monitor the agreed minimum number of ICU beds that hospitals provide daily for adult and paediatric patients. The minimum operating capacity is set individually at hospital level as agreed in the SoP.
Definitions	When referring to equivalent ICU capacity for adult and paediatric units, the following definitions apply. **Occupied bed:** staffed bed occupied by a patient **Empty bed:** staffed bed that is not occupied by a patient **Reserved bed:** empty bed reserved for a patient who is not currently in the unit, for example, in theatre or en route from another hospital (reserved bed is a subset of Empty bed) **Bed occupied by a patient waiting ward transfer:** staffed bed occupied by a patient who has been clinically assessed as ready to be transferred to a ward (a bed occupied by a patient waiting for a ward transfer is a subset of Occupied bed)
Calculating performance	The equivalent ICU minimum operating capacity is calculated by: • ICU bed × 1 (1:1 patient staff ratio) = 1.0 ICU equivalent bed • HDU bed × 1 (2:1 patient staff ratio) = 0.5 ICU equivalent bed • CCU bed × 1 (2:1 patient staff ratio) = 0.5 ICU equivalent bed. Incorporating CCU beds when calculating equivalent ICU capacity is restricted to units in hospitals that operate as a mixed ICU and CCU. The ICU-equivalent weighting is allocated to each bed type and summed to a total for the day, which is set according to the level of care. Absolute bed capacity is not represented by bed types only. Units will at times operate above the agreed ICU equivalent minimum operating capacity to meet high demand for ICU beds and, equally, will occasionally operate below this target when demand is low. It is important to note that it is permissible for a unit to operate below its agreed minimum capacity if a bed is reported as empty. The worst result of the four possible reports for each day is used to assess performance.
Numerator	The number of days where the ICU reported its operating capacity below the agreed minimum operating capacity and did not report an empty bed (ICU equivalent)
Statewide target	**0 days**

Adult and paediatric intensive care unit operate to their agreed minimum operating capacity

Example

In the example below, the unit has a target of 10 ICU equivalents for its minimum operating capacity.

Note that of the four reports below, at 20:00 hours the unit has provided only nine ICU equivalents but has still met the performance target by including an empty bed.

(For the purpose of this example, columns for reserved beds or patients awaiting transfer have been omitted as they are subsets of occupied and empty.)

Four-hourly report	ICU beds occupied	ICU beds empty	HDU beds occupied	HDU beds empty	ICU equivalent total	Target met/not met
08:00	6	0	8	0	10	Yes
12:00	7	1	2	2	10	Yes
16:00	5	0	4	0	7	No
20:00	7	1	2	0	9	Yes

Thresholds

Achieved	✓
Not achieved	✗

Frequency of reporting and data collection

Performance is monitored and assessed monthly.

A performance result is generated annually based on the full year data.

The data for this KPI is sourced from the Retrieval And Critical Health Information (REACH) website. This website is a real-time online entry system for daily transaction data. Hospitals are expected to update their bed status via the website four times per day, at approximately 8 am, 12 pm, 4 pm and 8 pm.

There is only a two-hour opportunity either side of the hour to record and verify the information. Data entry error correction is not possible after this time.

Hospitals are able to download their own ICU performance data from the REACH website at any time. Please refer to the REACH website instructions for further details.

Data is extracted from the REACH website by the department within the first week following the end of each month.

Neonatal intensive care unit operate to their agreed standard and flexible operating capacity	
Description	This indicator applies to hospitals funded for neonatal intensive care services and assists with understanding the availability of access to acute respiratory support treatment for neonates. The standard and flex-up operating capacity in neonatal intensive care units (NICUs) is based on ventilated cots only. However, NICUs also provide care to neonates who do not require respiratory support. The standard and flex-up operating capacity is agreed at an individual hospital level. Hospitals are expected to increase the number of ventilated cots into their agreed flex-up capacity to provide care in times of high demand. The agreed number of ventilated (standard and flex-up) and non-ventilated NICU cots at individual hospitals, including their occupancy, is recorded on the Victorian Perinatal Information Centre (VicPIC).
Definitions	When referring to NICU operating capacity the following definitions apply. Standard operating capacity: the number of ventilated NICU cots that a health service agrees to maintain as required Flex-up capacity: the number of additional ventilated cots above the standard operating capacity that a health service agrees to make available during peaks in demand Occupied cots: a cot that is occupied by a neonate receiving respiratory support Closed unit: the unit is unable to accept new admissions requiring respiratory support
Calculating performance	During instances when the NICU is closed, this KPI measures the number of days when the NICU is not able to accept new admissions and is operating under the agreed standard operating capacity for ventilated cots in the SoP. Individual NICU services can be closed and below the agreed standard operating capacity a maximum of 15 per cent of days per reporting quarter without being deemed in breach of the target. The indicator is expressed as a whole number.
Statewide target	**0 closures below the agreed standard number of NICU occupied cots**
Thresholds	Achieved target ✓ Target not achieved ✗
Frequency of reporting and data collection	Performance is monitored and assessed monthly. A performance result is generated annually based on the full year data. The data source for this KPI is the VicPIC, which is the information system used by each NICU. In order to validate actual cot occupancy, it is expected that each hospital will ensure the data is reported at least once per nursing shift. Hospitals are able to review and verify information daily. Data is extracted from VicPIC by the department in the first week following the end of each month.

Timely response (Ambulance Victoria only)

Percentage of emergency (code 1) incidents responded to within 15 minutes – statewide	
Description	Statewide response times are an indicator of the provision of accessible and effective ambulance service to communities (Report on government services). Code 1 incidents are potentially life threatening and are time critical, requiring a lights and sirens response. Response time measures the time from a triple zero (000) call being answered by the Emergency Services Telecommunications Authority (ESTA) to the time of the first arrival at the incident scene of an Ambulance Victoria (AV) paramedic, a community emergency response team or an ambulance community officer. This indicator applies to all emergency road code 1 incidents responded to statewide.
Calculating performance	This indicator excludes: • incidents for which response time was recorded as > 2 hours or where there are missing time stamps • responses to ambulance incidents by the Metropolitan Fire Brigade, the Country Fire Authority and remote area nurses • responses to air ambulance incidents. This indicator is expressed as a percentage to one decimal place.
Numerator	Number of emergency road code 1 incidents responded to within 15 minutes
Denominator	Total number of emergency road code 1 incidents responded to in that same reporting period
Statewide target	**85%**
Frequency of reporting and data collection	Performance is monitored and assessed monthly. Data is submitted to the department monthly.

Percentage of emergency (code 1) incidents responded to within 15 minutes in centres with population greater than 7,500	
Description	Statewide response times are an indicator of the provision of accessible and effective ambulance service to communities *(Report on government services)*. Code 1 incidents are potentially life threatening and are time critical, requiring a lights and sirens response. Response time measures the time from a triple zero (000) call being answered by the Emergency Services Telecommunications Authority (ESTA) to the time of the first arrival at the incident scene of an AV paramedic, a community emergency response team or an ambulance community officer. Urban response times are emergency (code 1) incidents responded to within 15 minutes in centres with a population > 7,500. Urban centres with a population > 7,500 are identified using the Australian Bureau of Statistics resident population statistics and Urban Centre Locality (UCL) boundaries. This indicator applies to all emergency road code 1 incidents responded to in centres with a population > 7,500.
Calculating performance	The locations of code 1 incidents are identified using the x and y coordinates generated by the ESTA Computer Aided Dispatch (CAD) system. These coordinates are mapped to UCL boundaries to identify those events that fall within the UCLs where the population exceeds 7,500. This indicator excludes: • incidents for which response time was recorded as > 2 hours or where there are missing time stamps. • responses to ambulance incidents by the Metropolitan Fire Brigade, the Country Fire Authority and remote area nurse • responses to air ambulance incidents. This indicator is expressed as a percentage to one decimal place.
Numerator	Number of emergency code 1 incidents aggregated across all the UCLs with a population > 7,500 responded to within 15 minutes
Denominator	Total number of emergency code 1 incidents across all the UCLs with a population > 7,500 responded to in that same reporting period
Statewide target	**90%**
Frequency of reporting and data collection	Performance is monitored and assessed monthly. Data reported is lagged by one month. Data is submitted to the department monthly.

Percentage of community emergency response team arrival prior to ambulance	
Description	Community emergency response teams (CERTs) are units without transport capability that are crewed by AV trained volunteers to provide an on-call response to code 1 incidents. CERTs are located throughout Victoria, within communities where the nearest ambulance branch is at a distance. A team is dispatched simultaneously with an ambulance to emergency code 1 incidents to initiate and provide treatment until an ambulance arrives. CERTs are always backed up by a transport-capable unit. Response time measures the time from a triple zero (000) call being answered by the Emergency Services Telecommunications Authority (ESTA) to the arrival of the CERT at the incident scene. This indicator applies to all CERTs operational in Victoria that responded to emergency road code 1 incidents.
Calculating performance	This indicator measures the proportion of emergency (code 1) incidents to which a CERT was dispatched and arrived prior to ambulance. CERT attendance time is compared with ambulance attendance time and prior arrivals are reported as a percentage of total cases. This indicator is expressed as a percentage to one decimal place.
Numerator	Total number of CERTs arriving at emergency code 1 scene prior to ambulance
Denominator	Total number of CERT dispatches to code 1 incidents
Statewide target	**85%**
Frequency of reporting and data collection	Performance is monitored and assessed quarterly. Data reported is lagged by one quarter. Data is submitted to the department quarterly.

Percentage of 000 events where the caller receives advice or service from another health provider – Melbourne metropolitan region	
Description	Referral calls are low-priority triple zero (000) events for which an alternative to an emergency ambulance response may be more appropriate. Call diversion is where a 000 call does not result in an emergency ambulance dispatch. Referrals include events which are returned for a non-emergency response or referral to an alternative service provider such as a medical practitioner, nursing service, other health professional service, home self-care or advice. AV manages call diversion via RefCom. This indicator applies to all 000 calls in the metropolitan region that do not result in an emergency dispatch.
Calculating performance	Proportion of 000 events where the caller receives advice or service from another health provider as an alternative to emergency ambulance response in the metropolitan area. This indicator is expressed as a percentage to one decimal place.
Numerator	Total number of metropolitan RefCom managed calls that did not result in an emergency response
Denominator	Total number of emergency cases (metropolitan) + total number of referral managed calls that did not result in an emergency response
Statewide target	**10%**
Frequency of reporting and data collection	Performance is monitored and assessed monthly. Data is submitted to the department monthly.