

# Public Health Services

## The 2008-09 Statement of Priorities and Performance Framework

Business Rules



**Public Health Services  
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Performance Framework  
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Department of Human Services, Victoria

September 2008

Victoria –The 2008–09 Statement of Priorities and Performance Framework.  
Business Rules

Victorian Government Department of Human Services  
Melbourne Victoria

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# 1 Introduction

## 1.1 About this document

The purpose of this document is to describe the mechanisms used by the Department of Human Services (the department) to formally monitor public health service performance in 2008-09.

This document is structured as follows:

1. Section 1 - an introduction and overview that provides a brief policy context for these business rules, as well as a summary of key changes
2. Section 2 - identifies the KPIs included in the Statement of Priorities (SoP)
3. Section 3 - describes the workings of the Performance Monitoring Framework (PMF) and Bonus Funding Framework (BFF), as well as the KPIs involved
4. Section 4 - presents the specific business rules for each KPI and the data sources for the KPIs
5. Section 5 - lists departmental contacts for the business rules.

## 1.2 Policy framework

The *Health Services Act (1988)* formally defines public health services. In 2008-09 there are 20 public health services, 15 in metropolitan Melbourne and 5 in regional Victoria. To ensure an appropriate level of accountability for these public health services, a framework has been implemented which includes;

- **Annual Statement of Priorities (SoP)** that sets out the policy priorities of the government, health service specific priorities and expected levels of performance in key areas for the financial year
- **Performance Monitoring Framework (PMF)** that enables the department to transparently monitor, analyse and evaluate a health service's performance. The PMF score reflects both access and financial aspects of performance
- **Bonus Funding Framework (BFF)** that provides health services with a quarterly financial incentive to meet elective surgery and emergency care performance targets.

The department implements a range of activities throughout the year to support performance, including providing benchmarking and performance results to public health services on a monthly basis.

The PMF score indicates the level of monitoring and the frequency with which the department meets with health service senior executives to assess performance. It should be noted that in implementing the PMF, the department may adopt different approaches for regional and metropolitan health services.

Ambulance Victoria and Dental Health Services Victoria have a different performance monitoring regime and are not subject to the approaches set out in this document.

### 1.3 Summary of key changes

The key changes for 2008-09 are some changes to the financial key performance indicators, additional key performance indicators, and an expansion in the number of hospitals participating in the PMF and BFF. The changes are summarised below with the rationale and detail of these changes described in section 4 of this document.

#### Statement of Priorities:

##### Financial Performance

- Net Movement in Cash - the monitoring of cashflow has been expanded from only capital activity to include all activities. The Net Movement in Cash KPI replaces the Net Cash flows from Capital Activities KPI. This finance KPI is included in the PMF.
- Debtors - The definition for the debtor KPI has been amended to exclude those debts that have been referred to a collection agency or have a similar plan for management.

##### Service Performance

These KPIs are additional to the SoP:

- Elective surgery admission targets
- Agreed minimum operating capacity for critical care services
- Agreed operating capacity for neonatal intensive care units (NICU)
- VICNISS infection surveillance performance
- Participation in the Hand Hygiene Program (part of the Start Clean Victorian Infection Control Strategy 2007-11)
- The rate of women discharged with prearranged postnatal home care

##### Access Performance

- Percentage of Triage Category 2 emergency patients seen within 10 minutes
- Percentage of Triage Category 3 emergency patients seen within 30 minutes

#### Performance Monitoring Framework and Bonus Funding Framework:

Effective 1 January 2009, the BFF will change to incorporate the Triage Category 2 and Triage Category 3 time to treatment KPIs as part of the 4 hour KPI assessment.

##### Changes to Service Mix

- Elective Surgery performance for Broadmeadows Health Service will be included in the Northern Health results.

The following hospitals have been added to the PMF and BFF:

- Williamstown Hospital and Royal Victorian Eye & Ear Hospital for 4hr Emergency KPI (percentage of non-admitted emergency patients with a length of stay of less than 4 hours)
- Rosebud Hospital for three of the four Emergency Care KPIs (8hrs, 4hrs and 24hrs).
- Casey Hospital for the elective surgery KPIs

## 2 Statement of Priorities

The SoP was introduced in 2004-05 as part of a series of governance reforms enacted in changes to the *Health Services Act (1988)* to improve accountability between Boards of Health Services and the Government. Only those health services designated as public health services are required to have a SoP.

The SoP incorporates system wide priorities and statewide benchmarks set by Government, but also allows for public health service specific priorities.

The department is committed to ensuring that the suite of performance indicators it uses to monitor health service provides a balanced perspective of service provision. The department will continue to work with health services to develop and refine indicators over time.

The suite of key performance indicators are outlined in Section 4.

## 2.1 Key Performance Indicators

Table 1 details the KPIs included in the 2008-09 SoP and identifies whether the KPI is part of the PMF and BFF for 2008-09. The BFF applies to emergency care and elective surgery KPIs only.

**Table 1: Key Performance Indicators in the 2008-09 Statement of Priorities**

Program	KPI #	KPI	KPI Description	Benchmark	PMF	BFF
<b>Financial performance</b>						
Finance	FIN KPI 1	Operating Result	Annual operating result	Health Service specific	✓	✗
	FIN KPI 2	Net Cash Movement	Net movement in cash	Health Service specific	✓	✗
	FIN KPI 3	Creditors	Trade creditors average age	60 days	✓	✗
	FIN KPI 4	Debtors	Debtors average age	60 days	✓	✗
	FIN KPI 5	PP WIES	YTD PP WIES activity	98 – 102% of target	✓	✗
<b>Service performance</b>						
Elective Surgery	SERV KPI 1	Admissions	Elective Surgery admissions	Health Service Specific	✗	✗
Critical Care	SERV KPI 2	ICU	Minimum operating capacity of Intensive Care Unit	Hospital Specific	✗	✗
	SERV KPI 3	PICU	Minimum operating capacity of Paediatric Intensive Care Unit	Hospital Specific	✗	✗
	SERV KPI 4	NICU	Standard and flex operating capacity of Neonatal Intensive Care Unit	Hospital Specific	✗	✗
Quality and Safety	SERV KPI 5	Accred	Health Service Accreditation	Full Accreditation	✗	✗
		Resi	Residential Aged Care compliance with accreditation standards	No instances of non-compliance	✗	✗
	SERV KPI 6	Cleaning	Cleaning Standards	85%	✗	✗
	SERV KPI 7	VICNISS Data	Infection surveillance data compliance (VICNISS)	Full	✗	✗
	SERV KPI 8	VICNISS Perf	VICNISS Infection Surveillance performance	No Outlier	✗	✗
	SERV KPI 9	Hand Hygiene	Hand Hygiene program compliance	Full	✗	✗
Maternity	SERV KPI 10	PostNatalCare	Proportion of women who have given birth and on discharge have prearranged postnatal home care	90% (Metro) 80% (Regional)	✗	✗

Program	KPI #	KPI	KPI Description	Benchmark	PMF	BFF
Mental Health	SERV KPI 11	MH28Day	Adult Mental Health 28 day readmission rate	14%	✗	✗
<b>Access performance</b>						
Emergency Care	ACCESS KPI 1	Bypass	% of operating time on hospital bypass	3%	✓	✓
	ACCESS KPI 2	8hrs	% of emergency patients transferred to an inpatient bed within 8 hours	80%	✓	✓
	ACCESS KPI 3	4hrs	% of non-admitted emergency patients with a length of stay of less than 4 hours	80%	✓	✓
	ACCESS KPI 4	24hrs	No of patients with a length of stay in the emergency department greater than 24 hours	0	✓	✓
	ACCESS KPI 9	Triage1	% of triage Category 1 patients seen immediately	100%	✓	✓
	ACCESS KPI 11	Triage2	% of triage Category 2 patients seen within 10 minutes	80%	✓	✓
	ACCESS KPI 12	Triage3	% of triage Category 3 patients seen within 30 minutes	75%	✓	✓
Elective Surgery	ACCESS KPI 5	Cat2	% of Category 2 elective surgery patients waiting less than 90 days	100%	✓	✓
	ACCESS KPI 6	Cat3	% of Category 3 elective surgery patients waiting less than 365 days	100%	✓	✓
	ACCESS KPI 7	ESWL	No of patients on the elective surgery waiting list	Health Services specific	✓	✓
	ACCESS KPI 8	HiPs	No of Hospital Initiated Postponements (HiPs) per 100 waiting list scheduled admissions	8	✓	✓
	ACCESS KPI 10	Cat1	% of Category 1 elective surgery patients admitted within 30 days	100%	✓	✓

✓ Included for assessment in the framework

✗ In SoP but not applicable to the framework



### 3 Performance Monitoring Framework and Bonus Funding Framework

This section provides an overview of the PMF and BFF, identifies the KPIs and scoring systems used in both of these frameworks, and how KPIs apply to each public health service or hospital.

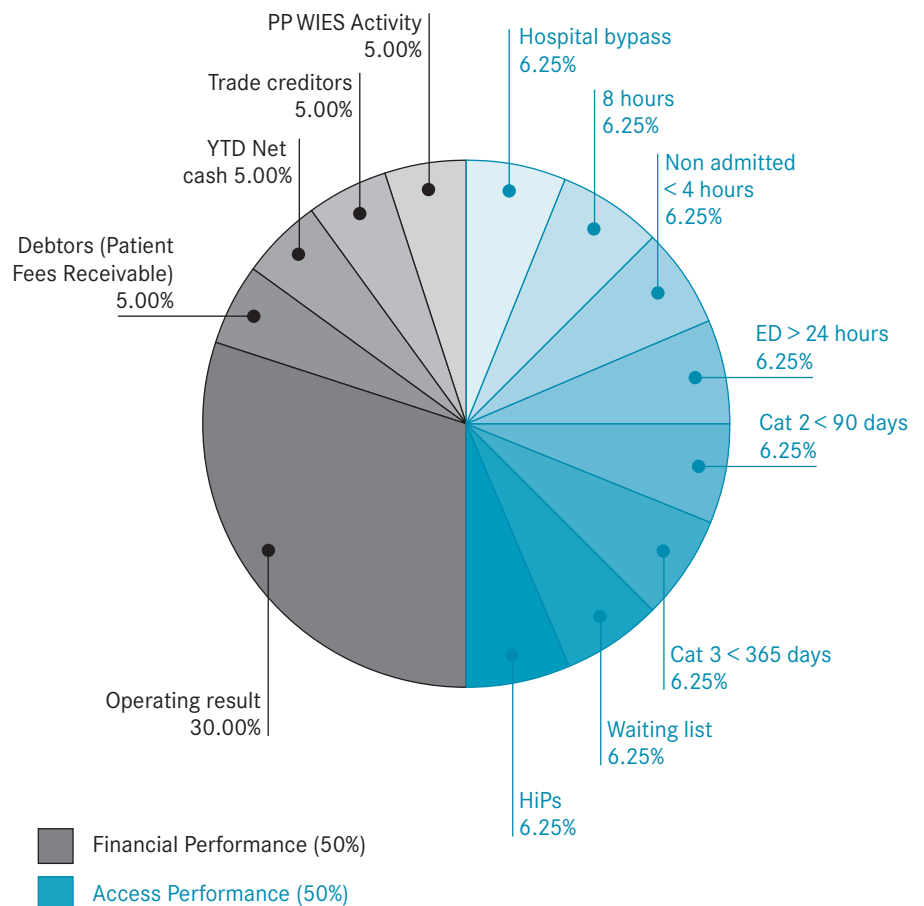
The department assesses and monitors the performance of public health services against the PMF and BFF on a quarterly basis. To assist in managing performance throughout the quarter, progress against each KPI is reported monthly. To facilitate timely reporting and feedback to public health services, where necessary, these monthly performance reports use preliminary or interim results.

#### 3.1 Overview of the Performance Monitoring Framework

The PMF is used to provide an overall assessment of the performance of public health services including finance and service performance identified in the SoP. The access performance KPIs relate to both emergency care and elective surgery. Each quarter, a PMF score out of 100 is calculated.

The relative contribution each KPI makes to the PMF score is represented in the diagram below. Financial performance and access performance KPIs each contribute up to 50 per cent of the PMF score.

The department uses the PMF score to determine the level of monitoring for public health services throughout the annual business cycle. As noted earlier, in implementing the PMF the department may adopt different approaches for regional and metropolitan public health services.



## 3.2 Levels of Monitoring

The three levels of monitoring are as follows:

**Standard Monitoring (70-100 points)** - applies to those public health services achieving their KPIs. It is the least intrusive level of monitoring with meetings occurring quarterly between the department and the public health service to discuss performance.

**Performance Watch (50-69 points)** - applies to those public health services with an emerging deterioration in performance against targets. The scope of monitoring is increased and performance meetings between the department and the public health service become more frequent, either monthly or bi-monthly.

**Intensive Monitoring (0-49 points)** - applies where there is consistent under achievement against performance indicators by a public health service. The scope and frequency of monitoring is intensified and requires public health services to provide more detailed information such as an access improvement plan.

A public health service's PMF score matching a monitoring level for **two** consecutive quarters will trigger monitoring at that level. However, if a public health service has a score of 49 points or less in a single quarter, it will automatically trigger intensive monitoring.

### Calculating the PMF Score

To calculate the PMF score, points are allocated to both the finance and access KPIs using the weightings and thresholds outlined in Tables 2 and 3. The scoring and thresholds for the access KPIs are the same for the PMF and BFF with a maximum score of 3 points per KPI possible. In the 2008-09 PMF, a maximum score of 50 points is achievable for both the finance and access performance KPIs. Aggregating the access and finance scores gives the total PMF score. If a public health service is not assessed against the access KPIs, the PMF finance score is doubled to give the total PMF score.

Where the KPI is measured at a campus level, the points are calculated for each campus service and then aggregated to provide an overall health service total.

As the time to treatment Triage 2 and Triage 3 emergency care KPIs are part of the 4 hour emergency care KPI, they are only used to calculate the scores for the BFF, and are not separately calculated for the PMF.

Tables 4, 5 and 6 outline which KPIs apply to each hospital/public health service and how the PMF and BFF apply to each indicator.

### 3.3 Targets and Performance Thresholds

The targets and performance thresholds of the PMF and BFF use a sliding scale to measure health service performance against set targets. Tables 2 and 3 show the weightings, performance thresholds and points allocations used for the PMF and BFF for each KPI. Only access performance indicators are included in the BFF.

**Table 2: Access Performance - PMF Weights, Performance Thresholds and PMF/Bonus points**

KPI	Description	Weight	Threshold	PMF/Bonus
Bypass	Percentage of operating time on hospital bypass	6.25%	0.0% to 3.0%	3
			3.1% to 4.0%	2
			4.1% to 5.0%	1
			> 5%	0
8hrs	Percentage of emergency patients transferred to an inpatient bed within 8 hours	6.25%	80%+	3
			75% to 79%	2
			65% to 74%	1
			0% to 64%	0
4hrs	Percentage of non-admitted emergency patients with a LOS of less than 4 hours	6.25%	80%+	3
			75% to 79%	2
			65% to 74%	1
			0% to 64%	0
24hrs	Number of patients with a LOS in the emergency department greater than 24 hours	6.25%	0	3
			1 to 15	2
			16 to 30	1
			30+	0
Triage1	Percentage of triage Category 1 patients seen immediately	100% - Conditional KPI *		
Triage2	Percentage of triage Category 2 patients seen within 10 minutes	80% - Conditional KPI ^		
Triage3	Percentage of triage Category 3 patients seen within 30minutes	75% - Conditional KPI ^		
Cat2	Percentage of Category 2 elective surgery patients waiting 90 days or less	6.25%	0%	3
			> 0% to 2% below target	2
			3% to 5% below target	1
			> 5% below target	0
Cat3	Percentage of Category 3 elective surgery patients waiting 365 days or less	6.25%	0%	3
			> 0% to 2% below target	2
			3% to 5% below target	1
			> 5% below target	0

KPI	Description	Weight	Threshold	PMF/Bonus
ESWL	Number of patients on the elective surgery waiting list - percentage variance to target	6.25%	0%	3
			> 0% to 2% over target	2
			3% to 5% over target	1
			> 5% over target	0
HiP	Number of Hospital Initiated Postponements per 100 scheduled admissions from the waiting list	6.25%	0 to 8.0%	3
			8.1 to 11.0	2
			11.1 to 15	1
			15.1 +	0
Cat1	Percentage of Category 1 patients admitted within 30 days		100% - Conditional KPI *	

\* Failure to meet the KPI will result in a point being deducted from each of the KPIs for the relevant system (Triage1 impacts on Emergency Care and Cat1 impacts on Elective Surgery), unless the score is already 0.

^ Non-achievement of the statewide benchmark for this KPI will result in 0 bonus points for the 4 hour emergency KPI. Not included in PMF calculations.

Results/variances are rounded before they are assessed - refer to definitions

**Table 3: Financial Performance - PMF Weights, Performance Thresholds and PMF points**

KPI	Description	Weight	Threshold	PMF
Operating Result	YTD operating result as a percentage of revenue - variance to budget	30%	Achieved budget	30
			If in surplus but behind target	24
			0% - 2% unfavourable variance	21
			> 2% - 3% unfavourable variance	10
			Over 3% unfavourable variance	0
Net Cash Movement	Difference between the actual closing cash and the phased target closing cash	5%	Achieved budget	5
			\$0m to \$2m unfavourable variance	3
			> \$2m to \$5m unfavourable variance	2
			Over \$5m unfavourable variance	0
Creditors	Trade Creditors - Average Days	5%	Less than or equal to 60 days	5
			61 - 65 days	3
			66 - 70 days	2
			More than 70 days	0
Debtors	Debtors - Average Days	5%	Less than or equal to 60 days	5
			61 - 70 days	3
			71 - 80 days	2
			More than 80 days	0
PP WIES	YTD PP WIES Activity	5%	+0 to 2.0% variance to target	5
			+2.01% to 2.50% variance to target	3
			+2.51% to 3% variance to target	2
			More than +3% variance to target	0

Results/variances are rounded before they are assessed - refer to definitions

### 3.4 Reporting by hospital/public health service

Tables 4, 5 and 6 set out which KPIs apply to the individual hospitals/public health services.

**Table 4: Emergency Care KPIs by Hospital**

Public Health Service/Hospital	Bypass	8hrs	4hrs	24hrs	Triage1	Triage2	Triage3
<b>Metropolitan</b>							
Angliss Hospital	✓	✓	✓	✓	☆	☆	☆
Austin Health	✓	✓	✓	✓	☆	☆	☆
Box Hill Hospital	✓	✓	✓	✓	☆	☆	☆
Casey Hospital	✗	✓	✓	✓	☆	☆	☆
Dandenong Hospital	✓	✓	✓	✓	☆	☆	☆
Frankston Hospital	✓	✓	✓	✓	☆	☆	☆
Maroondah Hospital	✓	✓	✓	✓	☆	☆	☆
Mercy Hospital for Women	✗	◆	◆	◆	◆	◆	◆
Mercy Werribee Hospital	✗	✓	✓	✓	☆	☆	☆
Monash Medical Centre - Clayton	✓	✓	✓	✓	☆	☆	☆
Rosebud Hospital	✗	✓	✓	✓	☆	☆	☆
Royal Children's Hospital	✗	✓	✓	✓	☆	☆	☆
Royal Melbourne Hospital	✓	✓	✓	✓	☆	☆	☆
Royal Victorian Eye and Ear Hospital	✗	✗	✓	✗	☆	☆	☆
Royal Women's Hospital	✗	◆	◆	◆	◆	◆	◆
Sandringham & District Hospital	✗	✓	✓	✓	☆	☆	☆
St Vincent's Hospital	✓	✓	✓	✓	☆	☆	☆
Sunshine Hospital	✓	✓	✓	✓	☆	☆	☆
The Alfred	✓	✓	✓	✓	☆	☆	☆
The Northern Hospital	✓	✓	✓	✓	☆	☆	☆
Western Hospital	✓	✓	✓	✓	☆	☆	☆
Williamstown Hospital	✗	✗	✓	✗	☆	☆	☆
<b>Regional</b>							
Ballarat Health Services	✗	✓	✓	✓	☆	☆	☆
Barwon Health	✗	✓	✓	✓	☆	☆	☆
Bendigo Health Care Group	✗	✓	✓	✓	☆	☆	☆
Goulburn Valley Health	✗	✓	✓	✓	☆	☆	☆
Latrobe Regional Hospital	✗	✓	✓	✓	☆	☆	☆
<b>Total assessed for PMF</b>	<b>13</b>	<b>23</b>	<b>25</b>	<b>23</b>	<b>-</b>	<b>-</b>	<b>-</b>
<b>Total eligible for BFF</b>	<b>13</b>	<b>23</b>	<b>25</b>	<b>23</b>	<b>25</b>	<b>25</b>	<b>25</b>

✗ KPI not applicable for this site.

◆ Public health service performance monitored against Statement of Priorities for this KPI but not subject to the PMF or BFF

❖ Public health service assessed against the Performance Monitoring Framework for this KPI

✓ Public health service assessed against the Performance Monitoring Framework and is subject to bonus funding for this KPI.

☆ Public health service is subject to bonus funding for this KPI – Non-achievement of the statewide benchmark will result in the reduction of bonus point for emergency KPIs in a given quarter (total of 4 bonus points deducted in a given quarter).

Table 5: Elective Surgery KPIs by Hospital

Public Health Service/Hospital	Cat2	Cat3	*ESWL	HiP	Cat1
<b>Metropolitan</b>					
Angliss Hospital	✓	✓	✓	✓	⊛
Austin Health	✓	✓	✓	✓	⊛
Box Hill Hospital	✓	✓	✓	✓	⊛
Casey Hospital	✓	✓	✓	✓	⊛
Dandenong Hospital	✓	✓	✓	✓	⊛
Frankston Hospital	✓	✓	✓	✓	⊛
Maroondah Hospital	✓	✓	✓	✓	⊛
Mercy Hospital for Women	◆	◆	◆	◆	❖
Mercy Werribee Hospital	✓	✓	✓	✓	⊛
Monash Medical Centre - Clayton	✓	✓	✓	✓	⊛
Monash Medical Centre - Moorabbin	✓	✓	✓	✓	⊛
Royal Children's Hospital	✓	✓	✓	✓	⊛
Royal Melbourne Hospital	✓	✓	✓	✓	⊛
Royal Victorian Eye and Ear Hospital	✓	✓	✓	✓	⊛
Royal Women's Hospital	◆	◆	◆	◆	❖
Sandringham & District Hospital	✓	✓	✓	✓	⊛
St Vincent's Hospital	✓	✓	✓	✓	⊛
Sunshine Hospital	✓	✓	✓	✓	⊛
The Alfred	✓	✓	✓	✓	⊛
The Northern Hospital	✓	✓	✓	✓	⊛
Western Hospital	✓	✓	✓	✓	⊛
Williamstown Hospital	✓	✓	✓	✓	⊛
<b>Regional</b>					
Ballarat Health Services	✓	✓	✓	✓	⊛
Barwon Health	✓	✓	✓	✓	⊛
Bendigo Health Care Group	✓	✓	✓	✓	⊛
Goulburn Valley Health	✓	✓	✓	✓	⊛
Latrobe Regional Hospital	✓	✓	✓	✓	⊛
<b>Total assessed for PMF</b>	<b>27</b>	<b>27</b>	<b>18</b>	<b>27</b>	<b>-</b>
<b>Total eligible for BBF</b>	<b>25</b>	<b>25</b>	<b>17</b>	<b>25</b>	<b>25</b>

✗ KPI not applicable for this site.

◆ Public health service performance monitored against Statement of Priorities for this KPI but not subject to the PMF or BFF.

❖ Public health service assessed against the Performance Monitoring Framework for this KPI

✓ Public health service assessed against the Performance Monitoring Framework and is subject to bonus funding for this KPI.

⊛ Public health service is subject to bonus funding for this KPI – Non-achievement of the statewide benchmark will result in the reduction of 1 bonus point across each of the elective surgery KPIs in a given quarter (total of 4 bonus points deducted in a given quarter).

\*ESWL Performance is assessed for the health service as a whole, not by hospital. Wangaratta District Base Hospital and West Gippsland Health Care are included in the performance assessment for the overall public health services.

Some hospitals incorporate the results of other campuses: Dandenong Hospital includes Cranbourne Integrated Care Centre, Frankston Hospital includes Rosebud Hospital, Northern Hospital includes Broadmeadows Health Service.

Table 6: Finance KPIs by Public Health Service

Public Health Service	Operating Result	Net Cash Movement	Creditors	Debtors	PP WIES
<b>Metropolitan</b>					
Austin Health	❖	❖	❖	❖	❖
Bayside Health	❖	❖	❖	❖	❖
Calvary Health	❖	❖	❖	❖	X
Eastern Health	❖	❖	❖	❖	❖
Melbourne Health	❖	❖	❖	❖	❖
Mercy Public Hospitals Inc	❖	❖	❖	❖	❖
Northern Health	❖	❖	❖	❖	❖
Peninsula Health	❖	❖	❖	❖	❖
Peter MacCallum Cancer Centre	❖	❖	❖	❖	❖
Royal Children's Hospital	❖	❖	❖	❖	❖
Royal Victorian Eye and Ear Hospital	❖	❖	❖	❖	❖
Royal Women's Hospital	❖	❖	❖	❖	❖
Southern Health	❖	❖	❖	❖	❖
St Vincent's Health	❖	❖	❖	❖	❖
Western Health	❖	❖	❖	❖	❖
<b>Regional</b>					
Ballarat Health Services	❖	❖	❖	❖	❖
Barwon Health	❖	❖	❖	❖	❖
Bendigo Health Care Group	❖	❖	❖	❖	❖
Goulburn Valley Health	❖	❖	❖	❖	❖
Latrobe Regional Hospital	❖	❖	❖	❖	❖
<b>Total assessed for PMF</b>	<b>20</b>	<b>20</b>	<b>20</b>	<b>20</b>	<b>19</b>

X KPI not applicable to the public health service.

❖ Public health service assessed against the Performance Monitoring Framework for this KPI

### 3.5 Bonus Funding Framework

The bonus funding pools for metropolitan and regional public health services will be distributed equally across each access KPI (see Table 2) and equally across each quarter in 2008-09. The BFF only applies to the access performance indicators as such, financial or service performance indicators do not attract bonus funding.

There are separate funding pools for metropolitan and regional public health services.

- For metropolitan health services, the total bonus funding pool is \$20.53M. The bonus funding pool for each quarter is \$5.13M.
- For regional health services, the total bonus funding pool is \$5.18M. The bonus funding pool for each quarter is \$1.29M.

The BFF provides public health services with an additional incentive for achieving performance targets. The total amount of bonus funding is \$25,709,042 in 2008-09, representing approximately 0.5% of the overall funding provided to public health services.

Bonus funding is distributed to public health services as follows:

1. A hospital/public health service is assessed according to its performance for the quarter against each access KPI as per Tables 4 and 5. Points are awarded according to the performance thresholds set out in Table 2 (taking into account performance against the conditional KPIs where applicable) and totalled for the metropolitan and regional bonus funding pools.
2. The funding allocation for each access KPI in the metropolitan and regional bonus funding pools is then divided by the total amount of bonus points achieved across all hospitals/public health services in the pool. This establishes a dollar value for each bonus point achieved.
3. Using these values, bonus funding is then allocated to each hospital/public health service according to the total number of bonus points achieved for the quarter.

### 3.6 Changes to the PMF and BFF for 2008-09

As outlined in the business rules of the Triage2 and Triage3 Emergency Care KPIs (Section 4), non-achievement of the benchmark for one or both of the KPIs will result in a score of 0 points for the 4hrs Emergency Care KPI. This will take effect from 1 January 2009. This requirement only impacts on the BFF, not the PMF.

Williamstown Hospital and Royal Victorian Eye & Ear Hospital have been included in the BFF and PMF for the 4hrs Emergency Care KPI.

Rosebud Hospital has been included in the BFF and PMF for three of the four Emergency Care KPIs (8hrs, 4hrs and 24hrs).

Casey Hospital has been included in the BFF for the Elective Surgery KPIs. Casey Hospital is already included in the PMF for these KPIs.

### 3.7 Force Majeure

The intent of the *force majeure* process is to address extraordinary and genuinely unforeseen events beyond the control of the organisation that affect service delivery or reporting requirements. The process should not be applied to ad hoc operational difficulties or for planned service interruptions such as capital works.

From time to time, unforeseen events may occur that adversely impact on hospital performance. Examples include internal disasters and third party-related failures leading to the interruption of service delivery (e.g. power failure). Where circumstances have a significant impact on targets, a health service may request that the department consider a *force majeure* claim.

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 in itself not regarded as an 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.

It is the policy of the department to only consider issues of *force majeure* retrospectively. Health services/hospitals should not apply for a force majeure in anticipation of poor results.

#### Submitting a *Force Majeure* request

A formal request for a *force majeure* should be made after the end of the reporting period in question. The request should clearly indicate the event(s) affecting performance against statewide benchmark targets and include supporting data and documentation. Formal *force majeure* requests should be forwarded to the Director, Access and Metropolitan Performance (AMP) branch (for metropolitan public health services) and the Director, Rural & Regional Health Services (for regional public health services).

At the discretion of the department, a *force majeure* may be applied system wide in extraordinary circumstances.

Further information about *force majeure* is also set out in the *Victoria-public hospitals and mental health services Policy and funding guidelines 2008-09*.

## 4 Key Performance Indicators

This section sets out the business rules for each of the KPIs in the SoP, PMF and BFF.

### 4.1 Data Requirements

The data sources used for the KPIs in the SoP, PMF and BFF are presented in the table below. The timing of the PMF and bonus funding allocations account for the DHS submission timeframes of the different data collections set out in the table below.

Where a public health service/hospital is unable to submit completed electronic ESIS, VAED, VEMD or AIMS data, the Health Data Standards and Systems Unit (HDSS) of the department must be notified in writing before the 10th day of the month following data collection. See HDSS contact list in this document.

Data submission and reporting requirements for SoP KPIs are outlined in Table 7. More comprehensive information about data submission and reporting requirements is provided in the Victoria - public hospitals and mental health services *Policy and Funding Guidelines 2008-09* (P&FG) and technical manuals associated with these data collections.

Time frame for ESIS data have been amended since the release of 2008-09 P&FG.

Table 7: Data Submission Requirements for Key Performance Indicators

Program	KPIs	Data Source	Data Submission Timeframes
Emergency Care	Bypass 8hrs 4hrs 24hrs Triage1 Triage2 Triage3	VEMD	<ul style="list-style-type: none"> <li>Submitted to DHS and error free 21 days after the end of the month.</li> </ul>
Elective Surgery	Cat1 Cat2 Cat3 ESWL Admissions HiPs	ESIS	<ul style="list-style-type: none"> <li>Refer to Table 7a (below) for timeframes, which supercede the 2008-09 Policy and Funding Guidelines</li> </ul>
Finance	Operating Result Net Cash Movement Creditors Debtors WIES Activity	AIMS F1	<ul style="list-style-type: none"> <li>AIMS F1 return due 12th day after the end of the month</li> </ul>
Critical Care	ICU PICU	Critical Care Bedstate Website	<ul style="list-style-type: none"> <li>Data reported on the <i>website</i> at least once each nursing shift</li> </ul>
Critical Care	NICU	Victorian Perinatal Information Centre Website	<ul style="list-style-type: none"> <li>Data reported on the <i>website</i> at least once each nursing shift</li> </ul>
Quality & Safety	Accreditation	Accreditation Processes	<ul style="list-style-type: none"> <li>Permission given to accrediting body to provide an electronic summary report of the hospital accreditation survey to DHS two weeks after health service receives survey result.</li> <li>Compliance status for residential aged care services provided by DHS Aged Care quarterly.</li> </ul>
Quality & Safety	Cleaning	November internal audit April external audit	<ul style="list-style-type: none"> <li>21 November 2008</li> <li>18 April 2009</li> </ul>
Quality & Safety	VICNSS Compliance	VICNISS Coordinating Centre	<ul style="list-style-type: none"> <li>7 November 2008</li> <li>6 February 2009</li> <li>8 May 2009</li> <li>7 August 2009</li> </ul>
Quality & Safety	VICNSS Infection	VICNISS Coordinating Centre	<ul style="list-style-type: none"> <li>7 November 2008</li> <li>6 February 2009</li> <li>8 May 2009</li> <li>7 August 2009</li> </ul>
Quality & Safety	Hand Hygiene	Hand Hygiene Coordinating Centre	<ul style="list-style-type: none"> <li>March, August and November</li> </ul>
Maternity	Postnatal Home Care	VAED	<ul style="list-style-type: none"> <li>6 weeks after the end of the month</li> </ul>
Mental Health	MH 28days	CMI/ODS	<ul style="list-style-type: none"> <li>As per admission requirements of CMI/ODS</li> </ul>

Table 7a: Data Submission Requirements for Elective Surgery Indicators

Reporting date	
<b>August</b>	
Friday 8	Health services submit July data
Wednesday 20	Health services submit 1-15 August data
<b>September</b>	
Wednesday 3	Health services submit August data
Thursday 18	Health services submit 1-15 September data
<b>October</b>	
Friday 3	Health services submit September data
Monday 20	Health services submit 1-15 October data
<b>November</b>	
Thursday 6	Health services submit October data
Wednesday 19	Health services submit 1-15 November data
<b>December</b>	
Wednesday 3	Health services submit November data
Thursday 18	Health services submit 1-15 December data
<b>January</b>	
	Dates to be confirmed

## 4.2 Financial Performance

Most information for the Financial Performance KPIs is sourced from the AIMS F1 report submitted by public health services to the department on a monthly basis. In addition, several of the financial key performance indicators are calculated using forecasts provided to the department, by public health services, at the commencement of the financial year.

### FIN 1 YTD Operating Result as a per cent of Total Revenue

#### Calculating Performance

In 2008-09, the year-to-date operating result as a percentage of total revenue will be calculated by:

#### Numerator:

YTD operating surplus/deficit (before capital and depreciation)

#### Denominator:

YTD Total Revenue

This indicator is calculated for both actual and target results. The variance between actual and target is the measured outcome, and is expressed as a percentage.

Performance is monitored monthly with assessment occurring on a quarterly basis.

#### 2008-09 Statewide Benchmark

In 2008-09, the statewide benchmark for this KPI has been set to a break even budget result. The performance thresholds used to allocate points against this KPI are as follows:

Achieved Budget	30 PMF points
In surplus but behind budget	24 PMF points
0% - 2% unfavourable variance	21 PMF points
>2% - 3% unfavourable variance	10 PMF points
Over 3% unfavourable variance	0 PMF points

#### Frequency of Reporting and Data Collection

The data is expected to be submitted by health services monthly via AIMS F1.

## FIN 2 Net Movements in Cash

The Net Movements in Cash KPI will help to monitor the agreed end-of-year cash position of health services in the Statement of Priorities. This KPI incorporates the Cashflows from Capital Activities indicator used in 2007-08 which reflected the nature of capital flows.

### Definition

Net Movements in Cash comprises of:

- Net cash flow from operational activities

- Net cash flow from investing activities (including capital activities)

- Net cash flow from financing activities (including capital activities)

Closed cash is defined as the sum of opening cash and net cash flow from operational, investing and financing activities as at the end of the month.

Each Health Service provides a phased monthly target at the beginning of the financial year as a forecast of net cash movement to meet the agreed end-of-year target in the Statement of Priorities.

Refer to Guidelines for Completing the F1 2008-09.

### Calculating Performance

The Net Movement Cash indicator is calculated as the difference between the actual closing cash and the phased target closing cash as at the end of the month. The difference is the measured outcome, and is expressed in dollars.

Performance is monitored monthly with assessment occurring as at the end of each quarter.

### 2008-09 Statewide Benchmark

In 2008-09, the statewide benchmark for this KPI is that the health service meet their cash movement forecast based on the agreed end of year position in the Statement of Priorities. The performance thresholds used to allocate points against this KPI for the PMF are as follows:

Achieved Budget	5 PMF points
>\$0m – \$2m unfavourable variance	3 PMF points
>\$2m – \$5m unfavourable variance	2 PMF points
Over \$5m unfavourable variance	0 PMF points

### Frequency of Reporting and Data Collection

The data is expected to be submitted by health services monthly via AIMS F1 Monthly Cashflow Statement.

### FIN 3 Trade Creditors

#### Calculating Performance

Performance is monitored monthly with assessment occurring on a quarterly basis. Performance is assessed on the average number of trade creditor days for the 3 months of the quarter.

The indicator is expressed as the number of whole days (rounded to 0).

#### 2008-09 Statewide Benchmark

In 2008-09, the statewide benchmark for this KPI has been set at 60 days. The performance thresholds used to allocate points against this KPI are as follows:

Less than or equal to 60 days	5 PMF points
61 – 65 days	3 PMF points
66 – 70 days	2 PMF points
More than 70 days	0 PMF points

#### Frequency of Reporting and Data Collection

The data is expected to be submitted by health services monthly via AIMS F1.

## FIN 4 Debtors

### Calculating Performance

For 2008-09, there is a minor change to the definition of this KPI. Debts referred to debt collection agencies or debts that are subject to active debt recovery plans will be excluded from the calculation of the debtor KPI. New accounts to identify these events have been created within the receivable range (71001-71499) and within the patient fees range (50001-50749). Refer to the F1 Completion guidelines at [www.health.vic.gov.au/accounts/finrep.htm](http://www.health.vic.gov.au/accounts/finrep.htm) for further details.

Performance is monitored monthly with assessment occurring on a quarterly basis. Performance is assessment on the average number of days for the 3 months of the quarter.

The indicator is expressed as the number of whole days (rounded to 0).

### 2008-09 Statewide Benchmark

In 2008-09, the statewide benchmark for this KPI has been set at 60 days. The performance thresholds used to allocate points against this KPI for the PMF are as follows:

Less than or equal to 60 days	5 PMF points
61 – 70 days	3 PMF points
71 – 80 days	2 PMF points
More than 80 days	0 PMF points

### Frequency of Reporting and Data Collection

The data is expected to be submitted by health services monthly via AIMS F1.

### FIN 5 PPWIES activity performance to target

The YTD Public/Private WIES activity performance 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 funding policy.

#### Calculating Performance

The KPI is YTD PP WIES activity performance to target, expressed as a percentage and rounded to 2 decimal places.

The WIES target variance refers to Public and Private WIES only. Renal WIES is excluded from this KPI (as it is paid to actual activity), as are DVA and TAC WIES. The target refers to the phased target submitted by the health service to the department at the commencement of the 2008-09 financial year. The AIMS F1 WIES targets health services submit to the department each month should reflect these.

#### 2008-09 Statewide Benchmark

The statewide benchmark for this KPI has been set at 98 per cent to 102 per cent.

This indicator is included as a financial performance measure in the PMF. The performance thresholds used to allocate points against this KPI are:

0 to 2.0% variance to target	5 PMF points
>2.0% to 2.5% variance to target	3 PMF points
>2.5% to 3.0% variance to target	2 PMF points
More than 3.0% variance to target	0 PMF points

In assessing performance, the department recognises that there may be exceptional circumstances whereby a health service exceeds the two per cent tolerance level without adversely impacting financial viability. These cases will be assessed by the department on a case-by-case basis.

#### Frequency of Reporting and Data Collection

The data is expected to be submitted by health services monthly via AIMS F1.

## 4.3 Service Performance

### SERV KPI 1 Elective Surgery Admissions

This indicator is designed to enhance monitoring of performance in the treatment of elective surgery patients.

#### Definition

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 an admission if the Reason for Removal is 'W', 'S', or 'X', and the Removal Date falls within the quarter being reported.

#### Calculating Performance

This indicator counts the number of patients that have been admitted for the awaited procedure, or a related procedure, that addresses the clinical condition for which they were added to the Elective Surgery Waiting List as at the end of the reporting period.

#### 2008-09 Statewide Benchmark

Targets for the number of patients admitted from the waiting list at the end of 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.

Individual health service targets are negotiated and based on performance as at 31 May 2008. Waiting list targets also take into account funding allocations in 2008-09 and the potential for health services to refer patients to Elective Surgery Centres.

#### Frequency of Reporting and Data Collection

The data is expected to be submitted by health services fortnightly via ESIS.

Performance is monitored monthly with assessment occurring on a quarterly basis.

This KPI is in the SoP, but not included in the PMF or BFF.

## Critical Care

### SERV KPI 2 ICU minimum operating capacity

The minimum operating capacity for Intensive Care Units (ICUs) can reflect the availability of access to acute treatment. This KPI is intended to reflect the minimum ICU capacity below which health services should not refuse an inter-hospital transfer. It is anticipated that hospitals will at times operate above this minimum capacity to meet the variable demand for ICU beds.

This indicator applies to hospitals with intensive care services. Some hospitals operate high dependency beds (HDUs) within their ICUs. For these hospitals the minimum operating capacity is calculated as ICU equivalent beds, whereby 2 HDU beds are equivalent to 1 ICU bed.

When referring to ICU capacity the following definitions apply:

ICU patient: a patient admitted to an intensive care unit

Open beds: a bed which is staffed, regardless of occupancy status

Available beds: a bed which will be able to accept a patient within 8 hours. This may include beds that are: currently open and empty; currently open and occupied but the patient is due to be discharged within 8 hours; currently not open but will be open within 8 hours

Closed unit: the unit is unable to accept any new ICU patients

### Calculating Performance

The number of days where there was a reported closure of the ICU (not able to accept any new patients) and the reported ICU equivalent beds that are open were below the agreed ICU minimum operating capacity specified in the Statement of Priorities.

The indicator is expressed as a whole number.

Results will be reported on a monthly basis and performance assessed quarterly.

### 2008-09 Statewide Benchmark Target

The minimum operating capacity is set individually at hospital level as the target in the Statement of Priorities.

The benchmark is zero days for reported closures below the agreed minimum number of ICU equivalent beds.

### Frequency of Reporting and Data Collection

The data source for this KPI is the Critical Care Bedstate website, which is the information system used by each ICU. In order to validate actual bed capacity, it is expected that each hospital will ensure the data is reported at least once per nursing shift.

This KPI is in the SoP, but is not included in the PMF or BFF.

### SERV KPI 3 PICU minimum operating capacity

The minimum operating capacity for paediatric intensive care units (PICUs) can reflect the availability of access to acute treatment for children under the age of 16 years. This KPI is intended to reflect the minimum ICU capacity below which health services should not refuse an inter-hospital transfer. It is anticipated that hospitals will at times operate above this minimum capacity to meet the variable demand for ICU beds.

This indicator applies to hospitals with paediatric intensive care services. All of these hospitals operate high dependency beds (HDUs) within their PICUs. Thus the minimum operating capacity is calculated as ICU equivalent beds, whereby 2 HDU beds are equivalent to 1 ICU bed.

When referring to PICU capacity the following definitions apply:

PICU patient: a patient admitted to a paediatric intensive care unit

Open beds: a bed which is staffed, regardless of occupancy status

Available beds: a bed which will be able to accept a patient within 8 hours. This may include beds that are: currently open and empty; currently open and occupied but the patient is due to be discharged within 8 hours; currently not open but will be open within 8 hours

Closed unit: the unit is unable to accept any new PICU patients

#### Calculating Performance

The number of days where there was a reported closure of the ICU (not able to accept any new patients) and the reported ICU equivalent beds that are open were below the agreed ICU minimum operating capacity specified in the Statement of Priorities.

The indicator is expressed as a whole number.

Results will be reported on a monthly basis and performance assessed quarterly.

#### 2008-2009 Statewide Benchmark Target

The minimum operating capacity is set individually at hospital level as the target in the Statement of Priorities.

The benchmark is zero days for reported closures below the agreed minimum number of ICU equivalent beds.

#### Frequency of Reporting and Data Collection

The source for this KPI is the Critical Care Bedstate website, which is the information system used by each PICU. In order to validate actual bed capacity and availability, it is expected that each hospital will ensure the data is reported at least once per nursing shift.

This KPI is in the SoP, but is not included in the PMF or BFF.

### **SERV KPI 4 NICU standard and flex operating capacity**

The standard operating capacity for ventilated cots in neonatal intensive care units (NICUs) can reflect the availability of access to acute treatment for neonates.

This indicator applies to hospitals funded for neonatal intensive care services.

Each hospital has its own individual standard operating capacity, with an agreed number of NICU cots to be open and flex capacity. Hospitals are expected to flex-up the number of cots in times of high demand.

When referring to NICU capacity the following definitions apply:

Occupied cots: a cot which 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 variance between the number of NICU occupied cots by neonates requiring respiratory support compared to the agreed standard operating capacity target in the Statement of Priorities.

This indicator will be expressed as the number of occupied cots by neonates requiring respiratory support when the unit is closed (not able to accept any new neonates requiring respiratory support) minus the agreed standard capacity.

The indicator is expressed as a whole number.

Results will be reported on a monthly basis and performance assessed quarterly.

#### **2008-09 Statewide Benchmark Target**

The standard and flex-up operating capacity is set individually at a hospital level is the target in the Statement of Priorities.

The benchmark is zero closures below the agreed standard number of NICU occupied cots.

#### **Frequency of Reporting and Data Collection**

The data source for this KPI is the Victorian Perinatal Information Centre (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.

This KPI is in the SoP, but is not included in the PMF or BFF.

## Quality and Safety

### SERV KPI 5 Accreditation Status

This KPI relates to hospitals and public residential aged care facilities.

It is a requirement that all hospitals and residential aged care sites are accredited and maintain full compliance with the relevant accreditation standards.

The Commonwealth government has primary responsibility for the funding and regulation of the residential aged care system. 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

Full accreditation/compliance will be referred to as 'achieved'. All episodes of partial/non-accreditation/non-compliance during the reporting period will be assessed as 'not achieved'.

Hospitals: Each health service is required to provide an electronic copy of the hospital accreditation survey, to the Statewide Quality Safety Branch of the department no later than two weeks after the health service receives it. This may occur directly from the health service or through the health service providing authority to the accrediting body to provide the electronic summary report. In the event of a high priority recommendation, the Department requires an action plan to address the issues within the set timeframe.

Residential Aged Care Services: Where applicable, each health service is required to notify the department's Aged Care Branch of any instances of non-compliance as soon as the Aged Care Standards and Accreditation Agency have identified them.

#### 2008-09 Statewide Benchmark

The 2008-09 benchmark for this KPI is that all sites within a health service achieve:

- Full accreditation according to the EQulP or equivalent accreditation process.
- Full compliance with 44/44 expected outcomes of the Aged Care Accreditation Standards in each public residential aged care service, at all times.

#### Frequency of Reporting and Data Collection

Results for the accreditation status KPI will be reported on a quarterly basis. For each quarter, the following data will be obtained:

- the accreditation status, as of the last day of the quarter, for each of the relevant hospitals/health services;
- a list of residential aged care services that have failed to comply with the Aged Care Accreditation Standards during the relevant quarter.

The department requires that health services accreditation information described comply with this schedule:

- 22 October 2008 for the September quarter
- 21 January 2009 for the December quarter
- 21 April 2009 for the March quarter
- 21 July 2009 for the June quarter

This KPI is in the SoP, but not included in the PMF or BFF.

## **SERV KPI 6 Cleaning Standards**

Cleaning standards aim to improve quality health care 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 focused on the outcome or output sought, rather than the method by which it is achieved.

This indicator is expressed as achieved/not achieved.

The assessments will be based on both internal and external audit results submitted to the department. Reporting of cleaning standards is mandatory for all health services.

### **Calculating Performance**

The principle behind the audit scoring system is to use a demerit based system. A campus is given 100 points at the commencement of the audit (both internal and external). Points are deducted on areas that are unacceptable.

Achieved = all campuses within a health service meet the level of acceptable cleaning quality set at 85%

Not Achieved = one or more campuses within a health service fail to meet the level of acceptable cleaning quality set at 85%

### **2008-09 Statewide Benchmark**

Acceptable quality level for campus: 85%

### **Frequency of Reporting and Data Collection**

Results will be reported on a six-monthly basis. The department requires that audit results be provided as follows:

- November internal audit results to be available by 21 November 2008 for the December quarter
- April external audit results need to be made available by 18 April 2009 for the June quarter

This KPI is in the SoP, but not included in the PMF or BFF.

## **SERV KPI 7 Submission of data to VICNISS**

The infection control data compliance KPI aims to improve the quality of infection control reporting by requiring health services to be fully compliant in their data submission to the Victorian Hospital Acquired Infection Surveillance System (VICNISS) Coordinating Centre. Health services have been providing data to VICNISS since 2002.

This indicator applies to hospitals participating in Type 1 and Type 2 surveillance. Where a health service has multiple campuses, the compliance is aggregated to produce a health service wide result.

This indicator is expressed as achieved/not achieved.

### **Calculating Performance**

- The VICNISS performance indicators are set out in the Surveillance Hospital Participation documents ([www.vicniss.org.au](http://www.vicniss.org.au)) and outline the defined set of surveillance activities and data quality indicators hospitals are required to perform and achieve.
- A public health service's performance will be analysed quarterly by the VICNISS Coordinating Centre.
- The VICNISS Coordinating Centre will provide a report to the Statewide Quality Branch of the department detailing each hospital's performance.

### **2008-09 Statewide Benchmark**

The benchmark for the health service is full compliance with VICNISS reporting requirements.

### **Frequency of Reporting and Data Collection**

The data is reported to the VICNISS Coordinating Centre each quarter. The public health service's performance is provided to the department six weeks later, resulting in a one quarter lag in reporting the KPI in the IPAR.

This KPI is in the SoP, but not included in the PMF or BFF.

## SERV KPI 8 VICNISS Infection Surveillance Indicator

This KPI focuses on surgical procedures and high risk clinical units where evidence suggests there may be an increased risk of hospital acquired infections. In Victoria, data about these infections is managed by the Victorian Hospital Acquired Infection Surveillance System (VICNISS) Coordinating Centre.

VICNISS collects and analyses data from individual hospitals, and reports quarterly to participants and the department on aggregate, risk adjusted, procedure-specific infection rates. This information contributes to the development of accurate and reliable benchmarks against which hospitals and health services can assess their performance. Health services have been providing data to VICNISS since 2002.

The VICNISS infection surveillance KPI aims to improve the patient infection outcomes post surgery and in adult intensive care units. This is a composite KPI with a limited set of specific types of surgical procedures and intensive care, these being:

- Hip Arthroplasty
- Knee Arthroplasty
- Caesarean section,
- Coronary Artery Graft Surgery and
- Adult Intensive Care Unit patients with central lines.

This indicator applies to hospitals participating in Type 1 and Type 2 surveillance. The Surveillance Hospital Participation documents available from the web ([www.vicniss.org.au](http://www.vicniss.org.au)) describe the VICNISS performance indicators and the website also enables hospitals to access their surveillance reports. The following table shows the surgical indicators that apply to each hospital.

This KPI is in the SoP, but not included in the PMF or BFF.

### Calculating Performance

The VICNISS Coordinating Centre will provide a report to the department detailing each hospital's performance and outlier status. For each surgery type, where a hospital is found to have a statistically significantly higher infection rate than the VICNISS aggregate rate, they are deemed an outlier.

Statistical significance testing by VICNISS is undertaken each quarter. Data for the most recent four quarters is used for the knee and hip arthroplasty surgery given the length of time that infections with this surgery may take to present. For all other surgery types, data from the most recent two quarters is used. For example, if quarter four performance is the subject of assessment, data for quarter three and quarter four will be used.

Table 8: VICNISS Infection Surveillance Indicators by hospital

	Surgical site surveillance				
	Coronary artery bypass grafts	Caesarean section	Hip arthroplasty	Knee arthroplasty	ICU central line associated bloodstream
<b>Metropolitan</b>					
Angliss Hospital		✓			
Austin Hospital	✓		✓	✓	✓
Box Hill Hospital			✓	✓	✓
Dandenong Hospital			✓	✓	✓
Frankston Hospital			✓	✓	✓
Maroondah Hospital			✓	✓	✓
Mercy Werribee Hospital		✓			
Monash Medical Centre - Clayton	✓		✓	✓	✓
Monash Medical Centre - Moorabbin			✓	✓	
Northern Hospital			✓	✓	✓
Royal Women's Hospital		✓			
Sandringham & District Memorial Hospital			✓	✓	
St Vincents Health	✓		✓	✓	✓
Sunshine Hospital			✓	✓	✓
The Alfred Hospital	✓		✓	✓	✓
The Royal Melbourne Hospital	✓		✓	✓	✓
Western Hospital Footscray			✓	✓	✓
<b>Regional</b>					
Ballarat Health Services		✓	✓	✓	✓
Bendigo Health Care Group			✓	✓	✓
Geelong Hospital	✓		✓	✓	✓
Goulburn Valley Health - Shepparton Campus		✓	✓	✓	✓
Latrobe Regional Hospital		✓	✓	✓	✓
<b>Total</b>	<b>6</b>	<b>6</b>	<b>18</b>	<b>17</b>	<b>16</b>

Performance is assessed for the health service as a whole, not by hospital. South West Health Care - Warrnambool Campus, Wangaratta District Base Hospital and Wodonga Regional Health Service are included in the performance assessment for the overall public health services.

### 2008-09 Statewide Benchmark

The statewide benchmark is no outliers. A health service that has an outlier for any one of the surgery types is deemed not to have met the benchmark. If a hospital does not submit infection surveillance data this will also be deemed as not meeting the benchmark

### **Frequency of Reporting and Data Collection**

The data is reported to the VICNISS Coordinating Centre each quarter. A public health service's performance will be analysed quarterly by the VICNISS Coordinating Centre.

Six weeks after the quarter, the performance result is to be provided to the department resulting in a one quarter lag in reporting the KPI.

## **SERV KPI 9 Participation in the Hand Hygiene Project**

The hand hygiene project aims to improve the hand hygiene compliance of health care workers when caring for patients, and to reduce hospital acquired infections. Methicillin resistant Staphylococcus aureus (MRSA) is used as the marker.

The aim of the KPI is to encourage health services to be fully compliant in their data submission to the Hand Hygiene Coordinating Centre.

This indicator applies to all hospitals and where a health service has multiple campuses, the compliance is aggregated to produce a health service wide result.

This indicator is expressed as achieved/not achieved.

### **Calculating Performance**

- Hospitals are to submit hand hygiene compliance and MRSA data to the hand hygiene coordinating centre by the required dates.
- The Hand Hygiene manual outlines the defined set of compliance audits and MRSA data that hospitals are required to achieve.
- A public health service's performance will be analysed every four months by the Hand Hygiene Coordinating Centre.

### **2008-09 Statewide Benchmark**

The benchmark for the health service is full compliance with hand hygiene reporting requirements.

### **Frequency of Reporting and Data Collection**

The data is reported every four months (March, August and November). The public health services performance is provided to the department four weeks later.

This KPI is in the SoP, but not included in the PMF or BFF.

## Maternity

### SERV KPI 10 Proportion of women with prearranged postnatal home care

- The provision of maternity services is a key activity of many public health services. While the inclusion of this indicator in the SoP is new, since 2003 all public hospitals that provide maternity services have been required to report annually against a set of maternity service indicators, including this indicator.

#### Calculating Performance

This indicator is the proportion of women that have prearranged appropriate postnatal domiciliary care prior to discharge from hospital or receive hospital in the home (HITH).

All hospitals are required to offer all women postnatal domiciliary visits. The offer of one or more postnatal domiciliary visits by a midwife, depending on need, has been a clearly established requirement of all Victorian maternity services.

This indicator applies to all maternity hospitals and only includes deliveries where the mother is discharged to private residence from hospital.

This indicator is expressed as a percentage, rounded to 0 decimal places.

#### Numerator

Number of women giving birth with postnatal domiciliary care arranged before discharge or Hospital-In-The-Home (HITH). Where appropriate, postnatal services is defined in VAED by women with a separation mode of H and separation referral includes 'F'. It includes patients discharged to the HITH program.

#### Denominator

Number of women giving birth excluding women transferred to another hospital.

To be counted as a delivery, each record must meet each of the following criteria:

1. A diagnosis code commencing with 'O' (for Obstetric) must appear within the string of ICD-10-AM diagnosis codes.
2. Birth indicator derived from Z37. Outcome of delivery on mother's record must be present.
3. Where VicDRG NOT in
  - O03Z Ectopic Pregnancy
  - O04Z Postpartum and post-abortion with operating room procedure
  - O61Z Postpartum and post abortion without operating room procedure
  - O05Z Abortion with operating room procedure
  - O63Z Abortion without operating room procedure
  - O64A False labour <37 weeks or with complications
  - O64B False Labour >=37 weeks without complications
  - O66A Antenatal and other obstetric admission
  - O66A Antenatal and other obstetric admission, sameday

### **2008-09 Statewide Benchmark**

Benchmarks have been set in recognition that not all women will accept the offer of post natal home care.

- Metropolitan hospitals: 90%
- Regional hospitals: 80%

### **Frequency of Reporting and Data Collection**

The data source is the Victorian Admitted Episode Dataset (VAED).

This KPI is included in the SoP, but not the PMF or BFF.

## **Mental Health**

### **SERV KPI 11 Readmissions within 28 days**

Adult specialist mental health services are aimed primarily at people with 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 post discharge, as well as other factors.

The percentage of mental health patients readmitted within 28 days will be calculated as follows:

#### **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.

Overnight separations for ECT, separations to other acute hospitals, to residential aged care or against medical advice/abscond are excluded.

#### **Denominator**

The number of non-sameday separations from adult general acute psychiatric inpatient units. Overnight separations for ECT, separations to other acute hospitals, to residential aged care or against medical advice/abscond are excluded.

This indicator is expressed as a percentage, rounded to 0 decimal places.

#### **2008-09 Statewide Benchmark**

The statewide benchmark for this KPI has been set at 14%.

#### **Frequency of Reporting and Data Collection**

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) that manages a set of select data items from each CMI. The acronym used for this data source is CMI/ODS.

Results will be reported on a quarterly basis. The 28 day lag inherent in the KPI means that reporting for this KPI is lagged by one month.

For example, the December 2008-09 performance report will report the mental health results for separations occurring in the period Sep/Oct/Nov 2008-09.

This KPI is in the SoP, but not included in the PMF or BFF.

## 4.4 Access Performance

### Emergency Care

The length of stay (LOS) of an emergency patient is calculated from the time of arrival to the time of departure.

### ACCESS KPI 1 Percentage of operating time on hospital bypass

The percentage of operating time on bypass will be calculated by:

**Numerator:**

Actual time on bypass

**Denominator:**

Actual time in the period

This indicator is expressed as a percentage rounded to 1 decimal place (.05 is rounded up).

### Calculating Performance

Calculations of performance are based on the 'Hospital Bypass Notification' data provided to DHS by Ambulance Victoria (AV)

For the purpose of Hospital Bypass notification, monitoring and reporting, AV and the department have agreed on the following for counted occasions of bypass:

All hospital bypass is recorded and monitored, however for the purpose of performance monitoring, only bypass that exceeds 30 minutes where the reason is 'A & E Full' is used.

All queries relating to the recording of bypass or requests to change the details of bypass events as recorded in the Hospital Bypass notification reports should be directed to the AMP Branch of the department in the first instance.

### 2008-09 Statewide Benchmark

The statewide benchmark for this KPI is three per cent. The performance thresholds used to calculate the PMF score and allocate bonus-funding against this KPI are as follows:

Less than or equal to 3.0%	3 points
>3.0% to 4.0%	2 points
>4.0% to 5.0%	1 point
Greater than 5.0%	0 points

## ACCESS KPI 2 Percentage of ED patients transferred to an inpatient bed within 8 hours

The percentage of emergency patients who are transferred to an inpatient bed within eight hours will be calculated by:

**Numerator:**

The number of patients with an emergency department length of stay of less than or equal to eight hours (480 minutes) who have a VEMD Departure Status of 3, 13, 14, 15, 16, 18 or 22.

**Denominator:**

The number of patients with a VEMD Departure Status of:

- 3 Short Stay Observation Unit
- 13 Emergency Medical Unit
- 14 Medical Assessment and Planning Unit
- 15 Intensive Care bed – this campus
- 16 Mental Health bed – this campus
- 18 Ward
- 22 Coronary Care Unit – this campus

This indicator is expressed as a percentage, rounded to 0 decimal places (0.5 is rounded up).

**Calculating Performance**

Transit lounges/holding areas are not considered to be inpatient wards. Thus, emergency patients located in these areas, prior to being transferred to a ward, should be considered to be in the care of the emergency department. The time spent in these areas is included in all calculations of the percentage of emergency patients transferred within eight hours until the patient is actually physically transferred to an inpatient bed/ward.

**2008-09 Statewide Benchmark**

The statewide benchmark for this KPI has been set at 80 per cent.

The performance thresholds used to calculate the PMF score and allocate bonus funding against this KPI are as follows:

Greater than or equal to 80%	3 points
75% to 79%	2 points
65% to 74%	1 point
Less than 65%	0 points

### ACCESS KPI 3 Percentage of non-admitted ED patients with a LOS of less than four hours

The percentage of emergency patients not admitted to a bed at any hospital, with a length of stay in the emergency department of less than four hours will be calculated by:

**Numerator:**

The number of patients with an emergency department length of stay of less than or equal to four hours (240 minutes) who have a VEMD Departure Status of 1, 10, 12, 23, 24.

**Denominator:**

The number of patients with a VEMD Departure Status of:

- 1 Home
- 10 Left after clinical advice regarding treatment options
- 12 Correctional/Custodial Facility
- 23 Mental health residential facility
- 24 Residential care facility

This indicator is expressed as a percentage, rounded to 0 decimal places (0.5 is rounded up).

**2008-09 Statewide Benchmark**

The statewide benchmark for this KPI has been set at 80 per cent.

Effective 1 January 2009, the BFF will change to incorporate the Triage Category 2 and Triage Category 3 time to treatment KPIs as a co-requirement to achieve the 4 hour KPI.

The performance thresholds used to calculate the PMF score and allocate bonus-funding against this KPI are as follows:

Greater than or equal to 80%	3 points
75% to 79%	2 points
65% to 74%	1 point
Less than 65%	0 points

### **ACCESS KPI 4 Number of patients with a LOS in the ED greater than 24 hours**

The total number of patients with a length of stay in the emergency department greater than twenty-four hours will be calculated by:

The numbers of patients with an emergency department length of stay of greater than twenty-four hours (1,440 minutes), regardless of departure status code.

#### **2008-09 Statewide Benchmark**

The statewide benchmark for this KPI is zero patients.

The performance thresholds used to calculate the PMF score and allocate bonus funding for this KPI are as follows:

0 patients	3 points
Between 1 and 15 patients	2 points
Between 16 and 30 patients	1 point
31 or more patients	0 points

## ACCESS KPI 9 Percentage of triage Category 1 emergency patients seen immediately

The Government sets targets for hospitals in consultation with hospital staff and clinical groups, to encourage achievement of standards of care for patients seeking emergency care. The Government monitors hospital achievement against these targets for the most urgent patients (triage categories 1-3), to encourage hospitals to treat as many patients within the desirable times as possible.

The Australasian College of Emergency Medicine has identified five triage categories and defined the desirable time by when treatment should commence for patients in each category.

The percentage of triage category 1 emergency patients seen immediately will be calculated by:

### Numerator:

Number of Category 1 emergency patients seen immediately

### Denominator:

Number of Category 1 emergency patients

This indicator is expressed as a percentage, rounded to 0 decimal places (0.5 is rounded up).

### Calculating Performance

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 **a-b**, where:

- a** is Arrival Date and Time; and
- b** is the Date and Time the patient is first seen by a nurse or doctor or mental health practitioner (whichever is earliest)

### 2008-09 Statewide Benchmark

The benchmark for the percentage of Category 1 emergency patients seen immediately is 100 per cent.

The performance thresholds used to calculate the PMF score and allocate bonus funding against this KPI are as follows:

100%	No loss of points
Less than 100%	Loss of 4 points representing one point deducted from each emergency KPI (KPIs 1 – 4)

A bonus point cannot be lost on a KPI that has achieved 0 bonus points.

### ACCESS KPI 11 Percentage of triage Category 2 emergency patients seen within 10 minutes

The Government sets targets for hospitals in consultation with hospital staff and clinical groups, to encourage achievement of national standards of care for patients seeking emergency care. The Government monitors hospital achievement against these targets for the most urgent patients (triage categories 1-3), to encourage hospitals to treat as many patients within the desirable times as possible.

The Australasian College of Emergency Medicine has identified five triage categories and defined the desirable time when treatment should commence for patients in each category

The percentage of triage category 2 emergency patients seen within 10 minutes will be calculated by:

**Numerator:**

Number of Category 2 emergency patients seen within 10 minutes

**Denominator:**

Number of Category 2 emergency patients

This indicator is expressed as a percentage rounded to 0 decimal places (0.5 is rounded up).

**Calculating Performance**

A patient is categorised as having been seen within 10 minutes where their “Time to Treatment” is less than or equal to 10 minutes. Time to treatment equals **a-b**, where:

- a** is Arrival Date and Time; and
- b** is the Date and Time the patient is first seen by a nurse or doctor or mental health practitioner (whichever is earliest first)

**2008-09 Statewide Benchmark**

The benchmark for the percentage of Category 2 emergency patients seen within 10 minutes is 80 per cent.

This KPI has no impact on the scoring for the PMF. It impacts on the performance incentive payment provided via the BFF.

Effective from 1 January 2009, the performance thresholds used to determine bonus funding are as follows:

80% or greater	No loss of points
Less than 80%	0 points for the 4 hour KPI - the percentage of non-admitted ED patients with a LOS of less than four hours (KPI 3)

## ACCESS KPI 12 Percentage of triage Category 3 emergency patients seen within 30 minutes

The Government sets targets for hospitals in consultation with hospital staff and clinical groups, to encourage achievement of national standards of care for patients seeking emergency care. The Government monitors hospital achievement against these targets for the most urgent patients (triage categories 1-3), to encourage hospitals to treat as many patients within the desirable times as possible.

The Australasian College of Emergency Medicine has identified five triage categories and defined the desirable time when treatment should commence for patients in each category.

The percentage of triage category 3 emergency patients seen 30 minutes will be calculated by:

### Numerator:

Number of Category 3 emergency patients seen within 30 minutes

### Denominator:

Number of Category 3 emergency patients

This indicator is expressed as a percentage rounded to 0 decimal places (0.5 is rounded up).

### Calculating Performance

A patient is categorised as having been seen within 30 minutes where their “Time to Treatment” is less than or equal to 30 minutes. Time to treatment equals **a-b**, where:

- a** is Arrival Date and Time; and
- b** is the Date and Time the patient is first seen by a nurse or doctor or mental health practitioner (whichever is earliest)

### 2008-09 Statewide Benchmark

The benchmark for the percentage of Category 3 emergency patients seen within 30 minutes is 75 per cent.

This KPI has no impact on the scoring for the PMF.

Effective from 1 January 2009, the performance thresholds used to determine bonus funding are as follows:

75% or greater	No loss of points
Less than 75%	0 points for the 4 hour KPI – the percentage of non-admitted ED patients with a LOS of less than four hours (KPI 3)

## Elective Surgery Services

Elective surgery performance indicators, targets and incentives are designed to encourage improved performance in the management of health care provision to elective surgery patients.

### ACCESS KPI 5 Percentage of Category 2 elective surgery patients waiting 90 days or less

Category 2 (semi-urgent) patients are elective surgery patients with 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 indicator measures the number of Category 2 patients waiting 90 days or less as a percentage of all Category 2 patients on the elective surgery waiting list at the end of the quarter.

Performance against this KPI is reported and monitored monthly with the performance assessment occurring on a quarterly basis.

Only records assigned an ESIS principal prescribed procedure code of less than 500 and with a readiness status of R (Ready for Care) are used to assess this KPI.

Procedures in the code range 500-513 will not be included in waiting list and waiting times reported by the Victorian Government, the Australian Institute of Health and Welfare and the Commonwealth Department of Health and Aged Care.

#### Calculating Performance

Health service/hospital performance against this indicator is expressed as a percentage. Performance is calculated on the census date (end of the month) using the formula:

$$\frac{\text{No. of Category 2 patients on the waiting list waiting } \leq \text{ 90 days}}{\text{Category 2 patients on the waiting list}}$$

#### 2008-09 Statewide Benchmark

The statewide benchmark for this KPI has been set at 80 per cent. To encourage health services to work towards this statewide benchmark, individual health services/hospitals also have separate improvement targets for this KPI. These are individually negotiated with the department and are included in the Statement of Priorities

The improvement targets are used as the basis for assessing performance for this KPI. The performance thresholds are as follows:

Target achieved	3 points
Between 0% and 2% below target	2 points
Between 3% and 5% below target	1 point
Greater than 5% below target	0 points

For the purpose of allocating points, target variance is rounded to a whole number. For example, 2.2 per cent is rounded down to 2 per cent and 2.5 per cent is rounded up to 3 per cent.

Individual health service/hospital targets are negotiated and based on performance as at 31 May 2008. Targets also take into funding allocations in 2008-09 and the potential for health services/hospitals to refer patients to Elective Surgery Centres.

## ACCESS KPI 6 Percentage of Category 3 elective surgery patients waiting 365 days or less

Category 3 (non-urgent) patients are elective surgery patients with a condition causing minimal or no pain, dysfunction or disability that is unlikely to deteriorate quickly or become an emergency. Although there is no nationally endorsed benchmark, 'admission within 365 days' is used to assess performance for the purpose of allocating bonus payments.

This indicator measures the number of patients waiting 365 days or less as a percentage of all Category 3 patients on the elective surgery waiting list at the end of the quarter.

Performance against this KPI is reported and monitored monthly with the performance assessment occurring on a quarterly basis.

Procedures in the code range 500-513 will not be included in waiting list and waiting times reported by the Victorian Government, the Australian Institute of Health and Welfare and the Commonwealth Department of Health and Aged Care.

### Calculating Performance

Health service/hospital performance against this indicator is expressed as a percentage. Performance is calculated on the census date (end of the month) using the formula:

$$\frac{\text{No. of Category 3 patients on the waiting list waiting } < \text{ or } = 365 \text{ days/}}{\text{Category 3 patients on the waiting list}}$$

### 2008-09 Statewide Benchmark

The statewide benchmark for this KPI has been set at 90 per cent. To encourage health services to work towards this statewide benchmark, individual health services/hospitals also have separate improvement targets for this indicator. These are individually negotiated with the department and are included in the SoP.

The improvement targets are used as the basis for assessing performance and in terms of the PMF score and bonus funding, performance thresholds are as follows:

Target achieved	3 points
Between 0% and 2% below target	2 points
Between 3% and 5% below target	1 point
Greater than 5% below target	0 points

For the purposes of allocating points, variances on target are rounded to a whole number. For example, 2.2 per cent is rounded down to 2 per cent and 2.5 per cent is rounded up to 3 per cent.

Individual health service/hospital targets are negotiated and based on performance as at 31 May 2008. Targets also take into funding allocations in 2008-09 and the potential for health services/hospitals to refer patients to Elective Surgery Centres.

## ACCESS KPI 7 Number of patients on the elective surgery waiting list

This indicator measures the number of patients waiting for elective surgery as at the end of the quarter.

### 2008-09 Statewide Benchmark

2008-09 marks the second year whereby benchmarks for the number of patients on the waiting list at the end of each quarter have been set at the health service, rather than individual hospital level.

The quarterly targets set for individual health service/hospitals reflect peaks in emergency demand and seasonal capacity limitations.

The performance thresholds used to calculate the PMF score and allocate bonus-funding against this KPI are as follows:

Target achieved	3 points
Between 0% and 2% over target	2 points
Between 3% and 5% over target	1 point
Greater than 5% over target	0 points

For the purposes of allocating points, variances on target are rounded to a whole number. For example, 2.2 per cent is rounded down to 2 per cent and 2.5 per cent is rounded up to 3 per cent.

Individual health service/hospital targets are negotiated and based on performance as at 31 May 2008. Waiting list targets also take into funding allocations in 2008-09 and the potential for health services/hospitals to refer patients to Elective Surgery Centres including The Alfred Centre.

## ACCESS KPI 8 Hospital Initiated Postponements (HiPs)

Hospital-initiated (elective surgery) postponements can result in significant distress and inconvenience for patients (especially for those who travel long distances to hospital or take time off from work for surgery). It is important to ensure postponements are minimised.

This indicator measures the number of HiPs experienced by elective surgery patients during a quarter (the numerator) as a percentage of all procedures scheduled to occur within the quarter (the denominator).

### Numerator

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. HiPs are counted for the quarter in which they actually occur, even if the procedure being cancelled was scheduled for a different quarter. A postponement is hospital-initiated if the patient has been informed of the scheduled admission date and the Reason for schedule admission date change in ESIS is coded as:

**100** – Surgeon unavailable – The surgeon booked to perform the procedure has cancelled some or all of their scheduled theatre time due to leave, illness, lateness or being called away. Where the postponement is due to leave, the surgeon has not informed the hospital within a timeframe that prevents the patient from being booked and informed of their date for surgery.

**101** – Surgical unit initiated – Surgery postponed due to surgeon/registrars preference to perform surgery on another patient. This code is used when the surgeon/registrars initiates the postponement and it is not due to leave, illness, lateness or being called away, or higher priority patient. This code is not used where surgery is postponed because of the need to perform surgery on a patient of higher clinical urgency (*Emergency priority or Elective priority is used*).

**102** – Hospital staff unavailable – Insufficient hospital staff (nurses, anaesthetists, non-clinical staff). This code is also used to report postponements due to industrial action.

**103** – Ward bed unavailable – A bed (other than a critical care bed) is unavailable in the hospital.

**104** – Critical care bed unavailable – A critical care bed (intensive care, coronary care or high dependency) is not available in the hospital.

**105** – Equipment unavailable – Equipment (including power or water) is unavailable or has failed, or prosthesis for implantation is unavailable.

**106** – Theatre overbooked – Too many cases scheduled in the planning of the list. If there was an unintentional list overrun because cases took longer than anticipated, code 107 (theatre over-run), which is not used to calculate HiPs performance, is used.

**108** – Emergency priority – Rescheduled due to a higher priority emergency patient requiring surgery. Includes:

- Emergency patients currently admitted
- Patients presenting via the emergency department
- Obstetric emergencies.

**109** – Elective priority – Rescheduled due to a higher priority elective patient requiring surgery. Includes elective patients seen in outpatients or private rooms.

**110** – Hospital/surgeon has not prepared patient – Further preoperative workup is required. This code is reported when the patient has been insufficiently prepared for surgery by the hospital/surgeon.

**111** – Clerical/booking error – The patient has been incorrectly advised of date of surgery. A clerical/booking error occurred, for example advising patient of incorrect date of surgery.

Within ESIS data an event is counted as a HiP if:

Event\_type = 'Reason SAD Changed'

Event\_value = '100', '101', '102', '103', '104', '105', '106', '108', '109', '110', '111'

Event\_date falls within the quarter being measured

The procedure being postponed is an included procedure (ppproc < 500).

**Denominator:**

The denominator is the number of procedures scheduled to occur within the quarter, regardless of whether the procedure actually takes place.

Within ESIS, procedures scheduled count if:

Event\_Type = 'Set SAD'

Event\_value (date procedure is scheduled for) falls within the quarter being measured

The procedure being scheduled is an included procedure (ppproc < 500)

**Data Source:**

ESIS

**Calculating Performance:**

Performance is calculated using the formula:

Number of HiPs within the quarter

---

Number of procedures scheduled to occur in the quarter

SQL code:

```

/* HiPs for quarter one of 2008/09 */
select count(*) as HiPs
from Episodes e, IntraEpisodes i
where i.episode_fk = e.pk
      and Event_Type = 'Reason SAD Changed'
      and txtEvent_value in ('H', 'D')
      and dtEvent_date between '01Jul08'd and '30Sep08'd
      and ppproc < 500;

/* Admissions scheduled for the quarter one of 2008/09 */
select count(*) as Admissions_scheduled
from Episodes e, IntraEpisodes I
where i.episode_fk = e.pk
      and Event_Type = 'Set SAD'
      and dtEvent_value between '01Jul08'd and '30Sep08'd
      and ppproc < 500;

```

### 2008-09 Statewide Benchmark

The statewide benchmark for this KPI has been set at 8.0. The performance thresholds used to calculate the PMF score and allocate bonus funding for this KPI are as follows:

Less than or equal to 8.0	3 points
> 8.0 to 11.0	2 points
> 11.0 - 15.0	1 point
Greater than 15.0	0 points

For the purpose of allocating points, the result is rounded to a one decimal point. For example, 8.12 is rounded down to 8.1 and 7.55 is rounded up to 7.6.

### ACCESS KPI 10 Percentage of Category 1 elective patients admitted within 30 days

Category 1 (urgent) 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 measures health service/hospital performance in admitting urgent elective surgery patients within the clinically desirable timeframe.

#### Calculating Performance

Health service/hospital performance against this indicator is expressed as a percentage. Performance is calculated on the census date (end of the month) using the formula:

#### Numerator:

Number of Category 1 patients removed for reasons W, S or X within time (30 days).

#### Denominator:

All Category 1 patients removed for reasons W, S or X

If a health service/hospital's quarterly data file shows that a Category 1 patient is overdue this must be confirmed or, if incorrect, amended by the health service/hospital within two weeks of notification by the department. If this is not done, the patient will be regarded as overdue for the purposes of performance measurement.

#### 2008-09 Statewide Benchmark

The statewide benchmark for health services/hospitals is 100% of Category 1 patients admitted from the waiting list within 30 days.

The performance thresholds used to calculate the PMF score and allocate bonus funding against this KPI are as follows:

100%	No loss of points
Less than 100%	Loss of 4 points representing one point deducted from each elective KPI (KPIs 5 – 8)

A bonus point cannot be lost on a KPI that has achieved 0 bonus points.



## 5 Contact Details

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

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Ph: 03 9096 7120

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Department of Human Services  
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Melbourne 3001  
Ph: 03 9096 9062

Health Services with data submission issues may contact the Health Data Standards and Systems Unit:

Assistant Director, Health Information  
Department of Human Services  
GPO Box 5047  
Melbourne 3001  
Ph: (03) 9096 7456





