Department of Health

health

The Victorian Health Service Performance Monitoring Framework

2010–11 Business Rules

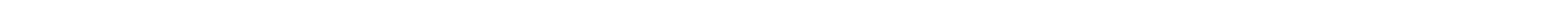
State Government Victoria

A Victorian Government initiative

The Victorian Health Service Performance Monitoring Framework

2010–11 Business Rules

November 2010



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1 Introduction

1.1 About this document

The Victorian Health Services Performance Monitoring Framework (VHSPMF) sets out the range of approaches and measures used to monitor health services and will be designed over time to ensure more consistent monitoring practices across the sector.

The purpose of this document is to describe the mechanisms used by the Department of Health (the department) to formally monitor health service performance in 2010–11.

This document is structured as follows:

- Section 2: Public health service Statement of Priorities – an overview of the policy context for the agreement as well as a summary of key changes for 2010–11
- Section 3: Sub-regional Statement of Priorities – an introduction and overview of the policy context for the agreement
- Section 4: Local health services – an overview of the policy context for local health services
- Section 5: the key performance indicators (KPIs) included in the Statement of Priorities
- Section 6: the workings of the Performance Monitoring Framework (PMF) and the KPIs involved for Statement of Priorities health services
- Section 7: the specific business rules for each KPI and the data sources for the KPIs pertaining to Statement of Priorities health services
- Section 8: departmental contacts for the business rules.

2 Public health services Statement of Priorities

2.1 Background

The *Health Services Act 1988* formally defines public health services. In 2010–11 there are 21 public health services: 12 in metropolitan Melbourne and six in regional Victoria, as well as three denominational health services based in Victoria.

Statement of Priorities

The Statement of Priorities (SoP) was introduced in 2004–05 as part of a series of governance reforms enacted in changes to the Health Services Act to improve accountability between boards of health services and the state government. The annual SoP facilitates delivery of, or substantial progress towards, the key shared objectives of financial viability, improved access and quality of service provision.

The SoP incorporates system wide priorities and statewide benchmarks set by government, but also allows for health service specific priorities. These local service specific priorities are linked to overarching and longer term strategic plans.

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

The Victorian Government has recently signed the Council of Australian Governments (COAG) *National Health and Hospitals Network Agreement* (NHHNA), which commits the government to work towards key national targets, national activity based funding and implementation of Local Hospital Networks. Under the new COAG agreement a new Performance and Accountability Framework will be developed for the NHHN, including national indicators agreed to by COAG in the *National Healthcare Agreement* (NHA), and national clinical quality and safety standards developed by the Australian Commission on Safety and Quality in Healthcare (ACSQH).

The suite of key performance indicators are outlined in Section 5.

Performance Framework

To ensure an appropriate level of accountability for these health services, a framework has been implemented, which includes a:

- **Statement of Priorities** 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** that enables the department to transparently monitor, analyse and evaluate a health service's performance. The PMF reflects access, financial and quality aspects of performance that are assessed on a quarterly basis. The PMF results are reported in the Victorian Health Service Performance Monitor (VHSPM) on a quarterly basis.

2.2 Summary of key changes

The SoP includes target and indicator changes as well as new indicators for 2010–11. Some minor changes have also been made to existing indicator definitions used in the SoP. The key changes to indicators are summarised below.

Statement of Priorities

KPIs new to SoP

- Rate of *Staphylococcus aureus bacteraemia* (SAB): a comprehensive definition of SAB can be found at www.hha.org.au/SabDefinition.aspx. The benchmark is equal to or less than two cases per 10,000 occupied bed days. All Victorian health services submit SAB rates, thrice yearly through the VICNISS coordinating centre.
- Post-discharge follow-up rate for adults: Health services will be expected to meet a benchmark of 75 per cent of discharged mental health clients seen by a specialist community-based mental health service within seven days of discharge.
- Seclusion rate for adults: the benchmark is equal to or less than 20 seclusions per 1,000 mental health bed days.
- A national emergency access target will be introduced from 1 January 2011. This benchmark requires 95 per cent of patients presenting to a public hospital emergency department who are classified as a triage category 1 to be admitted to hospital, referred for treatment or discharged within four hours, where it is clinically appropriate to do so.

Changes to targets and benchmarks

- The cleaning standards indicator has changed from the benchmark of 85 to a full compliance rate. The acceptable quality level (AQL) for high risk and moderate risk functional areas will remain at 85, but the AQL for very high risk areas has been lifted from 85 to 90 to reflect the updated *Cleaning standards for Victorian health facilities 2009*. To achieve full compliance, health services will be required to meet the AQL and have one external audit per year.
- The level of compliance with the hand hygiene indicator has increased from 60 per cent to 65 per cent, based on improved performance demonstrated by the majority of health services. Consequently, the 10 per cent improvement rate that was applied to specific health services in 2009–10 will not be required.

KPIs removed from SoP

- The net movement in cash balance indicator will not be included in the SoP for 2010–11. Health service cash management will continue to be a priority and alternative monitoring tools will be developed by the department in 2010–11.

Performance Monitoring Framework

Changes to targets and thresholds

- Financial performance: the assessment of financial performance in the PMF will be adjusted in 2010–11 to reflect the reduced number of KPIs. Financial performance will contribute 45 per cent of the PMF score.
- Service performance: the inclusion of the new Quality KPI, SAB rate, representing 5 per cent of the total PMF score in 2010–11.

3 Sub-regional Statement of Priorities

3.1 Background

The Sub-regional Statement of Priorities Agreement is being introduced as the formal funding and monitoring agreements between Victorian sub-regional health services and the Secretary for the Department of Health. The annual agreements will facilitate delivery of, or substantial progress towards, the key shared objectives of financial viability, improved access and quality of service provision.

The Sub-regional Statement of Priorities Agreement should be consistent with the health service's strategic plans or objectives and aligned to government policy directions and priorities.

The Agreement incorporates system wide priorities and statewide benchmarks set by government but also allows for health service specific priorities. These local service specific priorities are linked to overarching and longer term strategic plans.

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 Victorian Government has recently signed the Council of Australian Governments (COAG) *National Health and Hospitals Network Agreement* (NHHNA), which commits the government to work towards key national targets, national activity based funding and implementation of Local Hospital Networks. Under the new COAG agreement a new performance and accountability framework will be developed for the NHHN, including national indicators agreed to by COAG in the *National Healthcare Agreement* (NHA), and national clinical quality and safety standards developed by the Australian Commission on Safety and Quality in Healthcare (ACSQH).

The suite of key performance indicators are outlined in Section 5.

The Four Hour National Access Target will be introduced from 1 January 2011. This benchmark requires 95 per cent of patients presenting to a public hospital emergency department who are classified as a triage category 1 to be admitted to hospital, referred for treatment or discharged within four hours, where it is clinically appropriate to do so.

Sub-regional health services are requested to provide a complete monthly operating budget and cash flow statement in the AIMS F1. This is a change from previous years where only rural health services under close watch monitoring have been required to submit this level of financial information. This will provide consistent monitoring of performance across the sector.

Please refer to the *Guidelines for Completing the F1* for changes in 2010–11. The key changes to the F1 applicable to **all** health services are:

- submission of the AIMS F1 by the 12th calendar day
- completion of Cashflow 1 and 2 including the cash availability section
- provision of monthly phased budgets

See: http://www.health.vic.gov.au/accounts/f1-guidelines10-11.pdf

Performance Framework

To ensure an appropriate level of accountability for these health services, a framework has been implemented, which includes a:

- Statement of Priorities 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 that enables the department to transparently monitor, analyse and evaluate a health service's performance. The PMF reflects access and financial aspects of performance that are assessed on a quarterly basis. The PMF results are reported in the Victorian Health Service Performance Monitor (VHSPM) on a quarterly basis. The Quality KPI, SAB rate, will not apply to sub-regional health services for 2010–11.

4 Local health services

4.1 Background

In line with the increasing accountability focus in the *National Health and Hospitals Network Agreement*, the monitoring of local health service performance will be aligned with the Victorian Health Service Performance Monitoring Framework in 2010–11.

Health services will be required to advise the department in writing by 30 September 2010 of the health service board's agreed projected end-of-year operating result, phased monthly budgets and cashflow.

All local health services are requested to provide a complete monthly operating budget and cash flow statement in the AIMS F1. This is a change from previous years where only local health services under close watch have been required to submit this level of financial information.

Please refer to the *Guidelines for Completing the F1* for changes in 2010–11. The key changes to the F1 applicable to all health services are:

- submission of the AIMS F1 by the 12th calendar day
- completion of Cashflow 1 and 2 including the cash availability section
- provision of monthly phased budgets.

See: http://www.health.vic.gov.au/accounts/f1-guidelines10-11.pdf

The department will assess and monitor local health service performance against three levels of monitoring which aligns with the performance monitoring framework outlined in this document.

The three levels of monitoring are:

- Standard Monitoring – the least intrusive level of monitoring, with meetings occurring quarterly between the department and the health service to discuss performance
- Performance Watch – the scope of monitoring is increased and performance meetings between the department and the health service become more frequent, either monthly or bi-monthly
- Intensive Monitoring – applies where there is consistent under achievement by a health service. The scope and frequency of monitoring is intensified and requires health services to provide more detailed information such as an access improvement plan.

As no formal scoring system will be used in 2010–11, the level of monitoring proposed will be agreed in discussions between the department and local health services, and will be in accordance with performance against key priority areas.

All local health services that have a projected deficit budget or significant financial deterioration are required to submit a Financial Management Improvement Plan (FMIP) detailing the initiatives aimed at sustainable improvement of the health service's operating position.

5 Key Performance Indicators for Statement of Priorities health services

The department is committed to ensuring that the suite of KPIs it uses to monitor a health service provides a balanced perspective of service provision. The department continues to work with health services to develop and refine indicators over time based on feedback provided by the sector.

Table 1 lists the SoP KPIs for 2010–11 and identifies whether the KPIs are part of the PMF.

Table 1: Statement of Priorities Key Performance Indicators for 2010-11

Program	KPI #	KPI	KPI Description	Benchmark	PMF
Financial					
Finance	FIN KPI 1	Operating Result	YTD Operating Result as a per cent of Total Operating Revenue	Health Service Specific	✓
	FIN KPI 2	Creditors	Trade Creditors days	60 days	✓
	FIN KPI 3	Debtors	Patient Debtors days	60 days	✓
	FIN KPI 4	PP WIES	YTD PP WIES activity performance to target	98–102% of target	✓
Access performance					
Emergency Care	ACCESS KPI 1	Bypass	% of operating time on hospital bypass	3%	✓
	ACCESS KPI 2	8 hours	% of emergency patients transferred to an inpatient bed within 8 hours	80%	✓
	ACCESS KPI 3	4 hours	% of non-admitted emergency patients with a length of stay of within 4 hours	80%	✓
	ACCESS KPI 4	24 hours	No. of patients with a length of stay in the ED 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%	✕

Program	KPI #	KPI	KPI Description	Benchmark	PMF
Elective Surgery	ACCESS KPI 5	Cat2	% of Category 2 elective surgery patients waiting less than 90 days	80%	✓
	ACCESS KPI 6	Cat3	% of Category 3 elective surgery patients waiting less than 365 days	90%	✓
	ACCESS KPI 7	ESWL	No of patients on the elective surgery waiting list	Health Service 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%	✓
Service performance					
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 4	NICU	Standard and flex operating capacity of Neonatal Intensive Care Unit	Hospital Specific	✕

Program	KPI #	KPI	KPI Description	Benchmark	PMF
Quality and Safety	SERV KPI 5a	Accreditation	Hospital Accreditation	Full Accreditation	✕
	SERV KPI 5b	Residential	Residential Aged Care compliance with accreditation standards	No instances of non compliance	✕
	SERV KPI 6	Cleaning	Cleaning Standards	Full Compliance	✕
	SERV KPI 7	VICNISS Data	Submission of Infection Surveillance Data to VICNISS	Full compliance	✕
	SERV KPI 8	VICNISS Perf	VICNISS Infection Surveillance Indicator	No Outliers	✕
	SERV KPI 9	Hand Hygiene	Hand Hygiene compliance rate	65%	✕
	SERV KPI 13 *	SAB	*Staphylococcus aureus bacteraemia* (SAB) rate	≤ 2/10,000	✓
	SERV KPI 12	VPSM	Victorian Patient Satisfaction Monitor	OCI 73	✕
Maternity	SERV KPI 10	Post Natal Care	Proportion of women who have given birth and on discharge have prearranged postnatal care	90%	✕
Mental Health	SERV KPI 11	MH28Day	Adult Mental Health 28 day readmission rate	14%	✕
	SERV KPI 14	Post Discharge	Post-discharge follow-up rate	75%	✕
	SERV KPI 15	Seclusion	Seclusion rate	≤ 20/1,000	✕

* KPI 13 SAB not applicable to sub-regional health services

6 Statement of Priorities Performance Monitoring Framework

This section provides an overview of the PMF for Statement of Priorities health services, identifies the KPIs and scoring systems used in this framework and describes how KPIs apply to each health service or hospital.

The department assesses and monitors the performance of health services against the PMF 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 health services, where necessary, these monthly performance reports use preliminary or interim results.

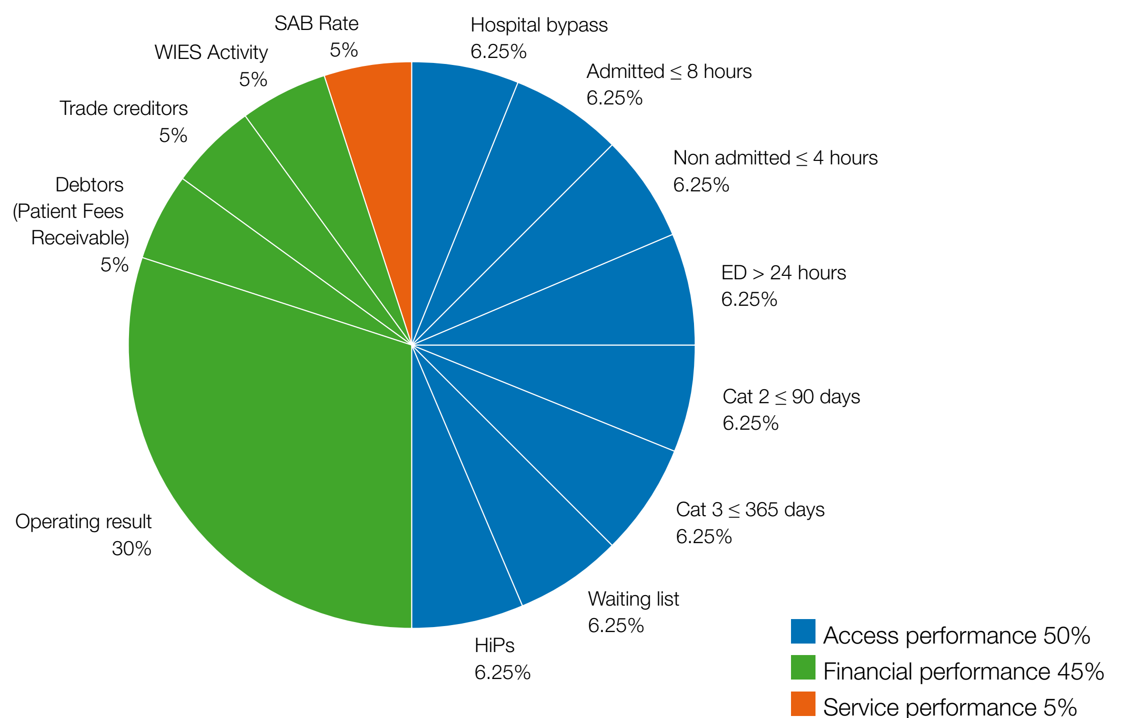
6.1 Overview of the Performance Monitoring Framework

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

The relative contribution each KPI makes to the PMF score is represented in Figure 1. Financial performance represents 45 per cent of the PMF score, access performance contributes 50 per cent and the quality indicator SAB rate contributes 5 per cent of the overall PMF score. The quality KPI does not apply to the sub-regional health services.

The department uses the PMF score to provide certainty and transparency about the level of monitoring health services will experience throughout the annual business cycle, given their performance results.

Figure 1: Overview of the PMF



6.2 Calculating the PMF Score for SoP health services

The PMF scoring process occurs in three steps:

1. Allocate PMF points based on the performance results
2. Apply the conditional KPIs for elective surgery and emergency care
3. Account for accepted *force majeure* claims that have impacted on performance.

The first step is to calculate the PMF score, by allocating points to the finance, service and access KPIs based on the weightings and thresholds outlined in Tables 2 and 3. In the 20101 PMF, a maximum score of 45 points is achievable for finance, 50 points for the access suite of KPIs and 5 points for service KPIs. Aggregating the access, service and finance scores gives the total PMF score, a maximum of 100 points. Tables 4, 5 and 6 outline which KPIs apply to each hospital/ health service and how the PMF applies to each indicator.

The suite of financial KPIs is assessed at the health service level. If a health service is not assessed against the suite of access KPIs, the PMF finance score is pro-rated to give a total PMF score.

Depending on the access KPI, performance assessment is at either campus or health service level. For health services with multiple campuses, a maximum score is determined across all relevant campuses.

Where an access KPI does not apply to a health service (such as Bypass), the overall PMF access score is calculated using the other access KPIs so that the PMF weighting per access KPI changes.

Two of the 10 access indicators in the PMF are conditional, whereby their results only impact on the score when the KPI benchmark is not met. The Access PMF 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 target, points are deducted. In this situation the PMF Access score is reduced by one point across each of the relevant emergency care or elective surgery KPIs in the given quarter.

The conditional KPIs for 2010–11 are:

- percentage of triage Category 1 patients seen immediately
- percentage of Category 1 elective surgery patients admitted within 30 days

The quality KPI performance is assessed at health service level. Where the quality KPI does not apply, the combined financial and access scores are pro-rated to calculate a PMF score out of 100.

The final step to reach the PMF score is to account for any agreed *force majeure* claims (refer to section 6.6 for details on this process).

6.3 Levels of Monitoring for SoP health services

The three levels of monitoring are as follows.

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

Performance Watch (50-69 points) – applies to those health services with an emerging deterioration in performance against targets. The scope of monitoring is increased and performance meetings between the department and the 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 health service. The scope and frequency of monitoring is intensified and requires health services to provide more detailed information such as an access improvement plan or financial improvement plan.

The status of a health service is determined by the PMF score matched against thresholds to determine the required level of monitoring. Matching a monitoring level for two consecutive quarters will trigger monitoring at that level. However, if a health service has a score of 49 points or less in a single quarter; it will automatically trigger intensive monitoring.

6.4 SoP Targets and Performance Thresholds

The targets and performance thresholds of the PMF 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 for each KPI.

Table 2: Access and Service Performance – PMF weights, performance thresholds and points

KPI	Description	Weight	Threshold	PMF
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
			> 5.1%	0
8 hours	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
4 hours	Percentage of non-admitted emergency patients with a LOS of within 4 hours	6.25%	80%+	3
			75% to 79%	2
			65% to 74%	1
			0% to 64%	0
24 hours	Number of patients with a LOS in the ED greater than 24 hours	6.25%	0	3
			1 to 15	2
			16 to 30	1
			31+	0
Triage1*	Percentage of triage Category 1 patients seen immediately	100%		
Cat2	Percentage of Category 2 elective surgery patients waiting 90 days or less	6.25%	80%+	3
			75% to 79%	2
			70% to 74%	1
			0% to 69%	0
Cat3	Percentage of Category 3 elective surgery patients waiting 365 days or less	6.25%	90%+	3
			85% to 89%	2
			80% to 84%	1
			0% to 79%	0

KPI	Description	Weight	Threshold	PMF
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 15.0	1
			15.1 +	0
Cat1*	Percentage of Category 1 patients admitted within 30 days	100%		
SAB rate **	Rate of SAB infections per 10,000 occupied bed days	5%	0 to 2.0	5
			2.1 to 2.5	3
			2.6 to 3.5	1
			3.6 +	0

* Failure to meet the conditional 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.

** SAB KPI not applicable to sub-regional health services.

Results/variances are rounded before they are assessed – refer to KPI definitions

Table 3: Financial Performance – PMF weights, performance thresholds and points

KPI	Description	Weight	Threshold	PMF
Operating Result	YTD Operating Result as a per cent of Total Operating Revenue	30%	Achieved budget	30
			If in surplus but behind target	24
			0% to 2% unfavourable variance	21
			2% to 3% unfavourable variance	10
			Over 3% unfavourable variance	0
Creditors	Trade Creditors days	5%	Less than or equal to 60 days	5
			61 to 65 days	3
			66 to 70 days	2
			More than 70 days	0
Debtors	Patient Debtors days	5%	Less than or equal to 60 days	5
			61 to 70 days	3
			71 to 80 days	2
			More than 80 days	0
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

6.5 Reporting by SoP hospital / health service

Tables 4 to 9 set out which KPIs apply to individual SoP hospitals / health services. The following key provides the meaning of symbols used throughout tables 4 to 9.

Symbol	Meaning
✕	KPI not applicable for this site
▣	Hospital performance monitored against SoP for this KPI but not subject to the PMF
✓	Hospital assessed against the PMF for this KPI
✧	Non-achievement of the statewide benchmark will result in the reduction of one1 point for each emergency KPI in a given quarter

Table 4: Emergency Care KPIs by hospital

Health Service / Hospital	Bypass	8hrs	4hrs	24hrs	Triage1	Triage2	Triage3
Metropolitan							
Angliss Hospital	✓	✓	✓	✓	✧	⧈	⧈
Austin Health	✓	✓	✓	✓	✧	⧈	⧈
Box Hill Hospital	✓	✓	✓	✓	✧	⧈	⧈
Casey Hospital	✓	✓	✓	✓	✧	⧈	⧈
Dandenong Hospital	✓	✓	✓	✓	✧	⧈	⧈
Frankston Hospital	✓	✓	✓	✓	✧	⧈	⧈
Maroondah Hospital	✓	✓	✓	✓	✧	⧈	⧈
Mercy Hospital for Women	✕	⧈	⧈	⧈	⧈	⧈	⧈
Monash Medical Centre – Clayton	✓	✓	✓	✓	✧	⧈	⧈
Rosebud Hospital	✕	✓	✓	✓	✧	⧈	⧈
Royal Children's Hospital	✕	✓	✓	✓	✧	⧈	⧈
Royal Vic Eye and Ear Hospital	✕	✕	✓	✕	✧	⧈	⧈
Sandringham and District Hospital	✕	✓	✓	✓	✧	⧈	⧈
St Vincent's Hospital	✓	✓	✓	✓	✧	⧈	⧈
Sunshine Hospital	✓	✓	✓	✓	✧	⧈	⧈
The Alfred	✓	✓	✓	✓	✧	⧈	⧈
The Northern Hospital	✓	✓	✓	✓	✧	⧈	⧈
The Royal Melbourne Hospital	✓	✓	✓	✓	✧	⧈	⧈
The Royal Women's Hospital	✕	⧈	⧈	⧈	⧈	⧈	⧈
Werribee Mercy Hospital	✕	✓	✓	✓	✧	⧈	⧈
Western Hospital	✓	✓	✓	✓	✧	⧈	⧈
Williamstown Hospital	✕	✕	✓	✕	✧	⧈	⧈

Health Service / Hospital	Bypass	8hrs	4hrs	24hrs	Triage1	Triage2	Triage3
Regional							
Ballarat Health Services	✕	✓	✓	✓	✧	▣	▣
Barwon Health	✕	✓	✓	✓	✧	▣	▣
Bendigo Health Care Group	✕	✓	✓	✓	✧	▣	▣
Goulburn Valley Health	✕	✓	✓	✓	✧	▣	▣
Latrobe Regional Hospital	✕	✓	✓	✓	✧	▣	▣
Wodonga Hospital	✕	✓	✓	✓	✧	▣	▣
Sub-regional							
Bairnsdale Regional Hospital	✕	✓	✓	✓	✧	▣	▣
Hamilton Base Hospital	✕	✓	✓	✓	✧	▣	▣
Northeast Health Wangaratta	✕	✓	✓	✓	✧	▣	▣
Swan Hill Hospital	✕	✓	✓	✓	✧	▣	▣
West Gippsland Healthcare Group	✕	✓	✓	✓	✧	▣	▣
Sale Hospital	✕	✓	✓	✓	✧	▣	▣
Warrnambool Hospital	✕	✓	✓	✓	✧	▣	▣
Horsham Hospital	✕	✓	✓	✓	✧	▣	▣
Echuca Regional Hospital	✕	✓	✓	✓	✧	▣	▣
Mildura Base Hospital	✕	✓	✓	✓	✧	▣	▣
Total assessed for PMF	13	34	36	34	36	0	0

Table 5: Elective surgery KPIs by hospital / health service

Health Service / Hospital	Cat2	Cat3	*ESWL	HiP	Cat1
Metropolitan					
Angliss Hospital	✓	✓	✓	✓	✧
Austin Health	✓	✓	✓	✓	✧
Box Hill Hospital	✓	✓	✓	✓	✧
Casey Hospital	✓	✓	✓	✓	✧
Dandenong Hospital	✓	✓	✓	✓	✧
Frankston Hospital	✓	✓	✓	✓	✧
Maroondah Hospital	✓	✓	✓	✓	✧
Mercy Hospital for Women	✓	✓	✓	✓	✧
Monash Medical Centre – Clayton	✓	✓	✓	✓	✧
Monash Medical Centre – Moorabbin	✓	✓	✓	✓	✧
Royal Children's Hospital	✓	✓	✓	✓	✧
Royal Victorian Eye and Ear Hospital	✓	✓	✓	✓	✧
Sandringham and District Hospital	✓	✓	✓	✓	✧
St Vincent's Hospital	✓	✓	✓	✓	✧
Sunshine Hospital	✓	✓	✓	✓	✧
The Alfred	✓	✓	✓	✓	✧
The Northern Hospital	✓	✓	✓	✓	✧
The Royal Melbourne Hospital	✓	✓	✓	✓	✧
The Royal Women's Hospital	✓	✓	✓	✓	✧
Werribee Mercy Hospital	✓	✓	✓	✓	✧
Western Hospital	✓	✓	✓	✓	✧
Williamstown Hospital	✓	✓	✓	✓	✧
Regional					
Ballarat Health Services	✓	✓	✓	✓	✧
Barwon Health	✓	✓	✓	✓	✧
Bendigo Health Care Group	✓	✓	✓	✓	✧
Goulburn Valley Health	✓	✓	✓	✓	✧
Latrobe Regional Hospital	✓	✓	✓	✓	✧

Health Service / Hospital	Cat2	Cat3	*ESWL	HiP	Cat1
Sub regional					
West Gippsland Healthcare Group	✓	✓	✓	✓	✧
Northeast Health Wangaratta	✓	✓	✓	✓	✧
Total assessed for PMF	**29**	**29**	**20**	**29**	**29**

* ESWL – Performance is assessed for the health service as a whole, not by hospital

Some hospitals incorporate the results of other campuses: Frankston Hospital includes Rosebud Hospital; The Northern Hospital includes Broadmeadows Health Service; Dandenong Hospital includes the Cranbourne Integrated Care Centre; and Austin Health includes Heidelberg Repatriation Hospital.

Table 6: Finance KPIs by Health Service

Health Service	Operating Result	Creditors	Debtors	WIES
Metropolitan				
Austin Health	✓	✓	✓	✓
Alfred Health	✓	✓	✓	✓
Calvary Health	✓	✓	✓	×
Eastern Health	✓	✓	✓	✓
Melbourne Health	✓	✓	✓	✓
Mercy Public Hospitals Inc	✓	✓	✓	✓
Northern Health	✓	✓	✓	✓
Peninsula Health	✓	✓	✓	✓
Peter MacCallum Cancer Institute	✓	✓	✓	✓
Royal Children's Hospital	✓	✓	✓	✓
Royal Vic Eye and Ear Hospital	✓	✓	✓	✓
Southern Health	✓	✓	✓	✓
St Vincent's Health	✓	✓	✓	✓
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	Operating Result	Creditors	Debtors	WIES
Sub regional				
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	✓	✓	✓	✓
Total assessed for PMF	31	31	31	30

Table 7: Critical Care and Maternity

Health Service / Hospital	ICU	NICU	Postnatal
Metropolitan			
Angliss Hospital	×	×	▣
Austin Health	▣	×	×
Box Hill Hospital	▣	×	▣
Casey Hospital	×	×	▣
Dandenong Hospital	▣	×	▣
Frankston Hospital	▣	×	▣
Maroondah Hospital	*	×	×
Mercy Hospital for Women	×	▣	▣
Monash Medical Centre – Clayton	▣	▣	▣
Peter MacCallum Cancer Institute	▣	×	×
Rosebud Hospital	×	×	×
Royal Children's Hospital	▣	▣	×
Royal Vic Eye and Ear Hospital	×	×	×
Sandringham and District Hospital	×	×	▣
St Vincent's Hospital	▣	×	×
Sunshine Hospital	×	×	▣
The Alfred	▣	×	×
The Northern Hospital	▣	×	▣
The Royal Melbourne Hospital	▣	×	×
The Royal Women's Hospital	×	▣	▣
Werribee Mercy Hospital	×	×	▣
Western Hospital	▣	×	×
Williamstown Hospital	×	×	×
Regional			
Ballarat Health Services*	▣	×	▣
Barwon Health	▣	×	▣
Bendigo Health Care Group*	▣	×	▣
Shepparton Hospital*	▣	×	▣
Latrobe Regional Hospital*	▣	×	▣
Wodonga Hospital	▣	×	▣

Health Service / Hospital	ICU	NICU	Postnatal
Sub-regional			
Bairnsdale Regional Hospital	✕	✕	▣
Hamilton Base Hospital	✕	✕	▣
Northeast Health Wangaratta	✕	✕	▣
Swan Hill Hospital	✕	✕	▣
West Gippsland Healthcare Group	✕	✕	▣
Sale Hospital	✕	✕	▣
Warrnambool Hospital	✕	✕	▣
Horsham Hospital	✕	✕	▣
Echuca Regional Hospital	✕	✕	▣
Mildura Base Hospital	✕	✕	▣

* Hospitals with a combined intensive care unit service mix where they operate ICU, HDU and CCU beds within one unit

Table 8: Quality and Safety

Health Service/ Hospital	Accred	Resi	Clean	VICNISS Data	VICNISS Perf	Hand Hygiene	SAB	VPSM
Metropolitan								
Austin Health	▣	▣	▣	▣	▣	▣	✓	▣
Alfred Health	▣	▣	▣	▣	▣	▣	✓	▣
Calvary Health	▣	×	▣	×	×	▣	✓	▣
Eastern Health	▣	▣	▣	▣	▣	▣	✓	▣
Melbourne Health	▣	▣	▣	▣	▣	▣	✓	▣
Mercy Public Hospitals Inc	▣	×	▣	▣	▣	▣	✓	▣
Northern Health	▣	▣	▣	▣	▣	▣	✓	▣
Peninsula Health	▣	▣	▣	▣	▣	▣	✓	▣
Peter MacCallum Cancer Institute	▣	×	▣	▣	×	▣	✓	▣
Royal Children's Hospital	▣	×	▣	▣	×	▣	✓	×
Royal Vic Eye and Ear Hospital	▣	×	▣	▣	▣	▣	✓	▣
Royal Women's Hospital	▣	×	▣	▣	▣	▣	✓	▣
Southern Health	▣	▣	▣	▣	▣	▣	✓	▣
St Vincent's Health	▣	▣	▣	▣	▣	▣	✓	▣
Western Health	▣	▣	▣	▣	▣	▣	✓	▣
Regional								
Albury Wodonga Health	▣	×	▣	▣	▣	▣	✓	▣
Ballarat Health Services	▣	▣	▣	▣	▣	▣	✓	▣
Barwon Health	▣	▣	▣	▣	▣	▣	✓	▣
Bendigo Health Care Group	▣	▣	▣	▣	▣	▣	✓	▣
Goulburn Valley Health	▣	▣	▣	▣	▣	▣	✓	▣
Latrobe Regional Hospital	▣	▣	▣	▣	▣	▣	✓	▣

Health Service/ Hospital	Accred	Resi	Clean	VICNISS Data	VICNISS Perf	Hand Hygiene	SAB	VPSM
Sub-Regional								
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	▣	▣	▣	▣	×	▣	×	▣
Total assessed for PMF							21	

Table 9: Mental Health

Area Mental Health Services	MH 28 Day	Post Discharge	Seclusion
Metropolitan			
Austin Health - North East	⧈	⧈	⧈
Alfred Health - Inner South East	⧈	⧈	⧈
Eastern Health - Central East	⧈	⧈	⧈
Eastern Health - Outer East	⧈	⧈	⧈
Melbourne Health - Inner West	⧈	⧈	⧈
Melbourne Health - Mid West	⧈	⧈	⧈
Melbourne Health - North West	⧈	⧈	⧈
Melbourne Health - Northern	⧈	⧈	⧈
Monash Medical Centre - Clayton	⧈	⧈	⧈
Melbourne Health (ORYGEN Youth Health)	⧈	⧈	⧈
Peninsula Health	⧈	⧈	⧈
Southern Health - Casey Hospital	⧈	⧈	⧈
Southern Health - Dandenong Hospital	⧈	⧈	⧈
Southern Health - Middle South	⧈	⧈	⧈
St Vincent's Hospital - Inner Urban East	⧈	⧈	⧈
Werribee Mercy Hospital - South West Angliss Hospital	⧈	⧈	⧈
Regional			
Ballarat Health - Grampians	⧈	⧈	⧈
Barwon Health - Barwon	⧈	⧈	⧈
Bendigo Health - Loddon Southern Mallee	⧈	⧈	⧈
Goulburn Valley Health - Campaspe	⧈	⧈	⧈
Latrobe Regional Hospital - Gippsland	⧈	⧈	⧈
Sub-regional			
Mildura Base Hospital - Northern Mallee	⧈	⧈	⧈
Northeast Health Wangaratta - Hume	⧈	⧈	⧈
South West Healthcare - Glenelg	⧈	⧈	⧈

6.6 *Force majeure*

In applying the PMF, it is critical that the scores reflect bona fide concerns about performance results. From time to time, unforeseen events may occur that adversely impact on hospital performance and it would be not useful for the monitoring status of a health service to change as a result of the event alone.

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. Examples include internal disasters beyond the control of the health service and third party-related failures leading to the interruption of service delivery (such as a power failure). Where circumstances have a significant impact on performance, 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 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 PMF score, depending on the circumstance.

Submitting a *force majeure* request

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.

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 *force majeure* at 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 written *force majeure* requests from the health service CEO should be forwarded to the Director, Performance, Acute Programs and Rural Health (PAPRH) branch.

Further information about *force majeure* is also set out in the *Victorian Health Services Policy and Funding Guidelines 2010-11 – Conditions of Funding.*

See: (http://www.health.vic.gov.au/pfg/downloads/hospitals/conditions_funding.pdf)

7 Statement of Priorities Key Performance Indicators

This section sets out the business rules for each of the KPIs in the SoP.

7.1 Data Requirements

The data sources and data submission timeframes for KPIs are presented in Table 10. More comprehensive information about data submission and reporting requirements is provided in the Victorian Health Services Policy and Funding Guidelines 2010–11 (www.health.vic.gov.au/pfg) and further information on these data collections is contained in their respective data collection manuals (www.health.vic.gov.au/hdss).

Where a health service or hospital is unable to submit completed electronic Elective Surgery Information System (ESIS), Victorian Emergency Minimum Dataset (VEMD), Victorian Admitted Patient Data (VAED, or Agency Information Management System (AIMS) data, the department (Manager, Health Data Acquisition) must be notified in writing before the submission date of the month following the affected data collection.

Table 10: Data submission requirements for Key Performance Indicators

Program	KPI	Data Source	Data Submission Timeframes
Emergency Care	Bypass	AV	• Hospital Bypass Notifications report
	8 hours	VEMD	• Submitted to the department three working days after the end of the month
	4 hours		
	24 hours		
	Triage 1		
	Triage 2		
	Triage 3		
Elective Surgery	Cat1	ESIS	• Submitted to the department three working days after the end of the month
	Cat2		
	Cat3		
	ESWL		
	Admissions		
	HiPs		
Finance	Operating Result	AIMS F1	• AIMS F1 return due 12th day after the end of the month or earlier if the 12th falls on a weekend or public holiday
	Creditors		
	Debtors		
	WIES Activity		
Critical Care	ICU	Victorian Critical Care Access website	• Data reported on the website four times a day.

Program	KPI	Data Source	Data Submission Timeframes
Critical Care	NICU	*Victorian Perinatal Information Centre* Website	• Data reported on the website at least once each nursing shift
Quality and Safety	Accreditation	Hospital Accreditation Processes	• Department summarises accreditation data quarterly.
		Residential Aged Care Accreditation	• Compliance status for residential aged care services provided by the department's Aged Care Branch quarterly
Quality and Safety	Cleaning	August external audit	• August 2010
Quality and Safety	VICNISS Compliance	VICNISS Coordinating Centre	• Quarterly
Quality and Safety	VICNISS Infection	VICNISS Coordinating Centre	• Quarterly
Quality and Safety	Hand Hygiene Rate	VICNISS Coordinating Centre	• August, November and April
Quality and Safety	SAB rate	VICNISS Coordinating Centre	• August, November and April
Quality and Safety	VPSM	Survey	• Monthly provision of eligible discharged patients to the survey contractor • Data issued six monthly, in October and April
Maternity	Postnatal Home Care	VAED	• Submitted to the department on the 10th day of the following month
Mental Health	MH 28days	CMI/ODS	• Submission requirements of CMI/ODS
Mental Health	Post-discharge	CMI/ODS	• Submission requirements of CMI/ODS
Mental Health	Seclusion	CMI/ODS	• Submission requirements of CMI/ODS

7.2 Financial performance

Data for the financial performance KPIs is sourced from the AIMS F1 finance return submitted by health services to the department on a monthly basis. In addition, several of the financial KPIs are calculated using phased monthly targets provided to the department by health services in September.

FIN 1 YTD operating result as a per cent of total operating revenue

This indicator is predicated on the year-to-date operating result in the SoP.

Calculating performance

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

The year-to-date operating result as a percentage of total revenue will be calculated by:

Numerator: YTD operating surplus/deficit result, before capital and depreciation.

Denominator: YTD Total Revenue

Phased monthly targets are based on the September F1 submission for the financial year. Opportunity to prospectively rephase monthly targets tracking to the agreed annual operating result is available with approval from the department. Should the phasings require adjustment, these changes will be considered on a quarterly basis and where agreed, may be provided to the department in the AIMS F1. Please note that the department does not support retrospective changes to phased targets.

Performance is monitored monthly, with assessment occurring quarterly.

Statewide benchmark

The statewide benchmark for this KPI is that the health service meets their operating result based on the agreed end of year position in the SoP.

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

Achieved or ahead of budget	30 points
If in surplus but behind budget	24 points
If in deficit and 0% – 2% unfavourable variance	21 points
If in deficit and >2% – 3% unfavourable variance	10 points
If in deficit and >3% unfavourable variance	0 points

Frequency of reporting and data collection

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

FIN 2 Trade Creditors

Calculating performance

Performance is monitored monthly with assessment occurring quarterly. Performance is based on the number of trade creditor days as reported at the end of the month or quarter.

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

Statewide benchmark

The statewide benchmark for this KPI has been set at 60 days.

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

Less than or equal to 60 days	5 points	✓
61 to 65 days	3 points	⦸
66 to 70 days	2 points	✕
More than 70 days	0 points	✕

Frequency of reporting and data collection

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

FIN 3 Debtors (Patient Fees Receivable)

Calculating performance

Performance is monitored monthly with assessment occurring quarterly. Performance is based on the number of patient debtor days as reported as at the end of the month or quarter.

The number of patient fees receivable days excludes debts subject to debt recovery plans.

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

Statewide benchmark

The statewide benchmark for this KPI has been set at 60 days.

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

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

Frequency of reporting and data collection

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

FIN 4 YTD Public and Private WIES performance

The year-to-date public and private WIES (PP WIES) activity performance KPI aims to reinforce the need for health services to manage their activity to within the 2 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 two decimal places.

The WIES target variance refers to public and private WIES only. Private WIES as reported in the F1 includes private insurance, ineligible, Workcover and other compensable WIES, as per the definitions in the VAED Data Manual.

Renal WIES is excluded from this KPI (because it is paid to actual activity), as are DVA and TAC 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.

Statewide benchmark

The statewide benchmark for this KPI has been set at between 98 per cent and 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 2.00% variance to target	5 points	✓
2.01% to 2.50% variance to target	3 points	⦸
2.51% to 3.00% variance to target	2 points	✕
Greater than 3.00% variance to target	0 points	✕

In assessing performance, the department recognises that there may be exceptional circumstances whereby a health service exceeds the 2 per cent tolerance level without adversely impacting financial viability. These cases are 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 Performance Indicators.

7.3 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

Definition

For the purpose of hospital bypass notification, monitoring and reporting, Ambulance Victoria and the department have agreed that this indicator includes occasions of bypass that exceeds 30 minutes where the reason is 'A & E Full'.

However, all hospital bypass is recorded and monitored.

Calculating performance

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

Numerator: Actual time on bypass

Denominator: Actual time in the reporting period

This indicator is expressed as a percentage rounded to one decimal place (0.05 is rounded up).

Statewide benchmark

Performance is monitored monthly, with assessment occurring quarterly. The statewide benchmark for this KPI is 3 per cent. This indicator is included as an access performance measure in the PMF. The performance thresholds used to calculate the PMF score against this KPI are:

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 5.1%	0 points	✕

Frequency of reporting and data collection

Data reported on the 'Hospital Bypass Notification' data provided to the department by Ambulance Victoria.

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

Definition

This indicator includes patients with the following VEMD Departure Status:

3 Short Stay Observation Unit
14 Medical Assessment and Planning Unit
15 Intensive Care Unit – this campus
18 Ward not elsewhere described
22 Coronary Care Unit – this campus
25 Mental Health Observation/Assessment Unit
26 Other Mental Health Bed – this campus
27 Cardiac catheter laboratory
28 Other operating theatre/procedure room

Emergency patients located in transit lounges or holding areas prior to being transferred to a ward, are considered to be in the care of the ED. 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.

Please refer to the Observation Medicine Guidelines for using departure statuses 3 and 14.

Calculating performance

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 ED length of stay of less than or equal to eight hours (480 minutes) who have a VEMD Departure Status of 3, 14, 15, 18, 22, 25, 26, 27 or 28.

Denominator: The number of patients with a VEMD Departure Status of 3, 14, 15, 18, 22, 25, 26, 27 or 28.

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

Statewide benchmark

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

Performance is monitored monthly, with assessment occurring quarterly. This indicator is included as an access performance measure in the PMF.

The performance thresholds used to calculate the PMF score against this KPI are:

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

Frequency of reporting and data collection

Data is expected to be submitted by health services fortnightly via VEMD.

ACCESS KPI 3 Percentage of non-admitted ED patients with a LOS of within four hours

Definition

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

Calculating performance

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

Numerator: The number of patients with an ED 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, 10, 12, 23, 24.

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

Statewide benchmark

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

Performance is monitored monthly, with assessment occurring quarterly. This indicator is included as an access performance measure in the PMF.

The performance thresholds used to calculate the PMF score against this KPI are:

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

Frequency of reporting and data collection

Data is expected to be submitted by health services fortnightly via VEMD.

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

Definition

All patients in the ED, excluding those whose status is dead on arrival.

Calculating performance

The total number of patients with a length of stay in the ED greater than 24 hours will be calculated by:

Numerator: The number of patients with an ED length of stay of greater than 24 hours (1,440 minutes), regardless of departure status code.

Denominator: Sum of the length of stay for the total number of patients in the ED, regardless of departure status.

Statewide benchmark

The statewide benchmark for this KPI is zero patients.

Performance is monitored monthly, with assessment occurring quarterly. This indicator is included as an access performance measure in the PMF.

The performance thresholds used to calculate the PMF score for this KPI are:

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

Data is expected to be submitted by health services fortnightly via VEMD.

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

Following clinical guidelines the department sets time to treatment standards for high priority emergency patients. The department monitors hospital achievement against these targets for the most urgent patients (triage categories 1–3) to encourage hospitals to treat as many patients as possible within the desirable times.

Definition

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. Triage category 1 emergency patients are recommended to be seen immediately.

Calculating performance

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

Numerator: Number of triage category 1 emergency patients seen immediately

Denominator: Number of triage category 1 emergency patients

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

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
- **b** is the date and time of the initiation of patient management (either by a doctor or a mental health practitioner or a nurse, whichever is earliest).

Statewide benchmark

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

Performance is monitored monthly, with assessment occurring quarterly. This indicator is included as an access performance measure in the PMF.

The performance thresholds used to calculate the PMF score against this KPI are:

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

Frequency of reporting and data collection

Data is expected to be submitted by health services fortnightly via VEMD.

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

Following clinical guidelines, the department sets time to treatment standards for high priority emergency patients. The department monitors hospital achievement against these targets for the most urgent patients (triage categories 1-3), to encourage hospitals to treat as many patients as possible within the desirable times.

Definition

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. Triage category 2 emergency patients are recommended to be seen within 10 minutes.

Calculating performance

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

Numerator: Number of triage category 2 emergency patients seen within 10 minutes

Denominator: Number of triage category 2 emergency patients

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

A patient is categorised as having been seen within 10 minutes where the time to treatment is less than or equal to 10 minutes. Time to treatment equals **a – b**, where:

- **a** is arrival date and time
- **b** is the date and time of the initiation of patient management (either by a doctor or a mental health practitioner or a nurse, whichever is earliest).

Statewide benchmark

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

Performance is monitored on a monthly basis. The thresholds used to reflect performance results are:

Target achieved	✓
Target not achieved	✕

Frequency of reporting and data collection

Data is expected to be submitted by health services fortnightly via VEMD.

This KPI is in the SoP but is not included in the PMF.

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

Following clinical guidelines the department sets time to treatment standards for high priority emergency patients. The department monitors hospital achievement against these targets for the most urgent patients (triage categories 1-3), to encourage hospitals to treat as many patients as possible within the desirable times.

Definition

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. Triage category 3 emergency patients are recommended to be seen within 30 minutes.

Calculating performance

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

Numerator: Number of triage category 3 emergency patients seen within 30 minutes

Denominator: Number of triage category 3 emergency patients

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

A patient is categorised as having been seen within 30 minutes where the time to treatment is less than or equal to 30 minutes. Time to treatment equals **a – b**, where:

- **a** is arrival date and time
- **b** is the date and time of the initiation of patient management (either by a doctor or a mental health practitioner or a nurse, whichever is earliest).

Statewide benchmark

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

Performance is monitored on a monthly basis and the thresholds used to reflect performance results are:

Target achieved	✓
Target not achieved	✕

Frequency of reporting and data collection

Data is expected to be submitted by health services fortnightly via VEMD.

This KPI is in the SoP but is not included in the PMF.

Elective Surgery Services

Elective surgery performance indicators, targets and benchmarks are designed to encourage improved performance in managing health care 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/pubs/elective_surgery_access_policy_2009.pdf

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

Elective surgery 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.

Definition

This indicator applies to campuses and 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 reporting period.

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.

Calculating performance

Performance is calculated on the census date (end of the month) using the formula:

Numerator: Number of Category 2 patients on the waiting list waiting less than or equal to 90 days

Denominator: Total number of Category 2 patients on the waiting list

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

Statewide benchmark

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

Performance against this KPI is monitored monthly and assessed quarterly. This indicator is included as an access performance measure in the PMF.

The performance thresholds used to calculate the PMF score against this KPI are:

Greater than or equal to 80%	3 points	✓
75% to 79%	2 points	⦸
70% to 74%	1 point	⦸
Less than 70%	0 points	✕

Frequency of reporting and data collection

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

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

Elective surgery 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.

Definition

This indicator applies to campuses and 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 reporting period.

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.

Calculating performance

Performance is calculated on the census date (end of the month) using the formula:

Numerator: Number of Category 3 patients on the waiting list waiting less than or equal to 365 days

Denominator: Total number of Category 3 patients on the waiting list

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

Statewide benchmark

The statewide benchmark for this KPI has been set at 90 per cent.

Performance against this KPI is monitored monthly and assessed quarterly. This indicator is included as an access performance measure in the PMF.

The performance thresholds used to calculate the PMF score against this KPI are:

Greater than or equal to 90%	3 points	✓
85% to 89%	2 points	⃠
80% to 84%	1 point	⃠
Less than 80%	0 points	✕

Frequency of reporting and data collection

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

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.

Definition

This indicator is measured at health service level. Where health services have multiple campuses, the aggregate for all campuses is used.

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.

Calculating performance

The number of patients, for all categories, waiting for elective surgery as at the end of the reporting period.

Individual health service targets are negotiated and based on performance and take into account funding allocations in the financial year.

The quarterly targets are negotiated with the department for performance monitoring and assessment purposes. The quarterly targets reflect peaks in emergency demand and seasonal capacity limitations. Notional monthly targets are also provided to assist with monitoring performance.

Statewide benchmark

The statewide benchmark for this KPI is that the health service meets their agreed end of year target in the SoP.

Performance against this KPI is monitored monthly and assessed quarterly. This indicator is included as an access performance measure in the PMF.

The performance thresholds used to allocate points against this KPI are:

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 0 decimal places (0.5 is rounded up).

Frequency of reporting and data collection

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

ACCESS KPI 8 Hospital Initiated Postponements

This indicator measures the number of Hospital Initiated Postponements (HiPs) experienced by elective surgery patients during a quarter.

Definition

This indicator is measured at the campus level. Only records assigned an ESIS 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 cancelled was scheduled for a different quarter.

A postponement is hospital-initiated if the reason for the scheduled admission date change in ESIS is coded 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

Calculating performance

Performance is calculated using the formula:

Numerator: Number of HiPs within the quarter

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

Denominator: Number of procedures scheduled to occur in 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)

Statewide benchmark

The statewide benchmark for this KPI has been set at 8.0 per hundred.

Performance against this KPI is monitored monthly and assessed quarterly. This indicator is included as an access performance measure in the PMF.

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

0 to 8.0	3 points	✓
8.1 to 11.0	2 points	⦸
11.1 to 15.0	1 point	⦸
15.1 +	0 points	✕

For the purpose of allocating points, the result is rounded to a one decimal point.

Frequency of reporting and data collection

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

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.

Definition

This indicator is measured at the campus level and measures hospital performance in admitting category 1 elective surgery patients within the clinically desirable timeframe. Within ESIS data, a removal is counted as an admission when the Reason for Removal is:

W Admitted to this hospital,

S Treated for awaited procedure arranged by ESAS,

X This hospital arranged admission to another hospital.

Calculating performance

Hospital performance against this indicator is expressed as a percentage. Performance is calculated using the formula:

Numerator: Number of Category 1 patients removed for reasons W, S or X within 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.

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

Statewide benchmark

The statewide benchmark is 100 per cent of Category 1 patients admitted from the waiting list within 30 days.

Performance against this KPI is monitored monthly and assessed quarterly. This indicator is included as an access performance measure in the PMF.

The performance thresholds used to calculate the PMF score against this KPI are:

100%	No loss of points	✓
Less than 100%	Loss of one point deducted from each elective surgery KPI (Access KPIs 5 – 8)	✕

Frequency of reporting and data collection

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

In the event that a patient is admitted, or scheduled to be admitted, as an overdue Category 1, health services are required to send a letter to the Director Performance, Acute Programs and Rural Health Branch within five days of the breach with the following information:

- advising the department of a Category 1 breach or expected breach ;
- explaining the circumstances of this Category 1 breach
- outlining the actions to be undertaken by the health service to avoid further Category 1 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. The department will continue to monitor overdue Category 1 patients through the ESIS reporting system and may contact the health service to clarify the status of these patients.

7.4 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 Removal Date falls within the quarter being reported and the Reason for Removal is:

W Admitted to this hospital,

S Treated for awaited procedure arranged by ESAS,

X This hospital arranged admission to another hospital.

Calculating performance

This indicator counts the number of patients during the reporting period who 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.

Statewide benchmark

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.

Health services provide notional monthly targets to enable the monitoring of this KPI on a monthly basis.

Performance is monitored on a monthly basis. The thresholds used to reflect performance results in the VHSPM are:

Achieved target	✓
>0% to 5% below target	⦸
>5% below target	✕

Frequency of reporting and data collection

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

This KPI is in the SoP but not included in the PMF.

Critical Care

Victoria's adult, paediatric and neonatal 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 a system level.

SERV KPI 2 ICU minimum operating capacity

This KPI is intended to monitor the agreed minimum number of intensive care unit beds that hospitals should provide daily for adult and paediatric patients. Previously, adult and paediatric ICUs were separate indicators.

The ICU Minimum Operating Capacity target is based on a calculation of nurse staffed ICU, high dependency unit (HDU and coronary care unit (CCU beds, to derive an 'ICU equivalent' minimum operating capacity. A weighting is allocated to each bed type and summed to a score for the day. The Minimum Operating Capacity target for each unit is set according to the level of care and bed types available and does not represent absolute bed capacity. Units will at times operate above the agreed ICU Equivalent minimum operating capacity to meet variable demand for ICU beds, and, equally, will occasionally operate below this target when demand is low.

ICU Equivalent bed-type weights

- ICU bed x 1 (1:1 patient staff ratio) = 1.0 ICU equivalent bed
- HDU bed x 1 (2:1 patient staff ratio) = 0.5 ICU equivalent bed
- CCU bed x 1 (2:1 patient staff ratio) = 0.5 ICU equivalent bed

The inclusion of CCU beds is restricted to units in regional health services that provide a combined ICU service mix.

Definitions

These definitions apply to adult and paediatric units.

When referring to ICU/HDU/CCU capacity, 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, e.g. 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. (Bed occupied by a patient waiting for ward transfers is a subset of Occupied Bed)

Calculating performance

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).

The indicator is rounded up to a whole number.

Statewide benchmark

The minimum operating capacity is set individually at hospital level as per the target in the SoP.

The benchmark is zero days for which the ICU reported its operating capacity below the agreed minimum capacity and did not report an empty bed (ICU equivalent). A monitoring threshold of 10 per cent has been introduced for 2010-11.

Performance is monitored on a monthly basis. The thresholds used to reflect performance results in the VHSPM are:

Achieved target	✓
Within 10% of target	⦸
>10% below target	✕

Frequency of reporting and data collection

The data for this KPI is sourced from the Victorian Critical Care Access 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 8:00 am, 12:00 pm, 4:00 pm and 8:00 pm.

There is only a two-hour window 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 Critical Care Access website at any time. Please refer to the Critical Care Access website instructions for further details.

This KPI is in the SoP but is not included in the PMF.

SERV KPI 4 NICU standard and flex operating capacity

The standard operating capacity for ventilated cots in neonatal intensive care units (NICUs) assists with understanding 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 flexible 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 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 variance between the number of NICU occupied cots by neonates requiring respiratory support compared with the agreed standard operating capacity target in the SoP.

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.

Individual NICU services can be closed and below the minimum operating capacity a maximum of 10 per cent of occasions per reporting month, without being deemed in breach of the target.

The indicator is expressed as a whole number.

Statewide benchmark

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

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

Performance is monitored on a monthly basis and the thresholds used to reflect performance results in the VHSPM are:

Achieved target	✓
Below target	✕

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 applicable to the sub-regional health services. This KPI is not included in the PMF.

Quality and Safety

SERV KPI 5a Hospital Accreditation Status

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

Calculating performance

Full compliance with accreditation standards will be referred to as ‘achieved’. All episodes of partial compliance during the reporting period will be assessed as ‘not achieved’.

All health services are required to provide a copy of their hospital accreditation survey or consent to the release of a summary report directly from their accrediting body.

In the event of partial compliance and an associated high priority recommendation, the department (Quality, Safety and Patient Experience Branch or relevant region) requires an action plan addressing the issue(s) within one month of notification of the high priority recommendation.

Statewide benchmark

The benchmark for this KPI is that all hospitals within a health service achieve full accreditation according to the EQuIP or equivalent accreditation process.

Performance is monitored on a quarterly basis and the thresholds used to reflect performance results in the VHSPM are:

Achieved	✓
Not Achieved	✕

Frequency of reporting and data collection

The accreditation status as at the last day of the quarter for each relevant hospital or health service is to be reported.

The department requires that health services’ accreditation information is provided according to this schedule:

- 20 October 2010 for the September quarter
- 20 January 2011 for the December quarter
- 20 April 2011 for the March quarter
- 20 July 2011 for the June quarter.

This KPI is in the SoP but not included in the PMF.

SERV KPI 5b Residential Aged Care Accreditation Status

It is a requirement that all residential aged care sites 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 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 compliance with the accreditation standards will be referred to as 'achieved'.
All episodes of partial compliance identified during the reporting period will be assessed as 'significant non-achievement'. Monitoring will also separately distinguish those episodes of non-compliance that occur and are unresolved by the quarter's end.

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.

Statewide benchmark

The benchmark for this KPI is that all residential aged care sites achieve full compliance with all 44 expected outcomes of the Aged Care Accreditation Standards in each public residential aged care service, at all times.

Performance is monitored on a quarterly basis. The thresholds used to reflect performance results in the VHSPM are:

Achieved	✓
Not Achieved	✕

Frequency of reporting and data collection

The data source for this KPI is information received by the department from the Aged Care Standards and Accreditation Agency.

Results for the accreditation status KPI will be reported on a quarterly basis. 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.

This KPI is in the SoP but not included in the PMF.

SERV KPI 6 Cleaning Standards

Cleaning standards aim to improve the 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.

Definition

In 2010-11, the acceptable quality level (AQL) will remain at 85 for high risk and moderate risk functional areas and will be lifted from 85 to 90 for very high risk functional areas.

One external cleaning audit per year is required. The external cleaning standards audit must be undertaken by a qualified Victorian cleaning standards auditor. Qualified means having successfully passed the accredited *21909VIC Course in Cleaning Standards Auditing*. Reporting of the external cleaning standards audit is mandatory for all public acute health services.

This indicator is expressed as either achieved or not achieved. If the AQL is not achieved a repeat external audit is required within 60 days.

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.

The KPI is assessed as achieved if:

- the audits are conducted by a qualified Victorian cleaning standards auditor
- the overall score for **all** campuses within a 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 health services 2009*, have been met.

The KPI is assessed as not achieved if any of the above mentioned criteria have not been met.

2010–11 statewide benchmark

The statewide benchmarks are an AQL of:

- 90 points for very high risk functional areas
- 85 points for high risk and Moderate Risk functional areas.

Performance is monitored on annual basis and the thresholds used to reflect performance results are:

AQL met for all functional areas	✓
AQL not met for all functional areas	✕

Frequency of reporting and data collection

The external audit results will be submitted to the department via a secure web form in August 2010 and will be reported in Quarter 1.

This KPI is in the SoP but not included in the PMF.

SERV KPI 7 Submission of Infection Surveillance data

The submission of infection surveillance data 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.

Definition

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 an overall health service result.

This indicator is expressed as either achieved or not achieved.

Calculating performance

- The VICNISS performance indicators are set out in the Type 1 and Type 2 surveillance manuals (www.vicniss.org.au) and outline the defined set of surveillance activities that hospitals are required to perform and achieve.
- A health service's participation and performance will be analysed quarterly by the VICNISS Coordinating Centre.
- The VICNISS Coordinating Centre will provide a report to the department's Quality, Safety and Patient Experience Branch that includes detailing each hospital's participation.

Statewide benchmark

The benchmark for the health service is full compliance with submission of infection surveillance data.

Performance is monitored on a quarterly basis. The thresholds used to reflect performance results are:

Full compliance achieved	✓
Full compliance not achieved	✕

Frequency of reporting and data collection

The data is submitted to the VICNISS Coordinating Centre each quarter. Health service participation and performance is provided to the department six weeks later, resulting in a one quarter lag in reporting the KPI.

This KPI is in the SoP but not included in the PMF.

SERV KPI 8 Infection Surveillance Indicator

This KPI focuses on surgical procedures and high risk clinical units where evidence suggests there may be an increased risk of healthcare associated infections. In Victoria, data about these infections is managed by the 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.

Definition

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

- hip arthroplasty
- knee arthroplasty
- coronary artery graft surgery
- ICU patients with central lines.

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 4 performance is the subject of assessment, data for quarters 3 and 4 will be used.

This indicator applies to hospitals participating in Type 1 and Type 2 surveillance. The Type 1 and Type 2 surveillance manuals available from www.vicniss.org.au describe the VICNISS performance indicators. The website also enables hospitals to access their surveillance reports.

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.

If a hospital does not submit infection surveillance data this will also be deemed as not meeting the benchmark.

Statewide benchmark

The statewide benchmark is no outliers.

Performance is monitored on a quarterly basis. The thresholds used to reflect performance are:

No outlier	✓
Outlier	✗

Frequency of reporting and data collection

The data is submitted to the VICNISS Coordinating Centre each quarter. Six weeks after the quarter, the performance result is provided to the department resulting in a one quarter lag in reporting the KPI.

This KPI is in the SoP but not included in the PMF.

SERV KPI 9 Hand Hygiene compliance rate

The hand hygiene project aims to improve the hand hygiene compliance rates of health care workers undertaking direct patient care with the purpose of reducing hospital acquired infections. 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.

Definition

This indicator applies to all hospitals. Where a health service has multiple campuses, the compliance is aggregated to produce an average health service result.

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 as detailed by Hand Hygiene Australia (HHA). This information can be accessed online at www.hha.org.au.

Calculating performance

HHA specifies the required number of:

- audits per year
- areas per audit
- Observations per area.

The performance measure for the health service is determined by calculating the mean average of all hand hygiene compliance rate results from all audited areas.

Health services are assessed as meeting the KPI when an average hand hygiene compliance rate of 65 per cent has been achieved.

Statewide benchmark

The benchmark for the health service is 65 per cent compliance rate.

Performance is monitored on a quarterly basis. The thresholds used to reflect performance are:

Target achieved	✓
Target not achieved	✕

Frequency of reporting and data collection

The dates for data submission to VICNISS are as follows:

- August 2010, reported in VHSPM Quarter 1
- November 2010, reported in VHSPM Quarter 2
- April 2011, reported in VHSPM Quarter 4

This KPI is in the SoP but not included in the PMF.

SERV KPI 13 *Staphylococcus aureus bacteraemia* rates

Staphylococcus aureus bacteraemia (SAB) are serious causes of morbidity and mortality. Most SABs are associated with health care procedures and are thus potentially preventable. SAB rates have been included in the Australian Health Care Agreement as a performance measure.

SAB rates have been collected from health services in Victoria since January 2009 and have been submitted to VICNISS since 1 September 2009.

Definition

This indicator applies to all health services.

This indicator is expressed as the rate of infections per occupied bed days (OBD). The SAB definition can be found at www.hha.org.au/SabDefinition.aspx

Calculating performance

The rate of SAB should be no more than two SAB per 10,000 OBD.

OBD 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.

This indicator is expressed as a rate, rounded to one decimal place (0.05 is rounded down).

Statewide benchmark

The benchmark for the health service is no more than two SAB infections per 10,000 OBD.

Performance is monitored and assessed on a quarterly basis at the health service level. This indicator is included as a service performance measure in the PMF. The performance thresholds used to allocate points against this KPI are:

Less than or equal to 2.0/10,000	5 points	✓
2.1/10,000 to 2.5/10,000	3 points	⃠
2.6/10,000 to 3.5/10,000	1 point	⃠
Greater than or equal to 3.6/10,000	0 points	✕

Frequency of reporting and data collection

The dates for SAB data submission to VICNISS are as follows:

- August 2010 for the period April to June 2010, reported in Quarter 1
- November 2010 for the period July to September 2010, reported in Quarter 2
- February 2011 for the period October to December 2010, reported in Quarter 3
- May 2011 for the period January to March 2011, reported in Quarter 4

This KPI is not applicable to sub-regional health services.

SERV KPI 12 Victorian Patient Satisfaction Monitor

The Victorian Patient Satisfaction Monitor (VPSM) provides feedback on the quality of a public hospital experience from the adult patient perspective. The results from the survey provide government and hospital management with important information as to where quality improvement activities should be directed for greatest effect.

Detailed information about the VPSM is available at:
www.health.vic.gov.au/patsat/index.htm or www.vpsm.com.au/

Definition

There are a number of patient groups that are excluded from the sample. These are patients who:

- decline participation
- are under 18 years of age
- have passed away
- were transferred to another hospital
- are in care types for Drug and Alcohol services, Mental Health or Palliative care (these patients are surveyed separately)
- their preferred language is other than the 15 community languages that the survey has been translated into.

If responses are received from less than 30 patients the score will not be used.

Calculating performance

The questionnaire consists of 24 items. A series of 25 grouped questions is used to derive the six sub indices of care, which are:

- Access and Admission
- General Patient Information
- Treatment and Related Information
- Complaints Management
- Physical Environment
- Discharge and Follow up.

The scores of the six sub indices contribute to the calculation of the indicator, the Overall Care Index (OCI). The OCI acts as the global indicator for the patients' hospital experience.

Statewide benchmark

The statewide benchmark for this KPI is an OCI of 73 for all campuses

Performance is monitored on a bi-annual basis. The thresholds used to reflect performance results in the VHSPM are:

OCI Greater than or equal to 73	✓
OCI 71-72	⦸
OCI Less than 70	✕

Frequency of reporting and data collection

Hospitals are required to submit details of eligible discharged patients to the survey contractor each month.

The survey contractor will provide data to the department as follows:

- October 2010 for the period 1 January to 30 June 2010, reported in Quarter 1
- April 2011 for the period 1 July – 31 December 2010, reported in Quarter 3.

This KPI is in the SoP but not included in the PMF.

Maternity

SERV KPI 10 Proportion of women with prearranged postnatal home care

The provision of maternity services is a key activity of many health services. Since 2003 all public hospitals that provide maternity services have been required to report annually against a set of maternity service performance indicators, including referral to postnatal domiciliary care.

Definition

This indicator is the proportion of women who have arranged appropriate postnatal domiciliary care prior to discharge from hospital or receive hospital in the home (HITH). Hospitals are required to offer all women one or more postnatal domiciliary visits by a midwife, depending on need. This indicator applies to all maternity hospitals and only includes deliveries where the mother is discharged to a private residence.

To be counted as a birth, 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. the birth indicator derived from Z37. (the outcome of the birth must be present on the mother's record.
3. where VicDRG is 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.
4. excludes women transferred to another hospital

Calculating performance

Numerator: Number of women given birth referred to postnatal domicillary care or HITH

Denominator: Number of women given birth (excluding women transferred to another hospital)

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

Statewide benchmark

The statewide benchmark of 90 per cent has been set in recognition that not all women will accept the offer of post natal home care.

Performance is monitored on a monthly basis. The thresholds used to reflect performance results in the VHSPM are:

Achieved target	✓
0% to 5% below target	⦸
>5% below target	✕

Frequency of reporting and data collection

Data is expected to be submitted by health services monthly via VAED. This KPI is included in the SoP but not the PMF.

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.

Definition

This indicator includes adult mental health patients who are admitted overnight or longer in hospital.

Exclusions are overnight separations for ECT, transfers to other acute hospitals or to residential aged care, and patients who leave against medical advice or abscond.

Calculating performance

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.

Denominator: The number of non-sameday separations from adult general acute psychiatric inpatient units.

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

Statewide benchmark

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

Performance is monitored on a quarterly basis. The thresholds used to reflect performance results are:

Less than or equal to 14%	✓
15% to 17%	⃠
18% to 20%	⃠
Greater than 20%	✕

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.

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–November 2010–11.

This KPI is in the SoP but not included in the PMF.

SERV KPI 14 Post discharge follow-up rate

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.

Definitions

This indicator applies to all Area Mental Health Services in Victoria that provide adult acute mental health services.

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.

Calculating performance

This KPI is expressed as a percentage of post discharge follow-ups on the total number of non-sameday acute adult separations.

Numerator: Number of post discharge follow-ups within seven days

Denominator: Total non-sameday acute mental health adult separation to a private residence or residential aged care.

Statewide benchmark

The statewide benchmark for this KPI has been set at 75 per cent of adult acute separations to home to be followed up with seven days.

Performance is monitored on a quarterly basis. The thresholds used to reflect performance results are:

Greater than or equal to 75%	✓
71% to 74%	⃠
60% to 70%	⃠
Less than 60%	✕

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.

Separations are lagged seven days to allow all post discharge follow-ups during the reporting period to be captured. For example, Quarter 1 will report the separations from 24 June 2010 to 23 September 2010. This KPI is in the SoP but is not included in the PMF.

SERV KPI 15 Seclusion rate

Reducing restraint and seclusion is a national safety priority and inclusion of this indicator ensures appropriate monitoring of seclusion use in adult acute inpatient units in Victoria.

Definitions

This indicator comprises adult acute inpatient services provided by public mental health services and includes adult acute admissions as well as ORYGEN Youth Health and 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 hours of the admission events that overlap with the reporting period are counted. The hours for each adult acute admission event are then summed and divided by 24 to give the total occupied bed days for the campus for the reporting period.

Any period of seclusion relating to an adult acute admission, that overlaps with the reporting period is counted. Any period of seclusion that crosses a boundary between two reporting periods will be counted in both. This is by design, but means that quarterly results may sum to a slightly higher figure than YTD or full year figures.

Calculating performance

The rate of seclusion will be calculated as follows:

Numerator: Total adult acute seclusion events during the reference period

Denominator: Total adult acute occupied beddays during the reference period

The number of seclusions is divided by the number of occupied bed days. The quotient is then multiplied by 1000.

Statewide benchmark

The statewide benchmark for this KPI has been set at no more than 20 seclusions per 1000 bed days.

Performance is monitored on a quarterly basis. The thresholds used to reflect performance results are:

Less than or equal to 20/1,000	✓
21/1000 to 25/1,000	⦸
26/1000 to 30/1,000	⦸
Greater than 30/1,000	✕

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.

This KPI is in the SoP but is not included in the PMF.

8 Contact Details

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

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Manager, Performance Support and Strategy
Performance, Acute Programs and Rural Health
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Health Services with data submission issues may contact the
Health Data Standards and Systems Unit:

Assistant Director, Health Information
Department of Health
GPO Box 4057
Melbourne 3001
Ph: (03) 9096 7456