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| Victorian Health Services Performance Monitoring Framework 2025–26 |
| Business rules |
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# Introduction

All Victorian public health services including Ambulance Victoria and the Victorian Institute of Forensic Mental Health (Forensicare), agree to an annual Statement of Priorities (SoP) with the Minister for Health. The SoPs outline key performance expectations, targets, funding and department priorities for the financial year. The Department of Health (the department), as the system manager, ensures SoPs align with public health services’ plans and department policy directions.

The SoPs consist of four parts:

1. Part A provides an overview of service profiles, strategic priorities and deliverables for the upcoming financial year
2. Part B provides key financial, access and service performance priorities and targets
3. Part C outlines funding and associated activity
4. Part D contains the service agreement between each health service and the State of Victoria under the National Health Reform Agreement.

The Victorian Health Services Performance Monitoring Framework (PMF) details the mechanisms used to monitor health service performance against the SoPs. It promotes transparency, shared accountability for performance improvement and informs future policy and planning. It defines the roles of the department and Safer Care Victoria (SCV) in developing and monitoring best practice measures for implementing health service performance strategies.

This document complements the PMF by outlining the business rules for each performance measure contained within Part B of the SoP and the Victorian Health Services Performance Monitor (Monitor) report.

## Accountability and monitoring

Health services remain accountable for performance measures not listed in the PMF business rules as mandated by legislation. Removed measures will remain under departmental risk monitoring in the Program Report for Integrated Service Monitoring (PRISM) as:

* Shadow measures which support the development of new measures, baselines and targets, valid for two financial years
* Supplementary measures which provide additional information to support SoP measures, valid for three financial years.

Measures that have been superseded or are no longer considered best practice have been removed from all reports.

# Change summary

This section summarises key changes to SoP Part B measures including updated targets and reporting requirements. Key changes to Ambulance Victoria and Forensicare SoP Part B measures are summarised in appendices A and B, respectively.

## High quality and safe care

| Key performance measure | Change | Commentary |
| --- | --- | --- |
| The gap between the number of Aboriginal patients who left against medical advice compared to non-Aboriginal patients​ | **Rename to:** The difference between the percentage of Aboriginal and/or Torres Strait Islander patients and non-Aboriginal and/or non-Torres Strait Islander patients who left against medical advice | **Rationale:** Improves clarity and focus of the measure |
| The gap between the number of Aboriginal patients who did not wait presenting to hospital emergency departments compared to non-Aboriginal patients​ | **Rename to:** The difference between the percentage of Aboriginal and/or Torres Strait Islander patients and non-Aboriginal and/or non-Torres Strait Islander patients presenting to emergency departments who did not wait to be treated | **Rationale:** Improves clarity and focus of the measure |
| Percentage of consumers/families/carers reporting a ‘very good’ or ‘excellent’ overall experience of the service | **Business rule change:** Separate existing measure into the following:   * Percentage of consumers who rated their overall experience with a service in the last three months as positive * Percentage of families/carers reporting a ‘very good’ or ‘excellent’ overall experience of the service | **Rationale:** Measure was previously a consolidation of two separate measures supported by discrete surveys and questions. Keeping the measures separate is a robust and statistically sound approach. |

## Strong governance, leadership and culture

No changes to measures in this domain.

## Timely access to care

| Key performance measure | Change | Commentary |
| --- | --- | --- |
| Number of community mental health service hours | **New measure** accompanied by a health service specific target | **Rationale:** Ensures maintenance of effort following transition to Activity Based Funding. |
| Percentage of patients transferred from ambulance to emergency department within 40 minutes | **Target change:**   * Statewide target changed to greater than or equal to 80 per cent or at least 3 per cent improvement on prior year performance, with progress expected towards 90 per cent (Statewide). * Differential or ‘tiered’ targets introduced and set at the health service campus level[[1]](#endnote-2) | **Rationale:** Reflects expectation for continuous improvement. |
| Average ED length of stay (non-admitted), in minutes | **Rename to:** Average ED length of stay for non-admitted patients, in minutes | **Rationale:** Renamed to align with other length of stay measures. |
| Average ED length of stay (admitted), in minutes | **Rename to:** Average ED length of stay for admitted patients, in minutes  **Business rule change:** Departures to Short Stay Units (SSU) and Mental Health and AOD Hub SSUs no longer in scope  **Target change:** Less than or equal to 414 minutes or at least 5 per cent improvement on the same time last year | **Rationale:** Changes reflect consideration of past performance and renaming to align with other length of stay measures. |
| Percentage of patients on the waiting list who have waited longer than clinically recommended for their respective triage category | **Target change:** Target to remain at 25 per cent improvement compared to the same time last year; however, health services previously exempt from this target will now have the existing target applied[[2]](#endnote-3). | **Rationale:** Overachieving health services were exempt from the target in 2024–25. As there are no overachievers based on 2024–25 performance exemption is not necessary. |
| Optimisation of surgical inpatient length of stay, including through use of virtual and home-based pre- and post-operative models of care | **Target change:** Reduction in average LOS for surgical patients by at least 2 per cent on prior year performance | **Rationale:** Terminology updated for consistency with other targets and to reduce the need to update the reference year each performance cycle. |
| Percentage of admitted bed days delivered at home | **Target change:** Health service specific | **Rationale:** Improves accountability and considers previous performance of individual health services. |
| Average Inpatient length of stay, in minutes | **Measure removal** | **Rationale:** Sector feedback indicates the measure is not useful. An alternative measure will be developed for subsequent cycles. |

## Effective financial management

| Key performance measure | Change | Commentary |
| --- | --- | --- |
| Variance between forecast and actual Net result from transactions (NRFT) for the current financial year ending 30 June | **Rename to:** Variance between the forecast and actual operating result (OR) as a percentage of the forecast OR for the current financial year ending 30 June.  **Business rules change:** Variance between the forecast and actual OR as a percentage of the forecast OR for the current financial year | **Rationale:** Operating result forecast is a more useful indicator of financial performance |

# 2025–26 Key performance measures

## High quality and safe care

| Program | Measure | Target |
| --- | --- | --- |
| Infection prevention and control | Percentage of healthcare workers immunised for influenza | 94 per cent |
| Continuing care | Average change in the functional independence measure (FIM) score per day of care for rehabilitation separations | Greater than or equal to 0.645 |
| Adverse events | Percentage of reported sentinel events for which a root cause analysis (RCA) report was submitted within 30 business days from notification of the event | All sentinel event reports submitted within 30 business days from notification |
| Aged care | Public Sector Residential Aged Care Services overall star rating | 100 per cent of services at 3 stars or above |
| Patient experience | Percentage of patients who reported positive experiences of their hospital stay | 95 per cent |
| Aboriginal health | The difference between the percentage of Aboriginal and/or Torres Strait Islander patients and non-Aboriginal and/or non-Torres Strait Islander patients who left against medical advice | 0 per cent |
| Aboriginal health | The difference between the percentage of Aboriginal and/or Torres Strait Islander patients and non-Aboriginal and/or non-Torres Strait Islander patients presenting to emergency departments who did not wait to be treated | 0 per cent |
| Mental health patient experience | Percentage of consumers who rated their overall experience with a service in the last three months as positive | 80 per cent |
| Mental health patient experience | Percentage of families/carers reporting a ‘very good’ or ‘excellent’ overall experience of the service | 80 per cent |
| Mental health patient experience | Percentage of families/carers who report they ‘always’ or ‘usually’ felt their opinions as a carer were respected | 90 per cent |
| Mental health patient experience | Percentage of mental health consumers reporting they ‘usually’ or ‘always’ felt safe using this service | 90 per cent |
| Mental health seclusions | Rate of seclusion episodes per 1,000 occupied bed days – Inpatient | Less than or equal to 6 episodes |
| Mental health readmissions | Percentage of consumers re-admitted within 28 days of separation – Inpatient | Less than 14 per cent |
| Mental health post discharge follow-up | Percentage of consumers followed up within 7 days of separation – Inpatient | 88 per cent |

## Strong governance, leadership and culture

| Program | Measure | Target |
| --- | --- | --- |
| Organisational culture | People matter survey – Percentage of staff with an overall positive response to safety culture survey questions | 80 per cent |

## Timely access to care

| Program | Measure | Target |
| --- | --- | --- |
| Planned surgery | Percentage of urgency category 1 planned surgery patients admitted within 30 days | 100 per cent |
| Planned surgery | Percentage of planned surgery patients admitted within the clinically recommended time | 94 per cent |
| Planned surgery | Number of patients admitted from the planned surgery waiting list | Health service specific |
| Planned surgery | Percentage of patients on the waiting list who have waited longer than clinically recommended for their respective triage category | Greater than or equal to 25 per cent proportional improvement on prior year performanceii |
| Planned surgery | Optimisation of surgical inpatient length of stay (LOS), including through use of virtual and home-based pre- and post-operative models of care | Reduction in average LOS for surgical patients by at least 2 per cent on prior year performance |
| Emergency care | Percentage of patients transferred from ambulance to emergency department within 40 minutes | Statewide:   * Greater than or equal to 80 per cent **or** at least 3 per cent improvement on the same time last year   Health Services:   * This measure is assessed at the campus level; campus level targets are dependent on the assigned performance tieri |
| Emergency care | Number of patients with a length of stay in the emergency department greater than 24 hours | 0 |
| Emergency care | Average ED length of stay for non-admitted patients, in minutes | Less than or equal to 240 minutes **or** at least 3 per cent improvement on the same time last year |
| Emergency care | Average ED length of stay for admitted patients, in minutes | Less than or equal to 414 minutes **or** at least 5 per cent improvement on the same time last year |
| Mental health | Percentage of mental health-related emergency department presentations with a length of stay of less than 4 hours | 65 per cent |
| Mental health | Percentage of departures from emergency departments to a mental health bed within 8 hours | 80 per cent |
| Mental Health | Number of admitted mental health occupied bed days | Health service specific |
| Mental Health | Number of community mental health service hours | Health service specific |
| Specialist clinics | Percentage of patients referred by a GP or external specialist who attended a first appointment within the recommended timeframe[[3]](#endnote-4) | 95 per cent |
| Home based care | Percentage of admitted bed days delivered at home | Health service specific |

## Effective financial management

| Program | Measure | Target |
| --- | --- | --- |
| Effective financial management | Operating result ($M) | Health service specific |
| Effective financial management | Adjusted Current Asset Ratio (ACAR) | Greater than or equal to 0.7 **or** at least 3 per cent improvement from health service base target |
| Effective financial management | Variance between the forecast and actual operating result (OR) as a percentage of the forecast OR for the current financial year ending 30 June | Less than or equal to 5 per cent variance |

# Business rules

## High quality and safe care

### Infection prevention and control

#### Percentage of healthcare workers immunised for influenza

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| --- | --- |
| Measure | Percentage of healthcare workers immunised for influenza[[4]](#endnote-5),[[5]](#endnote-6) |
| Description | High coverage rates of immunisation in healthcare workers (HCW) are essential to reduce the risk of influenza transmission in healthcare settings.  This measures the percentage of eligible staff who were vaccinated against influenza. Eligible staff are those who were permanently, temporarily, or casually (bank staff) employed by the nominated hospital / health service (including residential aged care services and community health staff) and worked one or more shifts during the influenza vaccination campaign. |
| Calculating performance | The audit period used to calculate the rate of HCW immunisation is  7 April to 15 August.  The HCW categories used are aligned with the Australian Commission on Safety and Quality in Health Care (ACSQHC) Australian guidelines for prevention and control of infection in healthcare. Details can be found at [Vaccination for healthcare workers, Department of Health](https://www.health.vic.gov.au/immunisation/vaccination-for-healthcare-workers) <https://www.health.vic.gov.au/immunisation/vaccination-for-healthcare-workers>. |
| Numerator | Number of category A, B and C HCW vaccinated as at 15 August. |
| Denominator | Number of category A, B and C HCW employed who worked one or more shifts during the influenza vaccination campaign (7 April to 15 August). |
| Statewide target | 94 per cent |
| Achieved | Greater than or equal to 94 per cent |
| Not achieved | Less than 94 per cent |
| Improvement | For the purpose of the performance risk assessment, improvement is assessed against the previous year performance. |
| Frequency of reporting and data collection | Performance is monitored and assessed annually and reported in Q1 at the health service level.  Data on vaccination rates must be submitted to Victorian Nosocomial Infection Surveillance System ([VICNISS](http://www.vicniss.org.au/)) Coordinating Centre <http://www.vicniss.org.au> by 31 August. If possible, data should be submitted by HCW category.  Where data are not submitted, the target is deemed to be not achieved. |

### Continuing care

#### Average change in the functional independence measure (FIM) score per day of care for rehabilitation separations

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| --- | --- |
| Measure | Average change in the functional independence measure (FIM) score per day of care for rehabilitation separations |
| Description | The FIM™ instrument is a basic measure of patient disability and is used to track changes in the functional ability of a patient during an episode of hospital rehabilitation.  Patient function is assessed using the FIM™ instrument at the start of a rehabilitation episode of care and at the end of a rehabilitation episode of care. Admission assessment is collected within 72 hours of the start of a rehabilitation episode. Discharge assessment is collected within 72 hours prior to the end of a rehabilitation episode.  FIM™ is comprised of 18 items, grouped into two subscales ‒ motor and cognition ‒ each of which is assessed against a seven-point ordinal scale, where the higher the score for an item, the more independently the patient can perform the tasks assessed by that item. Total scores range from 18 to 126.  A low FIM™ score is a good measure of need for subacute bed-based care due to reduced function.  A higher FIM™ score may indicate that care through the Health Independence Program may be as effective in meeting the patient’s needs. |
| Calculating performance | FIM™ efficiency is measured by the difference between FIM™ on discharge and FIM™ on admission divided by the number of days of the episode of care.  This measure applies to all health services providing admitted rehabilitation care. It excludes Geriatric Evaluation and Management care, palliative care, non-acute care and paediatric rehabilitation. |
| Numerator | Sum of (Separation FIM Total Score minus Admission FIM Total Score) for all rehabilitation patients |
| Denominator | Sum of length of stay for all rehabilitation patients, excluding leave days |
| Statewide target | Greater than or equal to 0.645 |
| Achieved | Greater than or equal to 0.645 |
| Not achieved | Less than 0.645 |
| Improvement | For the purpose of the performance risk assessment, improvement is assessed against the previous quarter performance. |
| Frequency of reporting and data collection | Performance is reported quarterly at the health service level with a one quarter lag.  Data extracted from Victorian Admitted Episodes Dataset (VAED) |

### Adverse events

#### Percentage of reported sentinel events for which a root cause analysis (RCA) report was submitted within 30 business days from notification of the event

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| --- | --- |
| Measure | Percentage of reported sentinel events for which a root cause analysis (RCA)[[6]](#endnote-7) report was submitted within 30 business days from notification of the eventiv |
| Description | In Victoria a ‘sentinel event’ refers to an ‘unexpected and adverse event that occurs infrequently in a health service entity and results in the death of, or serious physical or psychological injury (category 11 only) to a patient as a result of system and process deficiencies at the health service entity.[[7]](#endnote-8) This measure is a trigger for discussion regarding quality, safety and improvement in health services, as well as compliance with mandatory reporting of sentinel events.  The sentinel event program aims to improve health service system design and delivery through shared learning from a defined range of serious adverse events (sentinel events).  Increasing numbers of sentinel events are concerning, particularly in the context of other safety and quality risks. Very low numbers may be a sign of an under-reporting culture. Of most importance is the timeliness of the response and effectiveness of the action taken to prevent re-occurrence.  Safer Care Victoria (SCV) coordinates the Victorian sentinel event program. All public and private health services, as well as the services under their governance[[8]](#endnote-9) are required to notify SCV within three business days of becoming aware of a sentinel and provide a report outlining a plan to prevent recurrence. A copy of the sentinel event report must be submitted to SCV within 30 business days of the notification.  Under special circumstances an extension beyond 30 business days may be provided by SCV. In these instances, this measure will be assessed against the new agreed submission date. |
| Calculating performance | This measure captures numbers of notifiable sentinel events for which a sentinel event report is submitted within 30 business days from notification of the event to SCV.  Health services that do not have any sentinel event reports due or have not submitted any sentinel event reports during the reference period will be assigned N/A for this measure.  Reportable sentinel events must meet the criteria for the Australian sentinel event (ASE) categories or those that fall under the Victorian only category 11.  Further information regarding the sentinel events program, reporting requirements and sentinel event criteria is available via the [Victorian sentinel events guide](https://www.safercare.vic.gov.au/best-practice-improvement/publications/sentinel-events-guide) <https://www.safercare.vic.gov.au/best-practice-improvement/publications/sentinel-events-guide> |
| Numerator | Number of sentinel event RCA forms submitted within 30 business days. |
| Denominator | Number of sentinel events with an RCA report due within or submitted during the reporting period.  Exclusions: sentinel events with a ‘withdrawn’ flag |
| Statewide target | All sentinel event reports submitted within 30 business days |
| Achieved | All sentinel event reports submitted within 30 business days |
| Not achieved | At least one sentinel event report not submitted within 30 business days |
| Improvement | For the purpose of the performance risk assessment, improvement is assessed against the previous quarter performance. |
| Frequency of reporting and data collection | Performance is reported quarterly and annually at the health service level. Data are sourced from the SCV Sentinel event data collection. |

### Aged care

#### Public Sector Residential Aged Care Services (PSRACS) overall star rating

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| --- | --- |
| Measure | Public Sector Residential Aged Care Services (PSRACS) overall star rating |
| Description | PSRACS Star Ratings for residential aged care were introduced by the Australian Government in response to recommendations from the Royal Commission into Aged Care Quality and Safety. They provide information about a provider’s quality of care and how they compare to others. The overall rating is based on a provider’s performance across four key areas of compliance, quality measures, resident’s experience, and staffing. |
| Calculating performance | This measure is calculated as the percentage of facilities managed by a Health Service with an overall rating of 3 or above.  The overall star rating is derived from weighting applied to each sub-category (compliance, quality measures, resident’s experience and staffing) rating.  Includes all PSRACS, except National Aboriginal and Torres Strait Islander Flexible Aged Care program services, Multi-Purpose Services or for aged care provided in the home, as all required data are not currently reported by these service types  For detailed information on the calculation of the overall star rating please refer to the [Department of Health and Aged Care – Star Ratings Provider Manual](https://www.health.gov.au/resources/publications/star-ratings-provider-manual?language=en) <https://www.health.gov.au/resources/publications/star-ratings-provider-manual?language=en>. |
| Numerator | Total number of facilities with an overall star rating of 3 or above |
| Denominator | Total number of facilities |
| Statewide target | 100 per cent of facilities with an overall star rating of 3 or above |
| Achieved | 100 per cent |
| Not achieved | Less than 100 per cent |
| Improvement | For the purpose of the performance risk assessment, improvement is assessed against the previous quarter performance. |
| Frequency of reporting and data collection | Performance is reported quarterly at the facility level with a one quarter lag.  Data sourced from the Australian Institute of Health and Welfare – GEN Aged care Star Ratings quarterly data extract |

### Patient experience

#### Percentage of patients who reported positive experiences of their hospital stay

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| --- | --- |
| Measure | Percentage of patients who reported positive experiences of their hospital stay |
| Description | Patient experience measures provide a patient-centred perspective on interactions with healthcare providers. Monitoring insights from these measures contributes to improving the provision of care and strengthens the relationship between patients and care providers. These measures contribute to overall safety and quality monitoring within the health system. |
| Calculating performance | The percentage of patients (or where patient is not able to report, their primary informal carer) who responded, 'Very good' or 'Good' to the question:  *‘Overall, how would you rate the care you received from the hospital?*’ in the adult inpatient section of the Victorian Healthcare Experience Survey (VHES) collected at all health services except Royal Children’s Hospital  or:  ‘*Overall, how would you rate the care your child received from the hospital?*’ in the inpatient section of the Victorian Paediatric Inpatient Survey collected at Royal Children’s Hospital only. |
| Numerator | Weighted sum of ‘Good’ or ‘Very good’ responses to the question: *'Overall, how would you rate the care you received while in hospital?*’ or ‘*Overall, how would you rate the care your child received from the hospital?*’ |
| Denominator | Weighted sum of all responses to the question *'Overall, how would you rate the care you received while in hospital?*' or ‘*Overall, how would you rate the care your child received from the hospital?*’ |
| Statewide target | 95 per cent |
| Achieved | Greater than or equal to 95 per cent |
| Not achieved | Less than 95 per cent |
| Improvement | For the purpose of the performance risk assessment, improvement is assessed against the previous quarter performance. |
| Frequency of reporting and data collection | Performance is reported quarterly at the health service level with a one quarter lag. Data are sourced from the VHES.  Results are reported at health service level. |

### Aboriginal health

#### The difference between the percentage of Aboriginal and/or Torres Strait Islander patients and non-Aboriginal and/or non-Torres Strait Islander patients who left against medical advice

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| --- | --- |
| Measure | The difference between the percentage of Aboriginal and/or Torres Strait Islander patients and non-Aboriginal and/or non-Torres Strait Islander patients who left against medical advice |
| Description | This measure reports the difference between the percentage of Aboriginal and/or Torres Strait Islander admitted patients who left against medical advice compared to non-Aboriginal and/or non-Torres Strait Islander admitted patients. |
| Calculating performance | This measure includes patients with a:   * Care Type = ‘4’   This measure excludes patients with a:   * Separation Mode = ‘S’ Statistical separation * Indigenous status code = ‘8’ Question unable to be asked or ‘9’ Patient refused to answer.   The denominator for the percentage of Aboriginal and/or Torres Strait Islander patients who left against medical advice is the number of patient episodes that satisfy the following condition:   * Indigenous status code = ‘1’ - Aboriginal but not Torres Strait Islander origin, ‘2’ - Torres Strait Islander but not Aboriginal origin, or ‘3’ - Both Aboriginal and Torres Strait Islander origin.   For non-Aboriginal and/or non-Torres Strait Islander patients, the denominator is the number of patient episodes that satisfy the following condition:   * Indigenous status code = ‘4’ - Neither Aboriginal nor Torres Strait Islander origin.   The numerator in both percentages is the number of patient episodes in the respective denominators that satisfy the following condition:   * Separation mode = ‘Z’ - Left against medical advice.   This measure is rounded to the nearest whole number.  Results are not reported where either percentage has a denominator less than 10. |
| Numerator | Percentage of non-Aboriginal and/or non-Torres Strait Islander admitted patients with a separation mode of ‘left against medical advice’ (Separation Mode Code = Z)  *minus*  Percentage of Aboriginal and/or Torres Strait Islander admitted patients with a separation mode of ‘left against medical advice’ (Separation Mode Code = Z) |
| Denominator | N/A |
| Statewide target | 0 per cent |
| Achieved | No difference between Aboriginal and/or Torres Strait Islander and non-Aboriginal and/or non-Torres Strait Islander patients |
| Not achieved | A difference between Aboriginal and/or Torres Strait Islander and non-Aboriginal and/or non-Torres Strait Islander patients |
| Improvement | For the purpose of the performance risk assessment, improvement is assessed against the previous quarter performance. |
| Frequency of reporting and data collection | Performance is reported quarterly at the health service level.  Data are sourced from the Victorian Admitted Episodes Dataset (VAED) |

#### The difference between the percentage of Aboriginal and/or Torres Strait Islander patients and non-Aboriginal and/or non-Torres Strait Islander patients presenting to ED who did not wait to be treated

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| --- | --- |
| Measure | The difference between the percentage of Aboriginal and/or Torres Strait Islander patients and non-Aboriginal and/or non-Torres Strait Islander patients presenting to hospital emergency departments who did not wait to be treated |
| Description | This measure reports the difference between the percentage of Aboriginal and/or Torres Strait Islander and non-Aboriginal and/or non-Torres Strait Islander emergency department patients who did not wait for treatment. |
| Calculating performance | This measure excludes patients with:   * Departure status code = ‘8’ Dead on Arrival * Departure status code = ‘30’ Left after clinical advice regarding treatment options - GP co-located clinic or Priority Primary Care Centre (PPCC) * Indigenous status code = ‘8’ Question unable to be asked or ‘9’ Patient refused to answer. * Victorian Virtual Emergency Department (VVED) presentations * Other virtual care presentations   The denominator for the percentage of Aboriginal and/or Torres Strait Islander patients who did not wait to be treated is the number of emergency presentations that satisfy the following condition:   * Indigenous status code of ‘1’ - Aboriginal but not Torres Strait Islander origin, ‘2’ - Torres Strait Islander but not Aboriginal origin, or ‘3’ - Both Aboriginal and Torres Strait Islander origin   For non-Aboriginal and/or non-Torres Strait Islander patients, the denominator is the number of emergency presentations that satisfy the following condition:   * Indigenous status code = ‘4’ - Neither Aboriginal nor Torres Strait Islander origin   The numerator in both percentages is the number of emergency presentations in the respective denominators that satisfy the following condition:   * Departure status code = ‘11’ - Left at own risk, without treatment   This measure is rounded to the nearest whole number.  Results are not reported where either percentage has a denominator less than 10. |
| Numerator | Percentage of Aboriginal and/or Torres Strait Islander emergency department presentations with a departure mode of ‘did not wait’ (Departure status code = 11).  *minus*  Percentage of non-Aboriginal and/or non-Torres Strait Islander emergency department presentations with a departure mode of ‘did not wait’ (Departure status code = 11). |
| Denominator | N/A |
| Statewide target | 0 per cent |
| Achieved | No difference between Aboriginal and/or Torres Strait Islander and non-Aboriginal and/or non-Torres Strait Islander patients |
| Not achieved | A difference between Aboriginal and/or Torres Strait Islander and non-Aboriginal and/or non-Torres Strait Islander patients |
| Improvement | For the purpose of the performance risk assessment, improvement is assessed against the previous quarter performance. |
| Frequency of reporting and data collection | Performance is reported quarterly at the campus level  Data are sourced from the Victorian Emergency Minimum Dataset (VEMD). |

### Mental health patient experience

#### Percentage of consumers who rated their overall experience with a service in the last three months as positive

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| --- | --- |
| Measure | Percentage of consumers who rated their overall experience of care with a service in the last 3 months as positive iv |
| Description | Personalised care and support is one of three national mental health and suicide prevention information priorities. It includes collecting and publishing consumer experience data at a range of levels to embed consumer experience of care at the heart of discussions about mental health services. Consumer surveys are a key part of efforts to embed and amplify the voices of mental health consumers in service improvement.  Additionally, the principles of the *Mental Health and Wellbeing Act 2022* require mental health and wellbeing service providers to:   * support the dignity and autonomy of people living with mental illness or psychological distress * ensure people are involved in decisions about their treatment, care and support * recognise the role of families, carers and supporters * ensure the service system responds to the diverse needs and preferences of Victorians.   These principles apply to all mental health and wellbeing service providers. |
| Calculating performance | Percentage of Your Experience of Service (YES) survey respondents reporting a positive overall experience of care in the last 3 months with a clinical mental health service provider.  The average score of questions 1-22 is calculated for each respondent, where scores range from 1 to 5 (responses of 4 and 5 are ‘positive’). A respondent with an average score greater than or equal to 4 is considered to have reported a positive rating of their overall experience of care in the last three months.  Only valid responses are used to calculate an average score and only respondents with valid responses to at least 12 of questions 1-22 are included.  Health services with less than 30 valid respondents (i.e. where a valid respondent is one who had a valid answer to at least 12 of questions 1-22) are not reported separately but contribute to the statewide results. |
| Numerator | Number of respondents whose average score to questions 1-22 is greater than or equal to 4. |
| Denominator | Number of survey respondents who had a valid answer to at least 12 of questions 1-22 of the YES survey. |
| Statewide target | 80 per cent |
| Achieved | Greater than or equal to 80 per cent |
| Not achieved | Less than 80 per cent |
| Improvement | For the purpose of the performance risk assessment, improvement is compared to previous period performance. |
| Frequency of reporting and data collection | Performance is reported annually by health service.  Data are sourced from the YES survey (clinical services). The YES survey is generally collected during a defined census period each year. Participation is based on health services providing the questionnaire to recipients. At least 30 responses are required to enable statistically significant analysis. |

#### Percentage of families/carers reporting a ‘very good’ or ‘excellent’ overall experience of service

|  |  |
| --- | --- |
| Measure | Percentage of families/carers reporting a ‘very good’ or ‘excellent’ overall experience of service iv |
| Description | Personalised care and support is one of three national mental health and suicide prevention information priorities. It includes collecting and publishing consumer experience data at a range of levels to embed consumer experience of care at the heart of discussions about mental health services. Carer experience surveys are a key part of efforts to embed and amplify the voices of mental health carers in service improvement.  Additionally, the principles of the *Mental Health and Wellbeing Act 2022* require mental health and wellbeing service providers to:   * support the dignity and autonomy of people living with mental illness or psychological distress * ensure people are involved in decisions about their treatment, care and support * recognise the role of families, carers and supporters * ensure the service system responds to the diverse needs and preferences of Victorians.   These principles apply to all mental health and wellbeing service providers.  Clinical best practice requires identification, recognition, and involvement of families and carers, including children, across the service continuum. Clinicians should actively engage with families and carers as an essential part of mental health service delivery and acknowledge that some consumers may not want their families involved or some families may not want to be involved. |
| Calculating performance | The percentage of valid responses to the Carer Experience of Service (CES) survey responding with 'Very good' or 'Excellent' to the overall experience question on each survey. |
| Numerator | Number of ‘Very good’ or ‘Excellent’ or responses to question 26, ‘*Overall, how would you rate your experience as a carer with this mental health service over the last six months?’*. |
| Denominator | Number of valid responses to question 26 ‘*Overall, how would you rate your experience as a carer with this mental health service over the last six months?’.*  The denominator excludes ‘don’t know’ or missing responses. |
| Statewide target | 80 per cent |
| Achieved | Greater than or equal to 80 per cent |
| Not achieved | Less than 80 per cent |
| Improvement | For the purpose of the performance risk assessment, improvement is compared to previous period performance. |
| Frequency of reporting and data collection | Performance is reported annually by health service.  Data are sourced from the CES survey. The CES survey is generally collected during a defined census period each year. Participation is based on health services providing the questionnaire to recipients. At least 30 responses are required to enable statistically significant analysis. |

#### Percentage of families/carers who report they ‘always’ or ‘usually’ felt their opinions as a carer were respected

|  |  |
| --- | --- |
| Measure | Percentage of families/carers reporting they ‘usually’ or ‘always’ felt their opinions as a carer were respected iv |
| Description | A key principle under the department’s *Mental Health Lived Experience Framework* includes valuing the experience and opinions of all those involved by providing meaningful opportunities and support to enable participation of families/carers. |
| Calculating performance | The percentage of carers who responded with ‘Usually’ or 'Always' to the question, ‘*Your opinion as a carer was respected’*. |
| Numerator | Number of ‘Usually’ or ‘Always’ responses to the question: ‘*Your opinion as a carer was respected’.* |
| Denominator | Number of valid responses to the question: ‘*Your opinion as a carer was respected’.*  The denominator excludes ‘don’t know’ or missing responses. |
| Statewide target | 90 per cent |
| Achieved | Greater than or equal to 90 per cent |
| Not achieved | Less than 90 per cent |
| Improvement | For the purpose of the performance risk assessment, improvement is compared to previous period performance |
| Frequency of reporting and data collection | Performance is reported annually by Designated Mental Health Service.  Data are sourced from the CES.  Participation is based on health services providing the questionnaire to in-scope consumers. At least 30 responses are required to enable statistically significant analysis. |

#### Percentage of mental health consumers reporting they ‘usually’ or ‘always’ felt safe using this service

|  |  |
| --- | --- |
| Measure | Percentage of consumers who reporting they ‘usually’ or ‘always’ felt safe using this service iv |
| Description | Patient safety is the prevention of harm to patients from the care that is intended to help them. Safety is an essential part of delivering quality care and a fundamental principle of person-centred care. Patients may be the most reliable reporters of some aspects of healthcare processes; their perspectives should be considered when pursuing changes to improve patient safety. |
| Calculating performance | Percentage of YES survey respondents reporting that in the last 3 months they ‘usually’ or ‘always’ felt safe using this service.  The denominator excludes:   * invalid responses to any question, * ‘not completed’ and ‘not needed’ responses. |
| Numerator | Number of consumers responding ‘Always’ or ‘Usually’ to the prompt (3): ‘*You felt safe using the service’* |
| Denominator | Number of consumers completing YES surveys with a valid response. |
| Statewide target | 90 per cent |
| Achieved | Greater than or equal to 90 per cent |
| Not achieved | Less than 90 per cent |
| Improvement | For the purpose of the performance risk assessment, improvement is compared to previous period performance |
| Frequency of reporting and data collection | Performance is reported annually by Designated Mental Health Service.  Data are sourced from the YES survey.  Participation is based on health services providing the questionnaire to in-scope consumers. At least 30 responses are required to enable statistically significant analysis. |

### Mental health readmissions and seclusions and follow-up

#### Rate of seclusion episodes per 1,000 occupied bed days – Inpatient

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| --- | --- |
| Measure | Rate of seclusion episodes per 1,000 occupied bed days ‒ Inpatient iv |
| Description | Reducing restraint and seclusion is a priority and incorporating this measure ensures appropriate monitoring of seclusion use in mental health inpatient units in Victoria. |
| Calculating performance | This measure calculates the rate of ended seclusion episodes within mental health inpatient units per 1,000 occupied bed days. Seclusion episodes ending within a mental health inpatient unit are counted. The number of seclusion episodes is divided by the number of occupied bed days. The quotient is then multiplied by 1,000.  Includes admission events that were open during the reference period and have an Admission Event Type in 'SA','R','A','T'.  Occupied bed days per admission event are calculated by taking the difference in minutes between the start date and time and end date and time, then converting the time difference into days. Exclude leave days, virtual wards, and units without a seclusion room.  When a seclusion episode is not recorded against an admitted episode as required (i.e., the admission ID is not recorded, or where the service location code is '3', '12' or '13'), the seclusion episode is recorded against the mental health inpatient unit where the consumer had an open admitted episode at the start of the seclusion episode.  Mental health inpatient units are determined at the CMI/ODS subcentre level. |
| Numerator | The number of seclusion episodes ended within a mental health inpatient unit. |
| Denominator | The number of occupied bed days within a mental health inpatient unit. |
| Statewide target | Less than or equal to 6 seclusion episodes per 1,000 bed days  **Forensicare**: Less than or equal to 6 seclusion episodes per 1,000 bed days or at least 5 per cent improvement |
| Achieved | Less than or equal to 6 seclusion episodes per 1,000 bed days  **Forensicare**: Less than or equal to 6 seclusion episodes per 1,000 bed days or at least 5 per cent improvement |
| Not achieved | Greater than 6 seclusion episodes per 1,000 bed days  **Forensicare**: Greater than 6 seclusion episodes per 1,000 bed days and less than 5 per cent improvement |
| Improvement | For the purpose of the performance risk assessment, improvement is compared to previous quarter performance |
| Frequency of reporting and data collection | Performance is reported quarterly and annually by health service.  Data are sourced from the Client Management Interface (CMI) / Operational Data Store (ODS). |

#### Percentage of consumers re-admitted within 28 days of separation – Inpatient

|  |  |
| --- | --- |
| Measure | Percentage of consumers re-admitted within 28 days of separation ‒ Inpatient |
| Description | Specialist mental health services are aimed primarily at people with a serious mental illness or mental disorder who have associated significant levels of disturbance and psychosocial disability due to their illness or disorder. Readmission rates for mental health consumers can reflect the quality of care, effectiveness of discharge planning and level of support provided to patients after discharge, as well as other factors. |
| Calculating performance | This measure calculates the percentage of non-same day separations from mental health inpatient units where the consumer was re-admitted (planned or unplanned) to any mental health inpatient unit within 28 days of separation.  Excludes: same day admissions; consumers that were originally separated because they were transferred to another inpatient unit or absconded; overnight ECT admissions (where ECT occurred on the day of separation).  Re-admissions exclude admissions to the following specialty inpatient units: Mother/Baby, Eating Disorder, PICU and Neuropsychiatry.  Mental health inpatient units are determined at the CMI/ODS subcentre level. |
| Numerator | Number of readmissions (planned or unplanned) to any mental health inpatient unit within 28 days of separation from a mental health inpatient unit. |
| Denominator | Total number of separations from a mental health inpatient unit, where the consumer was discharged home or to a residential service. |
| Statewide target | Less than 14 per cent |
| Achieved | Less than 14 per cent |
| Not achieved | Greater than or equal to 14 per cent |
| Improvement | For the purpose of the performance risk assessment, improvement is compared to previous quarter performance |
| Frequency of reporting and data collection | Performance is reported annually and quarterly by Designated Mental Health Service. Data are lagged by one month.  Data are sourced from the Client Management Interface (CMI) / Operational Data Store (ODS). |

#### Percentage of consumers followed up within 7 days of separation – Inpatient

|  |  |
| --- | --- |
| Measure | Percentage of consumers followed up within 7 days of separation – Inpatient |
| Description | A responsive, post-discharge community support system is essential for consumers who have experienced a mental health admission to maintain clinical and functional stability, and to minimise the need for readmission.  Consumers discharged after a mental health admission with linkages to community services and supports are less likely to be at risk of readmission.  Research indicates that mental health consumers have increased vulnerability immediately following discharge, including higher risk for suicide. |
| Calculating performance | This measure calculates the percentage of non-same day separations from a mental health inpatient unit where the consumer was discharged to a private residence or accommodation, for which an ambulatory service contact was recorded in the 7-days post-separation, excluding contact made on the date of separation.  Contacts can be of any duration, in any location for any type of recipient, carried out by the local mental health service or another mental health service.  Excludes same day stays.  Mental health inpatient units are determined at the CMI/ODS subcentre level. Performance is calculated based on the campus of separation. |
| Numerator | Number of separations from an inpatient unit to private residence/ accommodation where the consumer was contacted within 7 days post separation. |
| Denominator | Number of separations from a mental health inpatient unit to private residence/ accommodation. |
| Statewide target | 88 per cent |
| Achieved | Greater than or equal to 88 per cent |
| Not achieved | Less than 88 per cent |
| Improvement | For the purpose of the performance risk assessment, improvement is compared to previous quarter performance |
| Frequency of reporting and data collection | Performance is reported annually and quarterly by health service.  The separation date is between the start of the reporting period (minus seven days) and the end of the reporting period (minus seven days). Separations are lagged by seven days to allow all post-discharge follow-up in the reporting period to be captured. For example, separations from 24 June to 24 September are included if the reporting period is from 1 July to 30 September.  Performance is reported for the periods:   * 1 July to 30 September in quarter 1 * 1 October to 31 December in quarter 2 * 1 January to 31 March in quarter 3 * 1 April to 30 June in quarter 4.   Data are sourced from the Client Management Interface (CMI)/ Operational Data Store (ODS). |

### Ambulance Victoria

#### Percentage of respondents who rated their overall experience with the ambulance services as ‘satisfied’ or ‘very satisfied’

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| --- | --- |
| Measure | Percentage of respondents who rated their overall experience with the ambulance services as ‘satisfied’ or ‘very satisfied’.[[9]](#endnote-10) |
| Description | This measures the proportion of emergency patients, relatives or carers who were satisfied or very satisfied with the most recent experience using the ambulance service.  The patient satisfaction measure is reported annually in the *Report on Government Services.*  Patient experience measures provide a patient-centred perspective on interactions with ambulance services. Monitoring insights from these measures contributes to improving the provision of ambulance services. These measures contribute to overall safety and quality monitoring within the health system. |
| Calculating performance | The Council of Ambulance Authorities (CAA) conducts an annual survey to monitor the service quality and satisfaction ratings of ambulance services. The survey is based on a random sample of at least 3,000 (Code 1 and 2) patients.  Known deceased patients, cardiac arrest patients and children aged under five years are excluded from the random selection process to avoid the risk of distressing family members or carers.  Data are collected by Ambulance Victoria and submitted to the CAA.  Performance results are based on the findings of the CAA annual survey and exclude nil/don’t know responses and those that failed to identify if the respondent was a ‘patient’ or a ‘relative/care of the patient’.  This measure is expressed as a whole number percentage. |
| Numerator | Number of completed surveys from Code 1 and 2 respondents (patients, relatives or carers) who were satisfied or very satisfied when answering the question: ‘*How satisfied were you overall with your last experience using the Ambulance service?*’ |
| Denominator | Total number of completed surveys from Code 1 and 2 respondents (patients, relatives or carers) with a valid rating of the last experience using the ambulance service. |
| Statewide target | 95 per cent |
| Achieved | Greater than or equal to 95 per cent |
| Not achieved | Less than 95 per cent |
| Improvement | For the purpose of the performance risk assessment, improvement is compared to previous year performance. |
| Frequency of reporting and data collection | Performance is reported annually in Q4 at the statewide level.  Data are sourced from the Council of Ambulance Authorities (CAA) annual survey |

#### Percentage of respondents who rated the level of care provided by paramedics as ‘good’ or ‘very good’

|  |  |
| --- | --- |
| Measure | Percentage of respondents who rated the overall level of care provided by ambulance paramedics as ‘good’ or ‘very good’ ix |
| Description | The CAA conducts an annual survey to measure the service quality and satisfaction ratings of ambulance services. The patient satisfaction measure is reported annually in the *Report on Government Services.*  This measure indicates the proportion of respondents who reported that the level of care provided by ambulance paramedics was ‘good’ or ‘very good.’ |
| Calculating performance | The Council of Ambulance Authorities (CAA) conducts an annual survey to monitor the service quality and satisfaction ratings of ambulance services. The survey is based on a random sample of at least 3,000 (Code 1 and 2) patients.  Known deceased patients, cardiac arrest patients and children aged under five years are excluded from the random selection process to avoid the risk of distressing family members or carers.  Data is collected by Ambulance Victoria and submitted to the CAA.  Performance results are based on the findings of the CAA annual survey and exclude nil/don’t know responses and those that failed to identify if the respondent was a ‘patient’ or a ‘relative/care of the patient’.  This measure is expressed as a whole number percentage. |
| Numerator | Number of completed surveys from Code 1 and 2 respondents (patients, relatives or carers) who rated the level of care provided by ambulance paramedics as ‘good’ or ‘very good’ |
| Denominator | Total number of completed surveys from Code 1 and 2 respondents (patients, relatives or carers) with a valid rating of the care provided by ambulance paramedics. |
| Statewide target | 95 per cent |
| Achieved | Greater than or equal to 95 per cent |
| Not achieved | Less than 95 per cent |
| Improvement | For the purpose of the performance risk assessment, improvement is compared to previous year performance. |
| Frequency of reporting and data collection | Performance is reported annually in Q4 at the statewide level.  Data are sourced from the Council of Ambulance Authorities (CAA) annual survey |

#### Percentage of patients experiencing severe cardiac or traumatic pain whose level of pain was reduced significantly

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| --- | --- |
| Measure | Percentage of patients experiencing severe cardiac or traumatic pain whose level of pain was reduced significantly ix |
| Description | Adequate relief of pain is one of a series of key measures of the clinical effectiveness of interventions by paramedics. The measure of the proportion of patients experiencing severe cardiac or traumatic pain, whose level of pain is significantly reduced, focuses the attention of the organisation on the effectiveness of clinical interventions in two common areas of service provision – cardiac care and trauma care.  Assessment of pain severity and the extent of relief that paramedics can provide is central to the provision of appropriate care.  This measure calculates the difference between the initial pain score and the final pain score according to Ambulance Victoria’s [Clinical Practice Guidelines](https://www.ambulance.vic.gov.au/paramedics/clinical-practice-guidelines/) <https://www.ambulance.vic.gov.au/paramedics/clinical-practice-guidelines/>. |
| Calculating performance | Patients experiencing severe pain are defined as those having an initial pain score of 8 or more, with pain measured out of 10.  A patient is deemed to have had a significant reduction in pain if the difference between their initial and final pain score is 2 or more.  Excludes: patients with a Glasgow Coma Score less than 9; intubated patients; patients unable to rate pain; patients who have less than 2 recorded pain scores and patients who refuse analgesia.  This measure is expressed as a percentage to one decimal place.  Includes patients of all ages experiencing traumatic pain and patients who are 15 years old or older with cardiac pain. |
| Numerator | Total number of adult cardiac, adult trauma and paediatric trauma patients with an initial pain score assessed as 8 or more experiencing a reduction in score of 2 or more |
| Denominator | Total number of adult cardiac, adult trauma and paediatric trauma patients with an initial pain score assessed as 8 or more |
| Statewide target | 90 per cent |
| Achieved | Greater than or equal to 90 per cent |
| Not achieved | Less than 90 per cent |
| Improvement | For the purpose of the performance risk assessment, improvement is compared to previous quarter performance. |
| Frequency of reporting and data collection | Performance is reported quarterly at the statewide level.  Data are sourced from Ambulance Victoria. |

#### Percentage of adult stroke patients transported to definitive care within 60 minutes

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| --- | --- |
| Measure | Percentage of adult stroke patients transported to definitive care within 60 minutes ix |
| Description | This measure calculates ambulance response to adult patients (15 years or older) suspected of having a stroke within the last six hours who are transported within 60 minutes to a health service with the capability to deliver intravenous thrombolysis.  The early recognition of stroke symptoms and the timing and the destination to which patients are transported are critical to ensuring optimal outcomes for stroke patients.  A list of health services providing thrombolysis for stroke patients can be found at [HealthVic statewide frameworks for acute stroke services](https://www2.health.vic.gov.au/hospitals-and-health-services/quality-safety-service/clinical-networks/clinical-network-stroke/stroke-statewide-frameworks) <https://www2.health.vic.gov.au/hospitals-and-health-services/quality-safety-service/clinical-networks/clinical-network-stroke/stroke-statewide-frameworks>. |
| Calculating performance | Excludes inter-hospital transfers, patients with an estimated stroke onset of greater than six hours, patients with significant pre-existing disability, or patients dependent on others for daily living.  This measure is expressed as a percentage to one decimal place. |
| Numerator | Total number of adult patients suspected of having a stroke and meeting the above criteria who were transported within 60 minutes to a health service with the capability to deliver intravenous thrombolysis. |
| Denominator | Total number of adult patients suspected of having a stroke and meeting the above criteria |
| Statewide target | 90 per cent |
| Achieved | Greater than or equal to 90 per cent |
| Not achieved | Less than 90 per cent |
| Improvement | For the purpose of the performance risk assessment, improvement is compared to previous quarter performance. |
| Frequency of reporting and data collection | Performance is reported quarterly at the statewide level.  Data are sourced from Ambulance Victoria. |

#### Percentage of major trauma patients that meet destination compliance (by 45 minutes)

|  |  |
| --- | --- |
| Measure | Percentage of major trauma patients that meet destination compliance (by 45 minutes) ix |
| Description | This measures ambulance response to patients with major trauma who are transported to a major trauma service or to the highest-level designated trauma service within 45 minutes of the ambulance departing the scene.  Mortality and morbidity can be reduced by effective field triage, treatment, and transport of severely injured patients to specialised trauma hospitals.  Major trauma patients are defined by the Victorian State Trauma Registry. This process relies on hospital diagnostic procedures, and in-hospital treatment data, which causes a lag of one quarter for all data. |
| Calculating performance | Excludes inter-hospital transports and patients not meeting the Ambulance Victoria Trauma Triage Guidelines.  This measure is expressed as a percentage to one decimal place. |
| Numerator | Number of major trauma patients transported to a major trauma service or to the highest-level designated trauma service within 45 minutes travel time (from scene departure) |
| Denominator | Number of patients with major trauma as per the Ambulance Victoria Trauma Triage Guidelines. |
| Statewide target | 85 per cent |
| Achieved | Greater than or equal to 85 per cent |
| Not achieved | Less than 85 per cent |
| Improvement | For the purpose of the performance risk assessment, improvement is compared to previous quarter performance. |
| Frequency of reporting and data collection | Performance is reported quarterly at the statewide level.  Reported data are lagged by one quarter.  Data are sourced from Ambulance Victoria. |

#### Percentage of adult cardiac arrest patients surviving to hospital

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| --- | --- |
| Measure | Percentage of adult cardiac arrest patients surviving to hospital ix |
| Description | The cardiac arrest survival-to-hospital rate is measured as the percentage of adult patients in out-of-hospital cardiac arrest who initially present in a shockable rhythm where any chest compressions and/or defibrillation was undertaken by ambulance/EMS (fire brigade first responders, community emergency response teams or ambulance) or where defibrillation was performed by a public access defibrillator (PAD) and who have a return to spontaneous circulation (palpable pulse) on arrival at hospital.  Cardiac arrest survival is strongly impacted by Emergency Medical Services (EMS) response times, clinical interventions, and treatments. |
| Calculating performance | Data are collected and reported according to the internationally recognised Utstein template and definitions.  Includes adult patients (15 years or older) who are in ventricular fibrillation or pulseless ventricular tachycardia (VF/VT) on EMS arrival for whom resuscitation is commenced (minimum is cardiopulmonary resuscitation) by EMS or patients defibrillated by PAD.  Excludes cardiac arrests witnessed by EMS and patients where vital signs at hospital are unknown.  This measure is expressed as a percentage to one decimal place. |
| Numerator | The number of adult VF/VT cardiac arrest patients with a palpable pulse on arrival at hospital |
| Denominator | The total number of in-scope adult VF/VT cardiac arrest patients |
| Statewide target | 50 per cent |
| Achieved | Greater than or equal 50 per cent |
| Not achieved | Less than 50 per cent |
| Improvement | For the purpose of the performance risk assessment, improvement is compared to previous quarter performance. |
| Frequency of reporting and data collection | Performance is reported quarterly (using 12-month rolling percentages due to small sample sizes) at the statewide level.  Data are sourced from Ambulance Victoria. |

#### Percentage of adult cardiac arrest patients surviving to hospital discharge

|  |  |
| --- | --- |
| Measure | Percentage of adult cardiac arrest patients surviving to hospital discharge ix |
| Description | This measures the percentage of ventricular fibrillation or pulseless ventricular tachycardia (VF/VT) patients on EMS arrival for whom resuscitation is commenced (minimum is cardiopulmonary resuscitation) by EMS or defibrillated by a Public Access Defibrillator (PAD) who were discharged alive from hospital.  Cardiac arrest survival is strongly impacted by EMS response times, clinical interventions, and treatments. |
| Calculating performance | Data are collected and reported according to the internationally recognised Utstein template and definitions.  The scope of this measure includes adult patients (15 years or older) who are in ventricular fibrillation or pulseless ventricular tachycardia (VF/VT) on EMS arrival as described above.  Excludes cardiac arrests witnessed by EMS and patients where discharge status is unknown.  This measure is expressed as a percentage to one decimal place. |
| Numerator | The number of adult VF/VT cardiac arrest patients discharged alive from hospital |
| Denominator | The total number of adult VF/VT cardiac arrest patients meeting the criteria as described above. |
| Statewide target | 25 per cent |
| Achieved | Greater than or equal to 25 per cent |
| Not achieved | Less than 25 per cent |
| Improvement | For the purpose of the performance risk assessment, improvement is compared to previous quarter performance. |
| Frequency of reporting and data collection | Performance is reported quarterly (using 12-month rolling percentages) the statewide level.  Data are sourced from Ambulance Victoria. |

## Strong governance, leadership and culture

### Organisational culture

#### People Matter survey – Percentage of staff with an overall positive response to safety culture survey questions

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| --- | --- |
| Measure | People Matter survey – Percentage of staff with an overall positive response to safety culture survey questions iv,v |
| Description | Organisational culture can significantly influence patient safety through its impact on effective communication, collaboration, and engagement across the health service. Poor safety cultures have been identified internationally as recurring features of serious failings in care.  Organisational culture surveys (such as the People Matter survey) offer an independent mechanism of assessing staff’s anonymous perception of safety within the organisation.  All Victorian public healthcare organisations must participate in the People Matter survey annually.[[10]](#endnote-11) Health services receive a report on their results and are also benchmarked against other like healthcare organisations.  While staff participation in the survey is voluntary, low participation rates can generate misleading results or signal staff engagement concerns. |
| Calculating performance | This measures the proportion of survey respondents who report positive responses (i.e. ‘agree’ or ‘strongly agree’) across the following organisational climate questions:   * I am encouraged by my colleagues to report any patient safety concerns I may have. * Patient care errors are handled appropriately in my work area. * My suggestions about patient safety would be acted upon if I expressed them to my manager. * The culture in my work area makes it easy to learn from the errors of others. * Management is driving us to be a safety-centred organisation. * This health service does a good job of training new and existing staff. * Trainees in my discipline are adequately supervised. * I would recommend a friend or relative to be treated as a patient here |
| Numerator | The number of ‘agree’ or ‘strongly agree’ responses to in-scope questions. |
| Denominator | The number of valid responses (i.e. ‘agree’, ‘strongly agree’, ‘disagree’, ‘strongly disagree’, ‘neither agree nor disagree’, ‘don’t know’) to in-scope questions. |
| Statewide target | 80 per cent |
| Achieved | Greater than or equal to 80 per cent |
| Not achieved | Less than 80 per cent |
| Improvement | For the purpose of the performance risk assessment, improvement is compared to previous year performance. |
| Frequency of reporting and data collection | Performance is reported annually at the health service level.  Data are sourced from the Victorian Public Sector Commission. |

## Timely access to care

### Planned surgery

Planned surgery performance data are collected via the Elective Surgery Information System (ESIS) to monitor and evaluate the timeliness, efficiency and quality of planned surgery, ensuring patients receive care within clinically recommended timeframes, supporting accountability and improvement in accordance with the *Planned surgery access policy 2024.[[11]](#endnote-12)*

The policy sets out the department’s expectations for access to planned surgery and procedures within Victorian health services. All Victorian health services are required to adhere to the policy regardless of their ESIS reporting status.[[12]](#endnote-13)

#### Percentage of urgency category 1 planned surgery patients admitted within 30 days

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| --- | --- |
| Measure | Percentage of urgency category 1 planned surgery patients admitted within 30 days |
| Description | Urgency category 1 planned surgery patients are those for whom admission within 30 days is desirable for a condition that has the potential to deteriorate quickly to the point that it might become an emergency. |
| Calculating performance | This measure is reported at the health service level. Where a health service has multiple campuses, the aggregate for all campuses is used.  This measure is assessed using records assigned an intended procedure code other than IP401 (Gastroscopy) or IP402 (Colonoscopy)[[13]](#endnote-14) and with a “Readiness Status” code of either:   * ‘R’ ready for surgery * ‘V’ ready for surgery, but delayed due to COVID-19 response.   A patient is counted as being admitted if the admission date falls within the reporting period and the reason for removal is any one of the following:   * ‘W’ – admitted to the intended campus and has received the awaited procedure * ‘S’ – admitted to another campus arranged by ESAS and has received the awaited procedure * ‘X’ – admitted to another campus arranged by this campus/health service and has received the awaited procedure under other contract or similar arrangement * ‘P’ – special purpose, COVID-19  admitted to another campus arranged by this campus/health service and has received the awaited procedure under contract or similar arrangement due to the COVID-19 response.   Assessment of whether an admission was within time is based on the number of days the patient was waiting and ready for surgery.  The measure is expressed as a percentage rounded to two decimal places.  **Performance breach notification**  If a category 1 planned surgery patient is overdue and the event has been verified and confirmed as accurate, the patient will be regarded as a breach for the purposes of performance and a departmental notification procedure must be initiated by the health service. |
| Numerator | Number of urgency category 1 patients admitted within 30 days |
| Denominator | Total urgency category 1 patients admitted |
| Statewide target | 100 per cent |
| Achieved | 100 per cent |
| Not achieved | Less than 100 per cent |
| Improvement | For the purpose of the performance risk assessment, improvement is compared to performance at the same time last year. |
| Frequency of reporting and data collection | Performance is reported monthly at the health service level.  Data are sourced from the Elective Surgery Information System (ESIS). |

#### Percentage of planned surgery patients admitted within clinically recommended time

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| --- | --- |
| Measure | Percentage of planned surgery patients admitted within clinically recommended time |
| Description | All planned surgery patients are allocated an urgency category that indicates the desirable timeframe for admission due to their clinical condition.  The urgency categories are:   * urgency category 1 – admission within 30 days is desirable * urgency category 2 – admission within 90 days is desirable * urgency category 3 – admission within 365 days is desirable. |
| Calculating performance | This measure is reported at the health service level. Where a health service has multiple campuses, the aggregate for all campuses is used.  This measure is assessed using records assigned an intended procedure code other than IP401 (Gastroscopy) or IP402 (Colonoscopy)xiii and with a “Readiness Status” code of either:   * readiness status of ‘R’ (ready for surgery) * readiness status of ‘V’ (ready for surgery, but delayed due to COVID-19 response).   A patient is counted as being admitted if the admission date falls within the reporting period and the reason for removal is any one of the following:   * W – admitted to the intended campus and has received the awaited procedure * S – admitted to another campus arranged by planned Surgery Access Service (ESAS) and has received the awaited procedure * X – admitted to another campus arranged by this campus/health service and has received the awaited procedure under other contract or similar arrangement * P – special purpose, COVID-19  admitted to another campus arranged by this campus/health service and has received the awaited procedure under contract or similar arrangement due to the COVID-19 response   Assessment of whether an admission was within time is based on the number of days the patient was waiting and ready for surgery.  This measure is expressed as a percentage rounded to one decimal place. |
| Numerator | Number of patients admitted within clinically recommended timeframes, aggregated across all urgency categories. |
| Denominator | Total number of patients admitted |
| Statewide target | 94 per cent |
| Achieved | Greater than or equal to 94 per cent |
| Not achieved | Less than 94 per cent |
| Improvement | For the purpose of the performance risk assessment, improvement is compared to performance at same time last year. |
| Frequency of reporting and data collection | Performance is reported monthly at the health service level.  Data are sourced from the Elective Surgery Information System (ESIS). |

#### Percentage of patients on the waiting list who have waited longer than clinically recommended for their respective triage category

|  |  |
| --- | --- |
| Measure | Percentage of patients on the waiting list who have waited longer than clinically recommended for their respective triage category |
| Description | All planned surgery patients are allocated an urgency category that indicates the desirable timeframe for admissions due to their clinical condition.  The urgency categories are:   * urgency category 1 – admission within 30 days is desirable * urgency category 2 – admission within 90 days is desirable * urgency category 3 – admission within 365 days is desirable. |
| Calculating performance | This measure is reported at the health service level. Where a health service has multiple campuses, the aggregate for all campuses is used.  The measure considers the whole waiting list at a health service, not only patients who are ‘ready for surgery’. This includes patients with readiness status of:   * ‘R’ - ready for surgery * ‘S’ – Not ready for surgery – staged patients * ‘F’ – Not ready for surgery – programmed procedure * ‘C’ – Not ready for surgery – pending improvement of clinical condition * ‘P’ – Not ready for surgery – deferred for personal reasons * ‘V’ - ready for surgery but delayed due to COVID-19 response.   The actual time spent on the waiting list is calculated as the number of days between Administrative Registration Date[[14]](#endnote-15) and the Quarter end date during which the patient was waiting and ready for surgery. Elapsed days where the patient was not ready for surgery are excluded.  This measure is assessed using records assigned an intended procedure code other than IP401 (Gastroscopy) or IP402 (Colonoscopy).xiii  This measure is expressed as a percentage rounded to one decimal place.  **Example**  At 30 June (Year 1), Health Service A has:   * 120 patients on the planned surgery waiting list who have waited longer than clinically recommended for their given urgency category (regardless of their current readiness status). * 1,100 patients on the planned surgery waiting list (regardless of readiness status).   Therefore, 10 per cent of patients had waited longer than clinically recommended in Year 1.  At 30 June (Year 2), Health Service A has:   * 75 patients on the planned surgery waiting list who have waited longer than clinically recommended time for their given urgency category (regardless of their current readiness status) * 1,000 patients on the planned surgery waiting list (regardless of readiness status).   In Year 2, 8 per cent of patients had waited longer than clinically recommended.  To calculate performance from the previous year:   (75/1000 – 120/1100)/(120/1100) x100 = -31.3  Therefore, Health Service A had a 31 per cent reduction in patients who waited longer than clinically recommended and has met the target for this measure. |
| Numerator | Total number of patients on the planned surgery waiting list (regardless of readiness status) who have waited longer than clinically recommended times for their respective triage category. |
| Denominator | Total number of patients on the planned surgery waiting list (regardless of readiness status). |
| Statewide target | Greater than or equal to 25 per cent improvement based on prior year result |
| Achieved | Greater than or equal to 25 per cent improvement from prior year ii |
| Not achieved | Less than 25 per cent improvement from prior year |
| Improvement | Performance is monitored against the previous year’s performance |
| Frequency of reporting and data collection | Performance is monitored quarterly and assessed annually at the health service level.  Data are sourced from Elective Surgery Information System (ESIS). |

#### Number of patients admitted from the planned surgery waiting list

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| --- | --- |
| Measure | Number of patients admitted from the planned surgery waiting list |
| Description | This measures the stocks and flows of planned surgery patients and assists in understanding demand management of planned surgery patients. |
| Calculating performance | 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 planned surgery list.  This measure is assessed using records assigned an intended procedure code other than IP401 (Gastroscopy) or IP402 (Colonoscopy).xiii  A patient is counted as being admitted if the admission date falls within the reporting period and the reason for removal is any one of the following:   * W – admitted to the intended campus and has received the awaited procedure * S – admitted to another campus arranged by ESAS and has received the awaited procedure * X – admitted to another campus arranged by this campus/health service and has received the awaited procedure under other contract or similar arrangement. * P – special purpose, COVID-19  admitted to another campus arranged by this campus/health service and has received the awaited procedure under contract or similar arrangement due to the COVID-19 response.   Individual targets are negotiated with each health service and are set at the health service level, rather than individual hospital level. Health services provide the department with phased monthly targets which reflect peaks in emergency demand and seasonal capacity limitations to enable monitoring across the year.  The target will be reported as a year-to-date figure that will be cumulative across the financial year. |
| Numerator | Total number of admitted patients |
| Denominator | N/A |
| Statewide target | As agreed in the SoP for each health service |
| Achieved | Greater than or equal to health service target |
| Not achieved | Less than health service target |
| Improvement | For the purpose of the performance risk assessment, improvement is assessed quarterly based on performance against phased targets, compared to previous quarter performance. |
| Frequency of reporting and data collection | Year to date performance is reported monthly at the health service level.  Data are sourced from the Elective Surgery Information System (ESIS). |

#### Optimisation of surgical inpatient length of stay, including through use of virtual and home-based pre- and post-operative models of care

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| Measure | Optimisation of surgical inpatient length of stay, including through use of virtual and home-based pre- and post-operative models of care |
| Description | This measures the reduction in average inpatient length of stay for planned surgery patients using virtual and home-based pre- and post-operative models of care. |
| Calculating performance | This measure is calculated by comparing the average length of stay of in-scope planned surgery inpatient separations to the prior year average.  In-scope inpatient separations are those for which a matched Elective Surgery Information System (ESIS) waiting list episode exists, where the intended procedure is an ESIS-reportable procedure (excluding IP401 Gastroscopy and IP402 Colonoscopy)xiii, and where the reason for removal is one of the following:   * W - Admitted to the intended campus and has received the awaited procedure * X - Admitted to another campus arranged by this campus/health service and has received the awaited procedure under contract or similar arrangement * S - Admitted to another campus arranged by ESAS and has received the awaited procedure * P - COVID-19 - Admitted to another campus arranged by this campus/health service and has received the awaited procedure under contract or similar arrangement due to the COVID-19 response.   Average length of stay is calculated using the length of stay of planned surgery *acute* inpatient separations, including any *acute* transfers to facilities within the same health service only. Subacute and Hospital in the Home (HITH) length of stay are excluded. Leave days with and without permission are also excluded. The calculation of average length of stay excludes outliers. |
| Numerator | Average length of stay of planned surgery acute inpatient separations. |
| Denominator | N/A |
| Statewide target | 2 per cent reduction in average length of stay of planned surgery inpatient separations compared to previous financial year. |
| Achieved | Greater than or equal to 2 per cent reduction |
| Not achieved | Less than 2 per cent reduction |
| Improvement | For the purpose of the performance risk assessment, improvement is assessed against previous year’s performance |
| Frequency of reporting and data collection | Performance is reported monthly based on year-to-date results and annually at the health service level  Data are sourced from linked Victorian Admitted Episodes Dataset (VAED) and Elective Surgery Information System (ESIS). |

### Emergency care

#### Percentage of patients transferred from ambulance to emergency department within 40 minutes

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| --- | --- |
| Measure | Percentage of patients transferred from ambulance to emergency department within 40 minutesv |
| Description | This measures the percentage of patients who were transferred from paramedic care to hospital emergency care within 40 minutes of ambulance arrival.  Timely handover of patients arriving via ambulance to hospital emergency departments is crucial for delivering responsive and safe emergency care. Improved performance in this area leads to better patient outcomes by enabling faster assessment, diagnosis and treatment. |
| Calculating performance | The ED Departure Date (not Arrival Date) is used to identify presentations in scope for the reporting period.  Ambulance patient transfer time is the total time from ambulance arrival at the hospital (‘at destination time’) to the physical transfer of the patient and handover of care to hospital staff (‘ambulance handover complete’).  The following Arrival Transport Mode (VEMD) codes are applied:   * ‘01’ Air Ambulance – excludes helicopter * ‘02’ Helicopter * ‘03’ Road Ambulance Service.   Exclusions:   * Ambulance Handover In target Flag = ‘U’ (Unknown) * Triage Category = ‘6’ Dead on arrival * Departure status code = ‘30’ Left after clinical advice regarding treatment options - GP co-located clinic or PPCC * VVED presentations * Other virtual care presentations.   This measure is expressed as a percentage rounded to the nearest whole number (0.5 is rounded up). |
| Numerator | Patients arriving by emergency ambulance who are transferred within 40 minutes to the emergency department |
| Denominator | All patients arriving by emergency ambulance who are transferred to the emergency department that are in scope of this measure as defined above. |
| Statewide target | Statewide target: greater than or equal to 80 per cent or 3 per cent improvement on prior year performance with progress expected towards 90 per cent.  Tiered performance targets are set for individual health service campuses to encourage and recognise incremental improvement towards the overall statewide target:   * Tier 1: Greater than or equal to 80 per cent (i.e. maintain performance) * Tier 2: 8 per cent improvement on performance from the same quarter of previous year * Tier 3: 6 per cent improvement on performance from the same quarter of previous year * Tier 4: 4 per cent improvement on performance from the same quarter of previous year.   Ambulance Victoria: 80 per cent or 3 per cent improvement on performance from the same quarter of previous year with progress expected towards 90 per cent  For annual results, percentage improvement will be based on comparison with the performance for the whole of the previous financial year. |
| Achieved | Statewide and Ambulance Victoria: Greater than or equal to 80 percent, or 3 per cent improvement on performance from the same quarter of previous year  Health service campuses:   * Tier 1: Greater than or equal to 80 per cent * Tier 2: Greater than or equal to 8 per cent improvement on performance from the same quarter of previous year * Tier 3: Greater than or equal to 6 per cent improvement on performance from the same quarter of previous year * Tier 4: Greater than or equal to 4 per cent improvement on performance from the same quarter of previous year |
| Not achieved | Statewide and Ambulance Victoria: Less than 80 percent, and less than 3 per cent improvement on performance from the same quarter of previous year  Health service campuses:   * Tier 1: Less than 80 per cent * Tier 2: Less than 8 per cent improvement on performance from the same quarter of previous year * Tier 3: Less than 6 per cent improvement on performance from the same quarter of previous year * Tier 4: Less than 4 per cent improvement on performance from the same quarter of previous year |
| Improvement | For the purpose of the performance risk assessment, improvement is calculated based on same time last year performance. |
| Frequency of reporting and data collection | Performance is reported monthly and annually at the campus level.  Data are sourced from the Victorian Emergency Minimum Dataset (VEMD). |

#### Number of patients with a length of stay in the emergency department greater than 24 hours

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| --- | --- |
| Measure | Number of patients with a length of stay in the emergency department greater than 24 hours |
| Description | This measure monitors the timeliness of discharging or transferring ED patients to an inpatient bed. It reflects the effectiveness of hospital patient flow processes and discharge planning. |
| Calculating performance | Length of stay in ED is calculated as the departure date and time minus the arrival date and time (converted to hours).  The ED Departure Date (not Arrival Date) is used to identify presentations in scope for the reporting period.  Exclusions:   * Triage category = ‘6’ Dead on arrival * Departure status code = ‘30’ Left after clinical advice regarding treatment options - GP co-located clinic or PPCC * VVED presentations * Other virtual care presentations.   **Performance breach notification**  If a patient has exceeded 24hrs length of stay in ED and the event verified as accurate, the patient will be regarded as a breach for the purposes of performance and a departmental notification procedure must be initiated by the health service. |
| Numerator | Number of emergency department presentations with length of stay in ED greater than 24 hours (1,440 minutes). |
| Denominator | N/A |
| Statewide target | 0 |
| Achieved | 0 |
| Not achieved | Greater than 0 |
| Improvement | For the purpose of the performance risk assessment, improvement is calculated based on performance from the same period (quarter or year) in the previous year. |
| Frequency of reporting and data collection | Performance is reported monthly and annually at the campus level.  Data are sourced from the Victorian Emergency Minimum Dataset (VEMD). |

#### Average ED length of stay for admitted patients, in minutes

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| --- | --- |
| Measure | Average emergency department length of stay for admitted patients, in minutes |
| Description | This measures the average length of stay in ED for patients who were admitted to a ward, excluding Short Stay Units (SSUs).  It reflects continuous improvement in the efficiency of timely assessment and treatment of patients in the ED and encourages services to refine their processes across their hospitals, adopt best practices, and implement strategies that minimise the time admitted patients spend in the ED. |
| Calculating performance | Length of stay in ED is calculated as the departure date and time minus the arrival date and time (in minutes)  The ED Departure Date (not Arrival Date) is used to identify presentations in scope for the reporting period.  ED presentations in scope of this measure include the following:   * Presentations that departed ED during the reference period, up to 11:59pm on the reference period end date.   The departure status code is any of the following:   * Transfer to another hospital campus:   ‘17’ Mental Health bed at another hospital campus   * + ‘19’ Another hospital campus   + ‘20’ Another hospital campus - ICU   ‘21’ Another hospital campus - CCU   * Same hospital campus   + ‘14’ Medical Assessment. & Planning Unit   + ‘15’ ICU - this campus   + ‘18’ Ward not elsewhere described   + ‘22’ CCU - this campus   + ‘25’ Mental Health Observation/Assess Unit   + ‘26’ Other Mental Health Bed - this campus   + ‘27’ Cardiac catheter laboratory   + ‘28’ Other operating theatre/procedure room.   Exclusions:   * Triage Category code 6 (Dead on arrival) * VVED presentations * Other virtual care presentations.   This measure is reported at the campus level and expressed as the number of completed minutes rounded to zero decimal places. |
| Numerator | ED length of stay for patients subsequently admitted to hospital |
| Denominator | N/A |
| Statewide target | 5 per cent reduction compared to same period last year. Health services that had an ED length of stay for admitted patients of 414 minutes or less during the same period last year are expected to maintain this level of performance to achieve the target.  Quarterly performances will be compared with performance for the same quarter in the previous year. Annual performance will be compared with performance for the whole of the previous year. |
| Achieved | Average ED length of stay less than or equal to 414 minutes or at least 5 per cent improvement on performance for the same period (e.g. quarter) in the previous year. |
| Not achieved | Average ED length of stay greater than 414 minutes and less than 5 per cent improvement on performance for the same period (e.g. quarter) in the previous year. |
| Improvement | For the purpose of the performance risk assessment, improvement is calculated based on same time last year performance. |
| Frequency of reporting and data collection | Performance is reported monthly, quarterly and annually at the campus level.  Data are sourced from the Victorian Emergency Minimum Dataset (VEMD). |

#### Average ED length of stay for non-admitted patients, in minutes

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| --- | --- |
| Measure | Average emergency department length of stay for non-admitted patients |
| Description | This measures the average length of stay in ED for patients who were not subsequently admitted to hospital.  This measure reflects continuous improvement in the timely assessment, treatment, disposition and transfer of emergency patients who are not admitted and are discharged from the ED. It reflects the processes and models within the ED and effectiveness of hospital patient flow more broadly.  By focusing on this metric, health services aim to provide timely and high-quality care to patients to ensure their prompt assessment, treatment, and discharge. The measure encourages health services to streamline processes, optimise resource allocation, and adopt best practices that minimise waiting times and enhance patient flow. |
| Calculating performance | Length of stay in ED is calculated as the departure date and time minus the arrival date and time (in minutes).  The ED Departure Date (not Arrival Date) is used to identify presentations in scope for the reporting period. The scope includes presentations that departed ED during the reference period, up to 11:59pm on the reference period end date.  The following Departure status (VEMD) codes are applied:   * Return to usual residence:   ‘1’ Home  ‘12’ Correctional/Custodial Facility  ‘23’ Mental Health Residential Facility  ‘24’ Residential care facility   * Departed before treatment completed:   ‘5’ Left at own risk after treatment started  ‘7’ Died within ED  ‘10’ Left after clinical advice regarding treatment options  ‘11’ Left at own risk, without treatment.  Exclusions:   * Triage Category code ‘6’ Dead on arrival * VVED presentations * Other virtual care presentations. * SSUs because they are considered an admitted service.   This measure is reported at the campus level and expressed as the number of completed minutes rounded to zero decimal places. |
| Numerator | ED length of stay for patients who were not subsequently admitted to hospital |
| Denominator | N/A |
| Statewide target | 3 per cent reduction compared to same period last year. Health services that had an average ED length of stay for non-admitted patients of 240 minutes or less during the same period last yearare expected to maintain this level of performance to achieve the target.  Quarterly performances will be compared with performance for the same quarter in the previous year. Annual performance will be compared with performance for the whole of the previous year. |
| Achieved | Average ED length or stay less than or equal to 240 minutes or at least 3 per cent improvement on performance for the same period (e.g. quarter) in the previous year. |
| Not achieved | Average ED length or stay greater than 240 minutes and less than 3 per cent improvement on performance for the same period (e.g. quarter) in the previous year. |
| Improvement | For the purpose of the performance risk assessment, improvement is calculated based on same period last year performance. |
| Frequency of reporting and data collection | Performance is reported monthly, quarterly and annually at the campus level.  Data are sourced from the Victorian Emergency Minimum Dataset (VEMD). |

### Mental health

#### Percentage of mental health-related emergency department presentations with a length of stay of less than four hours

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| --- | --- |
| Measure | Percentage of mental health-related emergency department presentations with a length of stay of less than four hours |
| Description | Percentage of mental health–related presentations to Victorian emergency departments with a length of stay of less than four hours.  This measures the effectiveness of emergency department processes and patient flow. The measure aims to encourage more timely management of people presenting to emergency department for mental health-related reasons who are admitted to the hospital, referred to another hospital or departed within four hours. |
| Calculating performance | The ED Departure Date (not Arrival Date) is used to identify presentations in scope for the reporting period.  Length of stay in ED is calculated as the departure date and time minus the arrival date and time (converted to hours).  Mental health-related emergency department presentations include those flagged with any one of the following:   * A ‘referred by’ code of:   + 16: Mental health telephone assessment/advisory line   + 18: Other mental health staff   + 21: Apprehended under the *Mental Health and Wellbeing Act 2022* – Police/Protective Services Officer * A ‘human intent’ code of:   + 18: Intentional self-harm – non-suicidal self-injury   + 19: Intentional self-harm – suicide attempt   + 20: Intentional self-harm – suicidal intent cannot be determined * A primary or other diagnosis of:   + F01-F99: Mental and behavioural disorders   + Z004: General psychiatric examination, not elsewhere classified   + Z046: General psychiatric examination, requested by authority   + Z915: Personal history of self-harm   + R4581: Suicidal ideation * The ‘seen by mental health practitioner’ date/time field is not null * A ‘departure status’ code of:   + 17: Mental health bed at another hospital campus   + 23: Mental health residential facility   + 25: Mental health observation / assessment unit   + 26: Other mental health bed – this campus   + 31: Mental health and AoD hub short stay unit * A ‘referred to on departure’ code of ‘11’: Mental Health Community Service   Exclusions:   * Triage Category '6' Dead on Arrival. * VVED presentations * Other virtual care presentations * Presentations to Mercy Women's, Royal Women's and Eye and Ear emergency departments.   This measure is measured at the campus level. |
| Numerator | Number of mental health-related emergency department presentations where arrival to departure was less than four hours. |
| Denominator | Number of mental health-related emergency department presentations. |
| Statewide target | 65 per cent |
| Achieved | Greater than or equal to 65 per cent |
| Not achieved | Less than 65 per cent |
| Improvement | For the purpose of the performance risk assessment, improvement is calculated based on same period last year performance. |
| Frequency of reporting and data collection | Performance is reported monthly, quarterly and annually.  Data are sourced from the Victorian Emergency Minimum Dataset (VEMD). |

#### Percentage of departures from emergency departments to a mental health bed within 8 hours

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| --- | --- |
| Measure | Percentage of departures from emergency departments to a mental health bed within 8 hours |
| Description | Percentage of emergency department presentations departing to a mental health bed within 8 hours of arrival to the emergency department.  Mental health services provide a clear and consistent point of entry 24 hours a day, seven days a week, linking consumers and carers to appropriately qualified and experienced mental health professionals, or the right care and supports where a mental health service response is not required.  Monitoring access and response times is an important measure for how clinical models are being developed and implemented in the mental health triage system, to improve triage outcomes and identify areas for service and/or system improvement. |
| Calculating performance | The ED Departure Date (not Arrival Date) is used to identify presentations in scope for the reporting period.  Length of stay in ED is calculated as the departure date and time minus the arrival date and time (converted to hours).  Mental health-related emergency department presentations include those flagged with any one of the following:   * A ‘referred by’ code of:   + 16: Mental health telephone assessment/advisory line   + 18: Other mental health staff   + 21: Apprehended under the *Mental Health and Wellbeing Act 2022* –Police/Protective Services Officer * A ‘human intent’ code of:   + 18: Intentional self-harm – non-suicidal self-injury   + 19: Intentional self-harm – suicide attempt   + 20: Intentional self-harm – suicidal intent cannot be determined * A primary or other diagnosis of:   + F01-F99: Mental and behavioural disorders   + Z004: General psychiatric examination, not elsewhere classified   + Z046: General psychiatric examination, requested by authority   + Z915: Personal history of self-harm   + R4581: Suicidal ideation * The ‘seen by mental health practitioner’ date/time field is not null * A ‘departure status’ code of:   + 17: Mental health bed at another hospital campus   + 23: Mental health residential facility   + 25: Mental health observation / assessment unit   + 26: Other mental health bed – this campus   + 31: Mental health and AoD hub short stay unit * A ‘referred to on departure’ code of ‘11’: Mental Health Community Service   Exclusions:   * Triage Category '6' Dead on Arrival. * VVED presentations * Other virtual care presentations. * Presentations to Mercy Women's, Royal Women's and Eye and Ear emergency   This measure is reported at the campus level. |
| Numerator | Number of emergency department presentations transferred to a mental health bed within 8 hours of arrival. |
| Denominator | Number of emergency department presentations that were transferred to a mental health bed. |
| Statewide target | 80 per cent |
| Achieved | Greater than or equal to 80 per cent |
| Not achieved | Less than 80 per cent |
| Improvement | For the purpose of the performance risk assessment, improvement is calculated based on same period last year performance. |
| Frequency of reporting and data collection | Performance is reported monthly, quarterly and annually.  Data are sourced from the Victorian Emergency Minimum Dataset (VEMD). |

#### Number of admitted mental health occupied bed days

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| --- | --- |
| Measure | Number of admitted mental health occupied bed days |
| Description | This measure calculates the number of occupied bed days within mental health inpatient units and secure extended care units (SECU).  Occupied bed days are used by the department to monitor current levels of mental health activity and operational beds. |
| Calculating performance | Occupied bed days (including leave days) per admission event are calculated by taking the difference in minutes between the start date and time and end date and time, and converting the time difference to days, including part days. For example, 36 hours converts to 1.5 days.  Mental health inpatient units and SECUs are determined at the CMI/ODS subcentre level.  The following bed types are excluded from the calculation:   * Sub-contracted private beds - excluding the Women’s Recovery Network, and * The Victorian Institute of Forensic Mental Health. |
| Numerator | The number of occupied bed days within mental health inpatient units and secure extended care units (SECU), including leave days and same day admissions. |
| Denominator | N/A |
| Statewide target | As agreed in the SoP for each health service |
| Achieved | Greater than or equal to health service target |
| Not achieved | Less than health service target |
| Improvement | For the purpose of the performance risk assessment, improvement is based on same period last year performance |
| Frequency of reporting and data collection | Performance is reported quarterly and annually by Designated Mental Health Service.  Data are sourced from the Client Management Interface (CMI)/ Operational Data Store (ODS). |

#### Number of community mental health service hours

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| Measure | Number of community mental health service hours |
| Description | Service hours are a key component of the Policy and Funding Guidelines for Victorian health services, which articulates the performance and financial framework within which government-funded health sector entities operate. They are a reference for funded organisations regarding the parameters that they are expected to work to and within, as well as the funding linked to various services, in order to achieve the expected outcomes of the Victorian Government. |
| Calculating performance | This measure calculates the number of service hours, by sector, excluding (a) Bouverie Centre, Albury contacts, (b) contacts reported against inpatient or residential services and (c) block funded and PHN commissioned programs.  Step 1: Select reportable contacts that have occurred in the applicable time period.  Apply the following exclusions:   * Contacts reported by The Bouverie Centre (campus code 5910) and Albury (campus code 1691). * Contacts reported against CMI/ODS subcentres that the department has identified as ‘block funded’. * Contacts reported against CMI/ODS subcentres with a setting flag other than ‘community’. * Contacts reported against programs with the funding source of ‘costing’, ‘DHHS block funded’ or ‘PHN commissioned’.   Step 2: Sum the duration of in-scope contacts (in hours) and adjust for group session contacts. For group session contacts, multiply contact duration (in hours) by number of healthcare professionals present and divide by the number of consumers involved. |
| Numerator | Number of community mental health service hours, adjusted for group session contacts. |
| Denominator | N/A |
| Statewide target | As agreed in the SoP for each health service |
| Achieved | Greater than or equal to health service target |
| Not achieved | Less than health service target |
| Improvement | For the purpose of the performance risk assessment, improvement is based on same period last year performance |
| Frequency of reporting and data collection | Performance is reported quarterly and annually by Designated Mental Health Service.  Data are sourced from the Client Management Interface (CMI)/ Operational Data Store (ODS). |

### Specialist clinics

Specialist clinic performance measures aim to improve performance in managing access for patients who are referred to a specialist clinic by a GP or external specialist. Managing patient referrals to specialist clinics, including appointment allocation should be provided in accordance with *Managing referrals to non-admitted specialist services in Victorian public health services policy*.[[15]](#endnote-16)

#### Percentage of patients referred by a GP or external specialist who attended a first appointment within the recommended timeframe

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| --- | --- |
| Measure | Percentage of patients referred by a GP or external specialist who attended a first appointment within the recommended timeframe |
| Description | This measures the proportion of patients referred by a GP or external specialist who attended a first appointment within the recommended timeframe for the relevant clinical priority category (30 days for urgent appointments and 365 days for routine appointments) for non-admitted acute services. |
| Calculating performance | The measure includes all patients referred from either a GP or external specialist who attended a first appointment during the reference period or whose first appointment booked date was during the reference period, whichever date is earlier.  This measure excludes patients who failed to attend a scheduled appointment.  The waiting time for a first appointment is the number of days between the Referral in Received Date and either the first Contact Date/Time within an episode of care or the First Appointment Booked Date, whichever occurs first.  Patients in scope for this measure must satisfy the following criteria:   * Referral In Clinical Urgency Category is:   ‘1’ Urgent  ‘2’ Routine   * Referral In Service Type is:   ‘201’ GP  ‘202’ Specialist.  The measure is reported at the health service level. |
| Numerator | The number of patients referred by a GP or external specialist, who had a first appointment within the clinically recommended timeframe. |
| Denominator | The number of patients referred by a GP or external specialist, who attended a first appointment, or had a first appointment booked date during the reference period. |
| Statewide target | 95 per cent |
| Achieved | Greater than or equal to 95 per cent |
| Not achieved | Less than 95 per cent |
| Improvement | For the purpose of the performance risk assessment, improvement is compared to same time last year performance. |
| Frequency of reporting and data collection | Performance is reported monthly.  Data are sourced from the Victorian Integrated Non-Admitted Health (VINAH) Minimum Dataset. |

### Home based care

#### Percentage of admitted bed days delivered at home

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| --- | --- |
| Measure | Percentage of admitted bed days delivered at home |
| Description | This measures the proportion of total admitted bed days that are delivered to patients in their usual place of residence. |
| Calculating performance | The scope of the measure includes all inpatient episodes with no exclusions.  ‘Total bed days’ are the number of midnights during which a patient receiving admitted care occupies an inpatient bed at the health service. Leave with or without permission are excluded from total bed days.  ‘Bed days delivered at home’ are identified as those in which ‘Accommodation type’ at midnight is coded as ‘4 – Hospital in the Home (HITH).’  Same-day patients who are transferred to HITH accommodation before separation, or whose entire accommodation type is HITH will be included in scope and will have their bed day(s) recorded as ‘at home’. |
| Numerator | Total number of bed days delivered at home |
| Denominator | Total number of bed days delivered |
| Statewide target | As agreed in the SoP for each health service |
| Achieved | Greater than or equal to health service target |
| Not achieved | Less than health service target |
| Improvement | For the purpose of the performance risk assessment, improvement is assessed against the previous year’s performance. |
| Frequency of reporting and data collection | Performance is reported quarterly and annually at the health service level.  Data are sourced from the Victorian Admitted Episodes Dataset (VAED). |

### Ambulance Victoria

#### Percentage of emergency (Code 1) incidents (modified Secondary Triage call start time) responded to within 15 minutes

|  |  |
| --- | --- |
| Measure | Percentage of emergency (Code 1) incidents (modified Secondary Triage call start time) responded to within 15 minutes ix |
| Description | Statewide response times are an indicator of the provision of accessible and effective ambulance service to communities.  Code 1 incidents are potentially life threatening and are time-critical, requiring a lights and sirens response.  Some Code 1 incidents involve a ‘modified Secondary Triage call start time’, where the initial triple zero (000) call is redirected to secondary triage for further assessment. If the incident is subsequently deemed a priority, it is classified as Code 1. In these cases, the response time is measured from the point at which secondary triage confirms the Code 1 classification, rather than the time of the initial call. |
| Calculating performance | Response time is calculated as the time from a triple zero (000) call being answered by the Emergency Services Telecommunications Authority (ESTA) or when Ambulance Victoria’s Triage Services identifies the call requires a Code 1 response, to the time an Ambulance Victoria paramedic, community emergency response team or ambulance community officer first arrives at the incident scene.  This indicator applies to all emergency road Code 1 incidents to which a response had been dispatched.  This indicator excludes:   * incidents for which the response time was recorded as negative, greater than 2 hours or incidents with missing time stamps * responses to ambulance incidents by Fire Rescue Victoria, the Country Fire Authority, NSW Ambulance Service, and remote area nurses * responses by air ambulance resources.   This indicator is expressed as a percentage to one decimal place.  For incidents with a modified Secondary Triage call start time, the response time begins when secondary triage confirms the incident as a Code 1 priority, rather than the initial triple zero (000) call. |
| Numerator | Number of emergency road Code 1 incidents responded to, adjusted for changes in Secondary Triage call start times, where arrival occurred within 15 minutes |
| Denominator | Number of emergency road Code 1 incidents to which a response had been dispatched |
| Statewide target | 90 per cent or 4 per cent improvement on performance from the same period last year |
| Achieved | Greater than or equal to 90 per cent or 4 per cent improvement on performance from the same period last year |
| Not achieved | Less than 90 per cent and below 4 per cent improvement |
| Improvement | For the purpose of the performance risk assessment, improvement is compared to performance at the same period last year (Monthly, quarterly and annually). |
| Frequency of reporting and data collection | Performance is reported monthly.  Data are sourced by Ambulance Victoria |

#### Percentage of emergency (Code 1) incidents responded to within 15 minutes

|  |  |
| --- | --- |
| Measure | Percentage of emergency (Code 1) incidents responded to within 15 minutes ix |
| Description | Statewide response times are a measure of the provision of accessible and effective ambulance service to communities.  Code 1 incidents are potentially life threatening and are time-critical, requiring a lights and sirens response. |
| Calculating performance | Response time measures the time from a triple zero (000) call being answered by the Emergency Services Telecommunications Authority (ESTA) to the time an Ambulance Victoria paramedic, community emergency response team or ambulance community officer first arrives at the incident scene.  This measure applies to all emergency road Code 1 incidents to which a response had been dispatched.  This measure excludes:   * incidents for which the response time was recorded as greater than 2 hours * incidents with missing time stamps * responses to ambulance incidents by Fire Rescue Victoria, the Country Fire Authority, NSW Ambulance Service, and remote area nurses * responses by air ambulance resources.   This measure is reported by region and is expressed as a percentage to one decimal place. |
| Numerator | Number of emergency road Code 1 incidents responded to within 15 minutes |
| Denominator | Number of emergency road Code 1 incidents to which a response had been dispatched |
| Statewide target | 85 per cent or improvement of 4 per cent compared to the same time last year |
| Achieved | Greater than or equal to 85 per cent or 4 per cent improvement compared to the same time last year |
| Not achieved | Less than 85 per cent and below 4 per cent improvement |
| Improvement | For the purpose of the performance risk assessment, improvement is compared to performance at the same time last year (monthly, quarterly and annually). |
| Frequency of reporting and data collection | Performance is reported monthly.  Data are sourced by Ambulance Victoria |

#### Percentage of emergency (Priority 0) incidents responded to within 13 minutes

|  |  |
| --- | --- |
| Measure | Percentage of emergency (Priority Zero) incidents responded to within 13 minutes ix |
| Description | Percentage of emergency (Priority Zero) cases attended within 13 minutes of the Triple Zero (000) call.  Statewide response times are a measure of the provision of accessible and effective ambulance service to communities.  Priority Zero cases are immediately life-threatening emergencies where patient is known or suspected to be in cardiac arrest. |
| Calculating performance | Response time is calculated as the time from a triple zero (000) call being answered by the Emergency Services Telecommunications Authority (ESTA) to the time an Ambulance Victoria paramedic, community emergency response team or ambulance community officer first arrives at the incident scene.  This measure applies to all emergency road Priority Zero incidents to which a response had been dispatched.  This measure excludes:   * incidents for which the response time was recorded as greater than 2 hours * incidents with missing time stamps * responses to ambulance incidents by Fire Rescue Victoria , the Country Fire Authority, NSW Ambulance Service, and remote area nurses * responses by air ambulance resources.   This measure is reported by region and is expressed as a percentage to one decimal place. |
| Numerator | The sum of all first arrival responses from each emergency road Priority Zero incident responded to within 13 minutes |
| Denominator | Total number of emergency road Priority Zero incidents responded to in that same reporting period |
| Statewide target | 85 per cent or improvement of 3 per cent compared to same period last year |
| Achieved | Greater than or equal to 85 per cent or 3 per cent improvement |
| Not achieved | Less than 85 per cent and below 3 per cent improvement |
| Improvement | For the purpose of the performance risk assessment, improvement is compared to performance at the same period last year (monthly, quarterly and annually). |
| Frequency of reporting and data collection | Performance is reported monthly.  Ambulance Victoria submits data to the department monthly. |

#### Percentage of triple zero events where the caller receives advice or service from another health provider as an alternative to emergency ambulance response – statewide

|  |  |
| --- | --- |
| Measure | Percentage of triple zero cases where the caller receives advice or service from another health provider as an alternative to an emergency ambulance response – statewide ix |
| Description | Low-acuity triple zero (000) cases diverted to the Referral Service may be offered a more appropriate alternative to an emergency ambulance dispatch.  A successful referral is when a triple zero call does not result in an emergency ambulance dispatch and is diverted to a non-emergency response or referred to an alternative service provider such as a medical practitioner, nursing service, other health professional service, home self-care or advice.  Ambulance Victoria manages call diversion via a Referral Service that performs a secondary triage with the patient, following the primary triage from the Emergency Services Telecommunications Authority (ESTA) call-taker.  This measure calculates the percentage of triple zero calls statewide that do not result in an emergency dispatch after triage by the Referral Service. |
| Calculating performance | Proportion of triple zero cases where the caller receives advice or service from another health provider or non-emergency ambulance transport as an alternative to emergency ambulance response statewide.  This measure is expressed as a percentage to one decimal place. |
| Numerator | Number of cases managed by the Referral Service that did not result in an emergency response |
| Denominator | Number of triple zero calls that resulted in a referral or emergency first response. |
| Statewide target | 25 per cent or at least 5 per cent improvement compared to same time last year |
| Achieved | Equal to or greater than 25 per cent or 5 per cent improvement |
| Not achieved | Less than 25 per cent and below 5 per cent improvement |
| Improvement | For the purpose of the performance risk assessment, improvement is compared to performance at the same time last year (monthly, quarterly and annually). |
| Frequency of reporting and data collection | Performance is monitored and assessed monthly.  Ambulance Victoria submits data to the department monthly. |

#### Average ambulance hospital clearing time

|  |  |
| --- | --- |
| Measure | Average ambulance hospital clearing time ix |
| Description | This measures the average elapsed time between the time an ambulance paramedic transfers responsibility for a patient to a hospital emergency department and the completion time of all tasks necessary to ensure the ambulance crew is available to respond to another incident.  Clearing time is a key component of total paramedic hospital time that is directly attributable to Ambulance Victoria. |
| Calculating performance | Handover involves a patient being physically transferred to a hospital trolley, bed, chair or waiting area and the responsibility for patient care transferred to the hospital emergency department. Ambulance handover completion time (also known as ‘off-stretcher time’) is recorded in a Patient Care Record (PCR) by a paramedic after agreement with an emergency department clinician.  This measure applies to all emergency ambulance road transports to a hospital emergency department statewide where the emergency presentation departed ED within the reporting period.  This measure excludes:   * hospital transports where the reported clearing time was greater than 3 hours * hospital transports with missing time stamps * transports by air ambulance resources * non-emergency hospital transports * inter-hospital transports.   This measure is reported by region and expressed as minutes to one decimal place. |
| Numerator | The sum of in-scope emergency road clearing times |
| Denominator | The total number of patients transported to hospital |
| Statewide target | 20 minutes |
| Achieved | Less than or equal to 20 minutes |
| Not achieved | Greater than 20 minutes |
| Improvement | For the purpose of the performance risk assessment, improvement is compared to performance at the same period last year (Monthly, quarterly and annually). |
| Frequency of reporting and data collection | Performance is reported monthly with a one month lag.  Data are sourced from Ambulance Victoria’s Patient Care Record (PCR) and are submitted to the department monthly. |

### Forensicare

Forensicare is the trading name for the Victorian Institute of Forensic Mental Health. Forensicare provides adult mental health services in Victoria to people involved in the criminal justice system via the Thomas Embling Hospital.

#### Percentage of male security patients admitted to Thomas Embling Hospital within 7 days of recommendation for compulsory treatment

|  |  |
| --- | --- |
| Measure | Percentage of male security patients admitted to Thomas Embling Hospital within 7 days of recommendation for compulsory treatment [[16]](#endnote-17) |
| Description | This measures the proportion of male security patients admitted to Thomas Embling Hospital within 7 days of being certified as requiring compulsory treatment.  Thomas Embling Hospital manages the care of security patients (prisoners) who require compulsory mental health treatment under the *Mental Health and Wellbeing Act 2022.* |
| Calculating performance | Number of male security patients admitted within 7 days of being certified as requiring compulsory treatment divided by the total number of male security patients certified as requiring compulsory treatment within the reporting period, reported to one decimal place.  Data are lagged by seven days. |
| Numerator | Total number of male security patients admitted to Thomas Embling Hospital within 7 days of being certified as requiring compulsory treatment. |
| Denominator | Total number of male security patients certified as requiring compulsory treatment. |
| Statewide target | Greater than or equal to 80 per cent or 5 percentage point improvement compared to the same time last year |
| Achieved | Greater than or equal to 80 per cent or 5 percentage point improvement |
| Not achieved | Less than 80 per cent and below 5 percentage point improvement |
| Improvement | For the purpose of the performance risk assessment, improvement is compared to previous quarter performance. |
| Frequency of reporting and data collection | Performance is reported quarterly.  Data are sourced from the Client Management Interface (CMI) / Operational Data Store (ODS). |

#### Percentage of female security patients admitted to Thomas Embling Hospital within 7 days of recommendation for compulsory treatment.

|  |  |
| --- | --- |
| Measure | Percentage of female security patients admitted to Thomas Embling Hospital within 7 days of recommendation for compulsory treatment xvi |
| Description | This measures the proportion of female security patients admitted to Thomas Embling Hospital within 7 days of being certified as requiring compulsory treatment.  Thomas Embling Hospital manages the care of security patients (prisoners) who require compulsory mental health treatment under the *Mental Health and Wellbeing Act 2022.* |
| Calculating performance | Number of female security patients admitted within 7 days of being certified as requiring compulsory treatment divided by the total number of female security patients certified as requiring compulsory treatment within the reporting period, reported to one decimal place.  Data are lagged by seven days. |
| Numerator | Total number of female security patients admitted to Thomas Embling Hospital within 7 days of being certified as requiring compulsory treatment. |
| Denominator | Total number of female security patients certified as requiring compulsory treatment. |
| Statewide target | 80 per cent |
| Achieved | Greater than or equal to 80 per cent |
| Not achieved | Less than 80 per cent |
| Improvement | For the purpose of the performance risk assessment, improvement is compared to previous quarter performance. |
| Frequency of reporting and data collection | Performance is reported quarterly.  Data are sourced from the Client Management Interface (CMI) / Operational Data Store (ODS). |

#### Percentage of male security patients discharged from Thomas Embling Hospital to a correctional centre within 21 days

|  |  |
| --- | --- |
| Measure | Percentage of male security patients discharged from Thomas Embling Hospital to a correctional centre within 21 days of admission xvi |
| Description | This measures the proportion of male security patients discharged from Thomas Embling Hospital to a correctional centre within 21 days of admission, excluding same day stays.  Thomas Embling Hospital manages the care of security patients (prisoners) who require compulsory mental health treatment under the *Mental Health and Wellbeing Act 2022.* |
| Calculating performance | The scope for this measure includes:   * separations from Thomas Embling Hospital acute units within the reference period where the consumer was male and on a security order (order codes 105 and 202) at the time of separation. This is based on episode end date, except where a consumer was discharged while on leave, in which case the date sent on leave is used. * male consumers who have not been separated (i.e. open episodes) and were on a security order (order codes 105 and 202) and had length of stay of at least 21 days as at the end of the reference period.   Same day stays (i.e. patient was admitted and discharged on the same day) are excluded from scope.  Length of stay is calculated as the difference in minutes between the episode start date/time and the episode end date/time.  Data are lagged by 21 days. |
| Numerator | Number of separations from Forensicare inpatient units (Thomas Embling Hospital) during the reference period, where the consumer was male, on a security order and had a length of stay less than 21 days. |
| Denominator | Number of separations (regardless of length of stay but excluding same day stays) at Forensicare acute units (Thomas Embling Hospital) plus admitted episodes that have not been separated as at the end of the reference period with a length of stay greater than or equal to 21 days, where the consumer was male and was on a security order (at discharge/end of reporting period). |
| Statewide target | Greater than or equal to 80 per cent or a 5 percentage point improvement compared to the same period last year |
| Achieved | Equal to or greater than 80 per cent or a 5 percentage point improvement |
| Not achieved | Less than 80 per cent and below a 5 percentage point improvement |
| Improvement | For the purpose of the performance risk assessment, improvement is compared to previous quarter performance. |
| Frequency of reporting and data collection | Performance is reported quarterly.  Data are sourced from the Client Management Interface (CMI) / Operational Data Store (ODS). |

#### Percentage of female security patients discharged from Thomas Embling Hospital to a correctional centre within 28 days

|  |  |
| --- | --- |
| Measure | Percentage of female security patients discharged from Thomas Embling Hospital to a correctional centre within 28 days of admission xvi |
| Description | This measures the proportion of female security patients discharged from Thomas Embling Hospital to a correctional centre within 28 days of admission.  The Thomas Embling hospital manages the care of security patients (prisoners) who require compulsory mental health treatment under the *Mental Health and Wellbeing Act 2022.* |
| Calculating performance | The scope for this measure includes:   * separations from Thomas Embling Hospital acute units within the reference period where the consumer was female and on a security order (order codes 105 and 202) at the time of separation. This is based on episode end date, except where a consumer was discharged while on leave, in which case the date sent on leave is used. * female consumers who have not been separated (i.e. open episodes) and were on a security order (order codes 105 and 202) and had length of stay of at least 28 days as at the end of the reference period.   Same day stays (i.e. patients who were admitted and discharged on the same day) are excluded from scope.  Length of stay is calculated as the difference in minutes between the episode start date/time and the episode end date/time.  Data are lagged by 28 days. |
| Numerator | Number of separations from Forensicare inpatient units (Thomas Embling Hospital) during the reference period, where the consumer was female, on a security order and had a length of stay less than 28 days. |
| Denominator | Number of separations (regardless of length of stay but excluding same day stays) at Forensicare acute units (Thomas Embling Hospital) plus admitted episodes that have not been separated as at the end of the reference period with a length of stay greater than or equal to 28 days, where the consumer was female and was on a security order (at discharge/end of reporting period). |
| Statewide target | 80 per cent |
| Achieved | Equal to or greater than 80 per cent |
| Not achieved | Less than 80 per cent |
| Improvement | For the purpose of the performance risk assessment improvement is compared to previous quarter performance. |
| Frequency of reporting and data collection | Performance is reported quarterly.  Data are sourced from the Client Management Interface (CMI) / Operational Data Store (ODS). |

#### Percentage of male security patients discharged within 7 days of becoming a civil client

|  |  |
| --- | --- |
| Measure | Percentage of male security patients at Thomas Embling Hospital discharged within 7 days of becoming a civil client**.**xvi |
| Description | This measures the proportion of male security patients at Thomas Embling Hospital whose security order expired and were discharged to community or a Designated Mental Health Service within 7 days.  The Thomas Embling hospital manages the care of security patients (prisoners) who require compulsory mental health treatment under the *Mental Health and Wellbeing Act 2022*. |
| Calculating performance | The scope for this measure includes all male clients who were admitted to Thomas Embling Hospital acute units, had a security order end (code 105 & 202) during the reference period, and a subsequent civil order.  Those who have had an extension with a subsequent security order or who have returned to Melbourne Assessment Prison (MAP) are excluded.  Data are lagged by seven days. |
| Numerator | Number of in-scope male security patients discharged from Thomas Embling Hospital to the community or an area mental health service within 7 days. |
| Denominator | Number of in-scope male Forensicare inpatient (Thomas Embling Hospital) clients whose security order ended during the reference period and became a civil client. |
| Statewide target | 80 per cent |
| Achieved | Equal to or greater than 80 per cent |
| Not achieved | Less than 80 per cent |
| Improvement | For the purpose of the performance risk assessment, improvement is compared to previous quarter performance. |
| Frequency of reporting and data collection | Performance is reported quarterly.  Data are sourced from the Client Management Interface (CMI) / Operational Data Store (ODS). |

## Effective financial management

### Effective financial management

#### Operating result ($M)

|  |  |
| --- | --- |
| Measure | Operating result ($M) iv,v |
| Description | The Year to Date (YTD) operating result before capital and depreciation.  This is a measure of financial sustainability.  The agreed SoP Operating Result ($M) target aims to achieve an operating surplus necessary to maintain or, where necessary, improve the current operating cash position. This requirement aligns with the department’s reform priority to increase the financial sustainability and productivity of the health system. |
| Calculating performance | The operating result is calculated as the YTD revenue from all sources minus YTD expenses from transactions for all cost centres, before capital and depreciation.  The measure excludes consolidated entities/foundations (with the exception of Monash Health, which includes Jessie McPherson Private Hospital and Western Health which includes the Foundation).  Phased monthly targets are based on the Health Agencies Reporting Tool (HeART) September submission for the current financial year. Changes thereafter are only reported on agreement between the department and the health service, regardless of the data submitted in HeART.  Should the phasings require adjusting; these changes will be considered on a quarterly basis and, where agreed, submitted in the HeART by the health service.  Note that the department does not support retrospective changes to phased targets. |
| Numerator | YTD operating result before capital and depreciation |
| Denominator | N/A |
| Statewide target | As agreed in the SoP for each health service |
| Achieved | Greater than or equal to health service target |
| Not achieved | Less than health service target |
| Improvement | For the purpose of the performance risk assessment, improvement is assessed against the previous quarter, except for Q1 (not assessed). |
| Frequency of reporting and data collection | Performance is reported monthly and annually.  Data are sourced from HeART. The annual result is generated on receipt of audited financial data submitted in HeART. |

#### Adjusted Current Asset Ratio (ACAR)

|  |  |
| --- | --- |
| Measure | Adjusted current asset ratio (ACAR) iv,v |
| Description | This measure assesses the financial liquidity of an organisation by comparing its current assets to its current liabilities.  The generally accepted current asset ratio (CAR) is a financial ratio that measures whether or not an organisation has enough resources to pay its debts over the next 12 months.  The CAR is adjusted to include ‘Long-Term Investments: Other financial assets’ (which excludes Land and Buildings) to recognise the different cash management approaches/ strategies employed by health services. For example, health services may move short-term cash assets into longer term investments, which are not recognised by traditional CAR calculations. Further, the Long Service Leave liability is adjusted to include only the current portion of liability. This uses a factor based on the previous year’s full year balances.  SoP targets recognise the different starting points for health services and focus on achieving performance improvement overtime or maintaining good performance. This aligns with the department’s reform priority to increase the financial sustainability and productivity of the health system. |
| Calculating performance | Performance is measured by the variance between actual ACAR based on the audited 30 June result and the target/benchmark. Targets are based on a health service’s final audited ACAR result for the previous financial year, which form the ‘base’ upon which health services will be measured.  Health services with a base of 0.7 or above (that is, their audited ACAR for the previous year was 0.7 or greater) will obtain full achievement of target provided they maintain their ACAR above 0.7 (statewide benchmark).  Health services starting with a base below 0.7 will be required to achieve a 3 per cent improvement (improvement target) from their base to achieve target. |
| Numerator | The sum of dollar values of current assets and long-term investments, defined by:   * accounts 70001 to 73391: cash at bank and on hand, patient trusts, other trusts, and short-term investments – cash equivalents * accounts 75001 to 75269: long-term investments. |
| Denominator | The sum of dollar values of all short-term liabilities, defined by accounts 80000 to 86699, excluding the non-current portion of long service leave (LSL) liability based on previous year’s per cent of total LSL balance for each health service. |
| Statewide target | 0.7 or 3 per cent improvement from base target |
| Achieved | At least 0.7 or greater than or equal to 3 per cent improvement from health service base target. |
| Not achieved | Less than 0.7 and less than 3 per cent improvement from health service base target. |
| Improvement | For the purpose of the performance risk assessment, improvement is assessed against the phased target results, except for Q1 which is assessed against same time last year performance. |
| Frequency of reporting and data collection | Performance is reported monthly and annually.  Data are sourced from HeART. The annual result is generated on receipt of audited financial data submitted in HeART. |

#### Variance between forecast and actual Operating Result (OR) as a percentage of the forecast OR for the current financial year ending 30 June

|  |  |
| --- | --- |
| Measure | Variance between forecast and actual operating result (OR) as a percentage of the forecast OR for the current financial year ending 30 June iv,v |
| Description | This measures the accuracy of forecasting the OR for the current financial year ending 30 June.  Health services should forecast the OR with sufficient accuracy. Acceptable variance is within five per cent of actual OR. |
| Calculating performance | The result compares the consolidated May forecast OR, as reported to the department on 20 June of the current financial year, in the Health Agencies Reporting Tool (HeART) Revised Estimates submission, with the consolidated actual OR reported in the Comprehensive Operating Statement in the Audited Financial Statements.  This comparison is calculated using numerical variance expressed as a percentage of forecast OR. If the forecast OR is zero, the measure will default to zero.  It is expected that the final HeART consolidated trial balance will accurately reflect the OR as reported in the audited financial statements.  The OR is the sum of all revenue and all expenses from transactions for all cost centres. This will exclude Other economic flows included in the net result. |
| Numerator | The difference between actual OR as reported in the audited financial statements, and the forecast OR as reported in the Revised Estimates HeART submission to the department on 20 June for the current financial year. |
| Denominator | Forecast OR as reported in the Revised Estimates HeART submission to the department by early October for the current financial year. |
| Statewide target | Variance within 5 per cent of forecast OR |
| Achieved | Variance less than or equal to 5 per cent of forecast OR |
| Not achieved | Variance greater than 5 per cent of forecast OR |
| Improvement | Performance is assessed based on the target only and not a reduced variance from the previous year. |
| Frequency of reporting and data collection | Performance is reported in Q4 (April to June) and annually.  Data are sourced from HeART.  The Revised Estimates are updated and provided to the Department of Treasury and Finance multiple times each financial year. As year-end approaches, the forecasts should be most accurate when the Revised Estimates for the final feed to the Department of Treasury and Finance are provided in early June.  These estimates assist the Treasurer in determining the State’s final financial result. |

# Appendices

# Appendix A – Ambulance Victoria

## Ambulance Victoria – Change summary

This section summarises key changes to SoP Part B measures including updated targets and reporting requirements.

### High quality and safe care

No changes to measures in this domain.

### Strong governance, leadership and culture

No changes to measures in this domain.

### Timely access to care

| Key performance measure | Change | Commentary |
| --- | --- | --- |
| Percentage of emergency (Code 1) incidents (modified Secondary Triage call start time) responded to within 15 minutes | **New measure**  **Target:** greater than or equal to 90 per cent or at least 4 per cent improvement from the same time last year | **Rationale:** Inclusion of this measure addresses current performance gaps by providing visibility on potential delays in secondary triage. |
| Percentage of patients transferred from ambulance to emergency department within 40 minutes | **Target change:** greater than or equal to 80 per cent or at least 3 per cent improvement on the same time last year | **Rationale:** Aligns with targets assigned to health services for this same measure with progress expected towards 90%. |
| Percentage of triple zero events where the caller receives advice or service from another health provider as an alternative to emergency ambulance response – statewide | **Target change:** greater than or equal to 25 per cent or at least 5 per cent improvement compared to the same time last year | **Rationale:** Reflects commitment to continue improving response times as AV consistently exceeding previous 20 per cent target, demonstrating capacity for improvement. |
| Percentage of emergency (Code 1) incidents responded to within 15 minutes in centres with a population greater than 7,500 | **Measure removal** | **Rationale:** The state-level ambulance response time metric already provides comprehensive coverage for monitoring code 1 response times across Victoria. The population-specific metric (>7500) creates an artificial subdivision that doesn't align with operational realities or drive additional improvement. The state-level metric maintains a realistic and achievable target without this subdivision.  To continue being monitored and tracked internally. |

### Effective financial management

| Key performance measure | Change | Commentary |
| --- | --- | --- |
| Variance between forecast and actual Net result from transactions (NRFT) for the current financial year ending 30 June | **Rename to:** Variance between the forecast and actual operating result (OR) as a percentage of the forecast OR for the current financial year ending 30 June.  **Business rules change:** variance between the forecast and actual OR as a percentage of the forecast OR for the current financial year | **Rationale:** Operating result forecast is a more useful indicator of financial performance |

## Ambulance Victoria – Key performance measures

### High quality and safe care

| Program | Measure | Target |
| --- | --- | --- |
| Infection prevention and control | Percentage of healthcare workers immunised for influenza | 94 per cent |
| Patient experience | Percentage of respondents who rated their overall experience with the ambulance services as ‘satisfied’ or ‘very satisfied’ | 95 per cent |
| Patient experience | Percentage of respondents who rated the level of care provided by paramedics as ‘good’ or ‘very good’ | 95 per cent |
| Patient experience | Percentage of patients experiencing severe cardiac or traumatic pain whose level of pain was reduced significantly | 90 per cent |
| Patient experience | Percentage of adult stroke patients transported to definitive care within 60 minutes | 90 per cent |
| Patient experience | Percentage of major trauma patients that meet destination compliance (by 45 minutes) | 85 per cent |
| Patient experience | Percentage of adult cardiac arrest patients surviving to hospital | 50 per cent |
| Patient experience | Percentage of adult cardiac arrest patients surviving to hospital discharge | 25 per cent |

### Strong governance, leadership and culture

| Program | Measure | Target |
| --- | --- | --- |
| Organisational culture | People matter survey – Percentage of staff with an overall positive response to safety culture survey questions | 80 per cent |

### Timely access to care

| Program | Measure | Target |
| --- | --- | --- |
| Emergency care | Percentage of patients transferred from ambulance to emergency department within 40 minutes | 80 per cent or 3 per cent improvement on the same time last year |
| Ambulance Victoria | Percentage of emergency (Code 1) incidents (modified Secondary Triage call start time) responded to within 15 minutes | Greater than or equal to 90 per cent or at least 4 per cent improvement compared to same time last year |
| Ambulance Victoria | Percentage of emergency (Code 1) incidents responded to within 15 minutes | Greater than or equal to 85 per cent or at least a 4 per cent improvement compared to same time last year |
| Ambulance Victoria | Percentage of emergency (Priority 0) incidents responded to within 13 minutes | Greater than or equal to 85 per cent or at least a 3 per cent improvement compared to same time last year |
| Ambulance Victoria | Percentage of triple zero events where the caller receives advice or service from another health provider as an alternative to emergency ambulance response – statewide | Greater than or equal to 25 per cent or at least 5 per cent improvement compared to the same time last year |
| Ambulance Victoria | Average ambulance hospital clearing time | 20 minutes |

### Effective financial management

| Program | Measure | Target |
| --- | --- | --- |
| Effective financial management | Operating result ($M) | Service specific |
| Effective financial management | Adjusted Current Asset Ratio (ACAR) | Greater than or equal to 0.7 or at least 3 per cent improvement from health service base target |
| Effective financial management | Variance between the forecast and actual operating result (OR) as a percentage of the forecast OR for the current financial year ending 30 June | Less than or equal to 5 per cent variance |

# Appendix B – Forensicare

## Forensicare – Change summary

This section summarises key changes to SoP Part B measures including updated targets and reporting requirements.

### High quality and safe care

| Key performance measure | Change | Commentary |
| --- | --- | --- |
| Percentage of consumers/families/carers reporting a ‘very good’ or ‘excellent’ overall experience of the service | **Business rule change:** Separate the existing measure into the following:   * Percentage of consumers who rated their overall experience with a service in the last three months as positive * Percentage of families/carers reporting a ‘very good’ or ‘excellent’ overall experience of the service | **Rationale:** Measure was previously a consolidation of two separate measures supported by discrete surveys and questions. Keeping the measures separate is a robust and statistical sound approach. |
| Rate of seclusion episodes per 1,000 occupied bed days - Inpatient | **Target change:** less than or equal to 6 seclusion episodes per 1,000 bed days or at least 5 per cent improvement compared to the same quarter last year. | **Rationale:** Reflects consideration for the unique patient mix served by Forensicare. |

### Strong governance, leadership and culture

No changes to measures in this domain.

### Timely access to care

| Key performance measure | Change | Commentary |
| --- | --- | --- |
| Percentage of male security patients admitted to Thomas Embling Hospital within 7 days of recommendation for compulsory treatment | **Target change:** greater than or equal to 80 per cent or at least a 5-percentage point improvement on the same quarter last year  This measure applies to Forensicare only. | **Rationale:** Acknowledges that Forensicare is unlikely to meet these key performance measures in 2025–26 due to the continuing high demand for Forensicare services.  Timely access to care key performance measures will be reviewed ahead of 2026–27, in the context of new capacity anticipated to come online. |
| Percentage of male security patients discharged from Thomas Embling Hospital to a correctional centre within 21 days | **Target change:** greater than or equal to 80 per cent or at least a 5-percentage point improvement on the same quarter last year  This measure applies to Forensicare only. | **Rationale:** Acknowledges that Forensicare is unlikely to meet these key performance measures in 2025–26 due to the continuing high demand for Forensicare services.  Timely access to care key performance measures will be reviewed ahead of 2026–27, in the context of new capacity anticipated to come online. |

### Effective financial management

| Key performance measure | Change | Commentary |
| --- | --- | --- |
| Variance between forecast and actual Net result from transactions (NRFT) for the current financial year ending 30 June | **Rename to:** Variance between the forecast and actual operating result (OR) as a percentage of the forecast OR for the current financial year ending 30 June.  **Business rules change:** variance between the forecast and actual OR as a percentage of the forecast OR for the current financial year | **Rationale:** Operating result forecast is a more useful indicator of financial performance |

## Forensicare – Key performance measures

### High quality and safe care

| Program | Measure | Target |
| --- | --- | --- |
| Infection prevention and control | Percentage of healthcare workers immunised for influenza | 94 per cent |
| Adverse events | Percentage of reported sentinel events for which a root cause analysis (RCA) report was submitted within 30 business days from notification of the event | All sentinel event reports submitted within 30 business days from notification |
| Mental health patient experience | Percentage of consumers who rated their overall experience with a service in the last three months as positive | 80 per cent |
| Mental health patient experience | Percentage of families/carers reporting a ‘very good’ or ‘excellent’ overall experience of the service | 80 per cent |
| Mental health patient experience | Percentage of families/carers who report they ‘always’ or ‘usually’ felt their opinions as a carer were respected | 90 per cent |
| Mental health patient experience | Percentage of mental health consumers reporting they ‘usually’ or ‘always’ felt safe using this service | 90 per cent |
| Mental health seclusions | Rate of seclusion episodes per 1,000 occupied bed days - Inpatient | Less than or equal to 6 episodes **or** at least 5 per cent improvement compared to the same quarter last year[[17]](#endnote-18) |

### Strong governance, leadership and culture

| Program | Measure | Target |
| --- | --- | --- |
| Organisational culture | People matter survey – Percentage of staff with an overall positive response to safety culture survey questions | 80 per cent |

### Timely access to care[[18]](#endnote-19)

| Program | Measure | Target |
| --- | --- | --- |
| Forensicare | Percentage of male security patients admitted to Thomas Embling Hospital within 7 days of recommendation for compulsory treatment | Greater than or equal to 80 per cent **or** at least a 5-percentage point improvement compared to the same quarter last year[[19]](#endnote-20) |
| Forensicare | Percentage of female security patients admitted to Thomas Embling Hospital within 7 days of recommendation for compulsory treatment. | 80 per cent |
| Forensicare | Percentage of male security patients discharged from Thomas Embling Hospital to a correctional centre within 21 days | Greater than or equal to 80 per cent **or** at least a 5-percentage point improvement compared to the same quarter last year xix |
| Forensicare | Percentage of female security patients discharged from Thomas Embling Hospital to a correctional centre within 28 days | 80 per cent |
| Forensicare | Percentage of male security patients discharged within 7 days of becoming a civil client | 80 per cent |

### Effective financial management

| Program | Measure | Target |
| --- | --- | --- |
| Effective financial management | Operating result ($M) | Service specific |
| Effective financial management | Adjusted Current Asset Ratio (ACAR) | Greater than or equal to 0.7 or at least 3 per cent improvement from health service base target |
| Effective financial management | Variance between the forecast and actual operating result (OR) as a percentage of the forecast OR for the current financial year ending 30 June | Less than or equal to 5 per cent variance |

# Endnotes

1. Differential targets have been set for each individual health service campus to encourage and recognise incremental improvement towards the overall statewide target.

   Tier 1: >= 80%

   Tier 2: 8% improvement from the same time last year

   Tier 3: 6% improvement from the same time last year

   Tier 4: 4% improvement from the same time last year [↑](#endnote-ref-2)
2. If there were no remaining long waiting patients at the end of the reference period, the health service is assessed as having met the target regardless of the improvement rate from the prior year. [↑](#endnote-ref-3)
3. 30 days for urgent patients, 365 days for routine patients [↑](#endnote-ref-4)
4. Measure is also captured in Forensicare’s statement of priorities and dedicated Monitor report [↑](#endnote-ref-5)
5. Measure is also captured in Ambulance Victoria’s statement of priorities and dedicated Monitor report [↑](#endnote-ref-6)
6. The term RCA is used interchangeably with other reports aligned with the applied review methodology such as London Protocol or AcciMap. [↑](#endnote-ref-7)
7. Definition extracted from the Victorian sentinel events guide [↑](#endnote-ref-8)
8. Examples of services managed within the governance structure of health services may include, but are not limited to, Hospital in the Home (HITH), residential aged care facilities and community health services. [↑](#endnote-ref-9)
9. Measure only applies to Ambulance Victoria – refer to Appendix A [↑](#endnote-ref-10)
10. PMS participation is voluntary for publicly funded Victorian denominational health services [↑](#endnote-ref-11)
11. This policy replaces the *Elective surgery access policy 2015* [↑](#endnote-ref-12)
12. All Victorian public health services report to planned surgery data to the department; however, not all services currently report to ESIS. As part of the department’s ESIS Expansion Project, 8 additional rural and regional health services are expected to commence reporting planned surgery activity via ESIS across 2024–25 and 2025–26. [↑](#endnote-ref-13)
13. Principal Prescribed Procedure (PPP) codes of less than 500 are accepted for episodes that were registered before 1 July 2019. [↑](#endnote-ref-14)
14. The Clinical Registration Date is used as the start of the waiting period where the Administrative Registration Date is greater than the Admission or Removal Date. [↑](#endnote-ref-15)
15. This policy replaces the Specialist clinics in Victorian public hospitals: access policy (2013) [↑](#endnote-ref-16)
16. Measure only applies to Forensicare – Refer to Appendix B [↑](#endnote-ref-17)
17. The department acknowledges that Forensicare is unlikely to meet this key performance measure in 2025‒26 due to its unique issue with rates of seclusion. While the target is < 6, Forensicare should also aim for a 5% improvement compared to same time last year. [↑](#endnote-ref-18)
18. The department acknowledges that Forensicare is unlikely to meet these key performance measures in 2025‒26 due to continuing high demand for Forensicare services. Timely access to care key performance measures will be reviewed ahead of 2026‒27, in the context of new capacity anticipated to come online. [↑](#endnote-ref-19)
19. The department acknowledges that Forensicare is unlikely to meet this key performance measure in 2025‒26 due to continuing high demand for Forensicare services. While the target is 80%, Forensicare should also aim for a 5-percentage point improvement compared to same time last year. [↑](#endnote-ref-20)