Key Performance Measures and Underlying Risk Factors 2019–20

August 2019 edition

The *Key Performance Measures and Underlying Risk Factors* (the Business Rules) summarise the list of Key Performance Measures and Underlying Risk Factors, with their corresponding temporal elements and technical specifications.

The Business Rules support and complement the *Victorian health services Performance Monitoring Framework* (the Framework). The Framework details the approach, rationale and operationalisation of the performance monitoring and support of our Victorian health services (published annually).

The most recent version of the Framework is available from:

> [Health.Vic Funding, performance and accountability](https://www2.health.vic.gov.au/hospitals-and-health-services/funding-performance-accountability/performance-monitoring) (refer to 'Performance monitoring')
> <https://www2.health.vic.gov.au/hospitals-and-health-services/funding-performance-accountability/performance-monitoring>

Throughout the Business Rules, the term 'health services' refers to the 'public hospitals', 'public health services' and 'multi-purpose services' listed in the *Health Services Act 1988 (Vic)*, unless otherwise specified.

Where the term 'Aboriginal' is used it refers to both Aboriginal and Torres Strait Islander people. Indigenous is retained when it is part of the title of a report, program or quotation.

Contents

The Business Rules

The *Key Performance Measures and Underlying Risk Factors* (the Business Rules) are the essential indicators, with their corresponding temporal elements and technical specifications, that support and complement the *Victorian health services Performance Monitoring Framework* (the Framework).

The Business Rules provide the list of all indicators that support the Framework, the detailed information to assist with calculating the performance of each indicator, as well as the methodology for assessing performance improvement.

The Business Rules were previously '*Part 2: Indicators Business Rules'* of the 2018-19 Framework and are now published separately from the Framework. This change allows for amendment of the indicators and metrics that support the Framework, as and when necessary, throughout the year. This adjustment reflects a simpler and more flexible approach to performance monitoring.

Key Performance Measures (performance input category 1)

The Key Performance Measures (performance input category 1) of the Framework are the indicators that build a quantifiable data picture of a health service's performance. The Key Performance Measures are used to inform performance risk as well as the Department of Health and Human Services' (the department) monitoring level of the respective health service.

The technical specifications for each Key Performance Measure are also detailed in the Business Rules, which describe and iterate the temporal, and other quantifiable and qualitative, elements of each indicator as well as how to accurately calculate the performance of the indicator.

Key changes for 2019-20 and future directions

Performance monitoring involves a process of continual improvement to ensure measurements are relevant to both system managers and health services, whilst remaining aligned to contemporary methods of service delivery. The Framework, monitoring process and supporting indicators must evolve over time to reflect health service progress, indicator relevance and best practice service delivery.

Several Key Performance Measures that support the 2019–20 Framework have undergone changes (listed in Tables 1a and 1b). For convenience, changes to Key Performance Measures that impact the Statement of Priorities (SOP) are also summarised in Table 1a.

2019-20 is the first instance in which a pipeline of indicator development will be established. Indicators under consideration for future inclusion in the Framework will be reported alongside the Key Performance Measures supporting the Framework. Although they will be reported, they will not impact the performance assessment and level of monitoring of the health service. The indicators will be 'shadowed' and will be a development focus in 2019–20. These indicators may be presented to health services for discussion during formal performance meetings.

Throughout the financial year, each 'shadow' indicator will be evaluated by the department and key stakeholders to determine its eligibility for inclusion in the Key Performance Measures input category of the Framework (performance input category 1). This approach aims to:

- develop a robust evaluation framework for assessing and evaluating proposed, and current, indicators, for inclusion or retainment in the Framework. The evaluation will also be applied to the SOP, where appropriate
- productively and constructively challenge the value of each indicator and, where possible, ensure indicators are future proofed as opposed to cyclic
- provide a transparent process, a platform for planning, and early communications with all stakeholders that may be impacted by these changes.

In 2019–20, areas with indicators under development (planned for shadow reporting) include:

- Percentage valid HoNOS compliance across all age groups and settings
- Your Experience Service Survey results
- Aboriginal health emergency and inpatient care
- Victorian Health Experience Survey results.

As each indicator is developed for reporting they will be added to existing reporting platforms for consideration and discussion at formal performance meetings.

Table 1a: Changes to Key Performance Measures in the Framework (that also impact the SOP)

KPI title	Change	Commentary
Accreditation against the National Safety and Quality Health Service Standards	Relocate	Remove as Key Performance Measure from PMF and SOP (Part B) indicators. Instead include within the existing "*Accountability and funding requirements*" section of the SOP
Compliance with the Hand Hygiene Australia program	Target Change	Increase from 80% to 83%
Percentage of healthcare workers immunised for influenza	Target Change	Increase from 80% to 84%, as the state progresses to 90% over the next four years
Rate of singleton term infants without birth anomalies with Apgar score < 7 to 5 minutes	Reporting Change	The result is to be reported as a 12 month rolling average (currently a six month rolling average)
VHES – Q72. "Overall, how would you rate the care you received from the ambulance service?"	New	New Ambulance Victoria KPI utilising the VHES reported results

Table 1b: Changes to Key Performance Measures in the Framework

KPI title	Change	Commentary
Percentage of staff who personally experienced bullying at work in last 12 months / People Matter Survey responses	Target Change	Decrease from ≥ 20 to ≥ 17% of People Matter Survey responses
Unplanned Readmission paediatric tonsillectomy and adenoidectomy	Relocate & Shadow	Replace with a new paediatric tonsillectomy and adenoidectomy readmission to any hospital (shadow)
Mortality Indicators (Standardised, Acute Myocardial Infarction, FNOF, Stroke, pneumonia)	Relocate & Shadow	This suite of five mortality indicators will undergo a change to reporting and related confidence limits that will impact the lower the upper confidence limits (shadow)
VHES – confidence and trust in nursing staff	Relocate & Shadow	Relocate and replace with Question 41. How would you rate how well the doctors and nurses worked together (shadow)
VHES – timely assistance from staff	Relocate & Shadow	Relocate and replace with Question 78. Overall did you feel you were treated with respect and dignity while you were in hospital (shadow)
VHES – Q55. "Overall, how would you rate the care and treatment you received from your paramedics?"	Data source change	This Ambulance Victoria KPI will undergo a data source changed from CAA to VHES

Key Performance Measures: Summary

High quality and safe care

Compliance

KPI	KPI description	Target / risk trigger
Residential aged care compliance	Compliance with Aged Care Standards	Full compliance

Infection prevention and control

KPI	KPI description	Target / risk trigger
Hand hygiene	Compliance with the Hand Hygiene Australia program	83%[1]
Healthcare worker immunisation	Percentage of healthcare workers immunised for influenza	84%[1,2]

Patient experience

KPI	KPI description	Target / risk trigger
Overall experience	Victorian Healthcare Experience Survey (VHES) – percentage of positive patient experience responses	95%
Key aspects of overall experience	VHES – understanding health professionals' explanations	Risk flag ≤ 90%
	VHES – involvement in care and treatment decisions	Risk flag ≤ 60%
Transition of care	VHES – percentage of very positive responses to questions on discharge care	75%
	VHES – sufficient information about managing at home	Risk flag ≤ 70%
	VHES – discharge planning considered patient's home situation	Risk flag ≤ 70%
	VHES – adequate services arranged as part of discharge planning	Risk flag ≤ 65%
Perception of cleanliness	VHES – patient's perception of cleanliness	70%

[1] Also captured in Forensicare SOP/Monitor

[2] Also captured in Ambulance Victoria's SOP/Monitor

Forensicare

KPI	KPI description	Target / risk trigger
Patient experience	% Inpatient's overall experience at Thomas Embling Hospital	90%
	% Community patient's overall experience at community Forensicare mental health services	90%

Healthcare-associated infections

KPI	KPI description	Target / risk trigger
Surgical site infection (SSI)	Rate of SSI (aggregate)	No outliers
	Rate of SSI post cardiac bypass	No outliers
	Rate of SSI post hip prosthesis	No outliers
	Rate of SSI post knee prosthesis	No outliers
	Rate of SSI post C section	No outliers
	Rate of SSI post colorectal surgery	No outliers
ICU CLABSI	Rate of patients with ICU central line-associated blood stream infection (CLABSI)	Nil
SAB	Rate of patients with SAB per 10,000 occupied bed days	≤ 1/10,000

Adverse events

KPI	KPI description	Target / risk trigger
Sentinel events	Sentinel events – root cause analysis (RCA) reporting	All RCA reports submitted within 30 business days[3]
Readmission	Unplanned readmission acute myocardial infarction	No outliers
	Unplanned readmission knee replacement	No outliers
	Unplanned readmission heart failure	No outliers
	Unplanned readmission – of mother after birth	No outliers
	Unplanned readmission – of newborn after birth	No outliers
	Unplanned readmission hip replacement	Annual rate ≤ 2.5%

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[3] Also captured in Forensicare SOP/Monitor

Mental health

KPI	KPI description	Target / risk trigger
Readmission	Percentage of adult acute mental health inpatients who are readmitted within 28 days of discharge	14%
Seclusion	Rate of seclusion events relating to a child and adolescent acute mental health admission	≤ 15/1,000
	Rate of seclusion events relating to an adult acute mental health admission	≤ 15/1,000[4]
	Rate of seclusion events relating to an aged acute mental health admission	≤ 15/1,000
Post-discharge follow-up	Percentage of child and adolescent acute mental health inpatients who have a post-discharge follow-up within seven days	80%
	Percentage of acute mental health adult inpatients with post-discharge follow-up within seven days	80%[4]
	Percentage of acute mental health aged inpatients who have a post-discharge follow-up within seven days	80%

Maternity and newborn

KPI	KPI description	Target / risk trigger
Apgar score	Rate of singleton term infants without birth anomalies with Apgar score < 7 to 5 minutes	≤ 1.4%
FGR	Rate of severe fetal growth restriction (FGR) in singleton pregnancy undelivered by 40 weeks	≤ 28.6%
Specialist clinic waiting time – obstetrics	Proportion of urgent maternity patients referred for obstetric care to a level 4, 5 or 6 maternity service who were booked for a specialist clinic appointment within 30 days of accepted referral	100%

Continuing care

KPI	KPI description	Target / risk trigger
Functional Independence Measure (FIM™) efficiency	Functional independence gain from admission to discharge relative to length of stay for rehabilitation patients	≥ 0.645

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[4] Also captured in Forensicare SOP/Monitor

Key Performance Measures and Underlying Risk Factors 2019–20

Ambulance Victoria

KPI	KPI description	Target / risk trigger
Patient satisfaction	VHES – percentage of patients that were satisfied or very satisfied with their care and treatment received from paramedics	95%
Patient satisfaction	VHES – percentage of patients that were satisfied or very satisfied with the care received from the ambulance service	95%
Pain reduction	Percentage of patients experiencing severe cardiac or traumatic pain whose level of pain was reduced significantly	90%
Stroke patients transport	Percentage of adult stroke patients transported to definitive care within 60 minutes	90%
Trauma patients transport	Percentage of major trauma patients that meet destination compliance	85%
Cardiac survival to hospital	Percentage of adult cardiac arrest patients surviving to hospital	50%
Cardiac survival on hospital discharge	Percentage of adult cardiac arrest patients surviving to hospital discharge	25%

Strong governance, leadership and culture

Organisational culture

Risk	KPI description	Target/risk
Safety culture	Percentage of staff with an overall positive response to safety cultures	80%[5,6]
	Staff encouraged to report patient safety concerns	80%[5,6]
	Patient care errors are handled appropriately	80%[5,6]
	Suggestions about patient safety are acted upon	80%[5,6]
	Management driving safety centred organisation	80%[5,6]
	Culture conducive to learning from errors	80%[5,6]
	Training new and existing staff	80%[5,6]
	Trainees are adequately supervised	80%[5,6]
	Would staff recommend a friend or relative to be treated as a patient there	80%[5,6]
Staff engagement	Low response rates to People Matter Survey	≤ 30%[5,6]
Bullying	Percentage of staff who personally experienced bullying at work in last 12mths / People Matter survey responses	Risk flag ≥ 17% of People Matter survey responses[5,6]

Learner's experience

Risk	KPI description	Target/risk
Safety	% learners feeling safe at the organisation / total number of respondents	Risk flag ≤ 80%
Wellbeing	% learners having a sense of wellbeing at the organisation /total number of respondents	Risk flag ≤ 80%
Bullying	% who reported experiencing or witnessing bullying at the organisation/total number of respondents	Risk flag ≥ 20%

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[5] Also captured in Forensicare SOP/Monitor

[6] Also captured in Ambulance Victoria's SOP/Monitor

Timely access to care

Emergency care

KPI	KPI description	Target
40-minute transfer	Percentage of patients transferred from ambulance to ED within 40 minutes	90%[7]
Triage 1	Percentage of triage category 1 emergency patients seen immediately	100%
Triage 1–5	Percentage of triage category 1 to 5 emergency patients seen within clinically recommended time	80%
ED < 4 hours	Percentage of emergency patients with a length of stay in the ED of less than four hours	81%
ED > 24 hours	Number of patients with a length of stay in the ED greater than 24 hours	0

Elective surgery

KPI	KPI description	Target
Cat 1, 2 & 3 admit	Percentage of urgency category 1, 2 and 3 elective surgery patients admitted within clinically recommended time	94%
Cat 1 admit	Percentage of urgency category 1 elective surgery patients admitted within 30 days	100%
ESWL	Number of patients on the elective surgery waiting list	Health service specific
Reducing long waiting elective surgery patients	Proportion of patients on the waiting list who have waited longer than clinically recommended time for their respective triage category	5% or 15% proportional improvement from prior year
Admissions	Number of patients admitted from the elective surgery waiting list	Health service specific
HiPS	Number of hospital-initiated postponements per 100 scheduled elective surgery admissions	≤ 7/100

Specialist clinics

KPI	KPI description	Target
Waiting time	Waiting time for urgent patients referred by a GP or external specialist who attended a first appointment in the waiting period	100%
Waiting time	Waiting time for routine patients referred by GP or external specialist who attended a first appointment in the waiting period	90%

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[7] Also captured in Ambulance Victoria's SOP/Monitor

Ambulance Victoria

KPI	KPI description	Target
Response times statewide	Percentage of emergency (Code 1) incidents responded to within 15 minutes	85%
	Percentage of emergency (Priority 0) incidents responded to within 13 minutes	85%
Response times urban	Percentage of emergency (Code 1) incidents responded to within 15 minutes in centres with a population greater than 7,500	90%
Call referral	Percentage of triple zero events where the caller receives advice or service from another health provider as an alternative to emergency ambulance response – statewide	15%
Clearing time	Average ambulance hospital clearing time	20 minutes

Forensicare

KPI	KPI description	Target
Admissions TEH	Number of security patients admitted to Thomas Embling Hospital (TEH) Male Acute Units – Security	> 80
	Percentage of male security patients admitted to TEH within 14 days of certification	100%
Length of stay (LOS) TEH – Male Acute Units – Security	Percentage of security patients discharged to prison within 80 days	75%
	Percentage of security patients discharged within 21 days of becoming a civil patient	75%

Key Performance Measures and Underlying Risk Factors 2019–20

Effective financial management

Finance

KPI	KPI description	Target
Operating result as percentage of revenue	Operating result as a percentage of total operating revenue	Health service specific[8,9]
Creditors	Average number of days to paying trade creditors	60 days[8,9]
Debtors	Average number of days to receiving patient fee debtors	60 days[9]
PP WIES	Public and Private Weighted Equivalent Inlier Separation activity performance to target	100%
Adjusted current asset ratio (ACAR)	Variance between actual ACAR and target, including performance improvement over time or maintaining actual performance	0.7 or 3% improvement from HS base target[8,9]
Forecast days available cash	Forecast number of days a health service can maintain its operations with unrestricted available cash (based on end of year forecast)	14 days[8,9]
Days of available cash (monthly)	Actual number of days a health service can maintain its operations with unrestricted available cash, measured on the last day of each month.	14 days[8,9]
Net result from transactions	Measures the accuracy of forecasting the *Net result from transactions (NRFT)* for the current financial year ending 30 June.	Variance ≤ $250,000[8,9]

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[8] Also captured in Forensicare SOP/Monitor

[9] Also captured in Ambulance Victoria's SOP/Monitor

Key Performance Measures: Technical Specifications

The technical specifications provide the next level of detail regarding calculating performance for the Key Performance Measures. The methodology for assessing improvement has also been included.

High quality and safe care

Indicator: Compliance with aged care standards

Element	Details
Description	It is a requirement that all residential aged care facilities are accredited and maintain full compliance with relevant standards.
	The Commonwealth Government has primary responsibility for funding and regulating the residential aged care sector. In Victoria, a number of residential aged care services are provided by public health services and are subject to national Aged Care Quality Standards.
Calculating performance	This indicator is assessed at the health service level. Where a health service has multiple facilities, all facilities are required to meet the aged care standards.
	To achieve this indicator all residential aged care services must be fully compliant with the aged care standards, at all times.
	Where a health service has a confirmed finding of non-compliance with the standards from a performance assessment conducted by the Aged Care Quality and Safety Commission (ACQSC) during the reporting period they will be referred to as 'not achieved'.
	Performance breach
	Non-compliance with the aged care standards is considered a performance breach.
	Health services are to notify the department's Quality Improvement, Care for Older People Unit of any findings of non-compliance by ACQSC.
	Any breach will require health services to make necessary improvements to comply with the aged care standards and meet a timetable for improvements set by the ACQSC.
Statewide target	Full compliance
Achievement	Achieved
	Not achieved
Improvement	Compliance with the aged care standards at follow-up performance assessments by ACQSA.

Element	Details
Frequency of reporting and data collection	Performance is monitored and assessed quarterly. In addition to quarterly monitoring, a performance result is generated annually. Where a health service does not achieve the indicator in any quarter the annual result is not achieved.
	Compliance status as at the end of the quarter for the health service is to be 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.
	For each quarter, a list of residential aged care services that have failed to comply with the aged care standards during the relevant quarter will be obtained.

Infection prevention and control

Indicator: Compliance with the Hand Hygiene Australia program

Element	Details
Description	The hand hygiene program aims to improve compliance with best practice hand hygiene processes so that healthcare-associated infections are reduced.
	The indicator encourages health services to achieve a high standard of hand hygiene and be fully compliant with the auditing and data submission to Hand Hygiene Australia (HHA) requirements.
	This indicator measures the percentage of hand hygiene compliance achieved. This percentage represents compliance with the '5 moments' for hand hygiene methodology.
Calculating performance	VICNISS coordinates the hand hygiene program for Victoria. Data is reported to HHA. VICNISS analyses the data for each audit period and reports results to the department.
	Auditing requirements are outlined by Hand Hygiene Australia <http://www.hha.org.au>.
	There are three hand hygiene audit periods per year:
	• 1 July to 31 October
	• 1 November to 31 March
	• 1 April to 30 June.
	The number of moments each campus is required to collect is based on acute inpatient bed numbers submitted to the Agency Information Management System.
	This indicator is assessed at the health service level. Where a health service has multiple campuses, the compliance is aggregated to produce an average health service result.
	Where a health service has fewer than 25 acute inpatient beds at each campus, the number of moments required to be collected will be based on the total number of acute inpatient beds at the health service.
	The department may determine alternative reporting arrangements for campuses with low bed numbers and low occupancy in consultation with Safer Care Victoria (SCV) and the relevant health services.
Statewide target	≥ 83%
Achievement	Equal to or above 83% Achieved
	Below 83% Not achieved
Improvement	For the purpose of the performance risk assessment, improvement is compared to previous audit period.
Frequency of reporting and data collection	Data is collected at the campus level and used to produce an aggregated health service result.
	Hand hygiene compliance data is submitted to HHA throughout the year, and VICNISS creates reports for the three audit periods:
	• 1 July to 31 October (reported with quarter 2)
	• 1 November to 31 March (reported with quarter 3)
	• 1 April to 30 June (reported with quarter 4).
	Where a campus fails to submit the required number of moments in an audit period the measure is deemed not met.

Indicator: Percentage of healthcare workers immunised for influenza

Element	Details
Description	High coverage rates of immunisation in healthcare workers (HCW) are essential to reduce the risk of influenza transmission in healthcare settings.
	This indicator aims to measure the percentage of vaccinated health service staff (including residential aged care services and community health staff) who are permanently, temporarily or casually (bank staff) employed by the nominated hospital / health service and worked one or more shifts during the influenza vaccination campaign.
	The HCW categories used are aligned with the Australian Council on Safety and Quality in Health Care (ACSQHC) *Australian guidelines for prevention and control of infection in healthcare*. Details can be found at VICNISS <http://www.vicniss.org.au>.
Calculating performance	The period used to calculate the rate of HCW immunisation is 15 April to 2 August 2019.
Numerator	Number of category A, B and C HCW vaccinated as at 2 August.
Denominator	Number of category A, B and C HCW employed as at 2 August who worked one or more shifts during the influenza vaccination campaign (15 April to 2 August).
Statewide target	≥ 84%
Achievement	Equal to or above 84% Achieved
	Below 84% Not achieved
Improvement	For the purpose of the performance risk assessment, improvement is assessed against the previous year performance.
Frequency of reporting and data collection	Data on vaccination rates must be submitted to VICNISS by 16 August 2019. If possible, data should be submitted by HCW category.
	Where data is not submitted, the measure is deemed as not achieved.
	Performance is monitored and reported annually in Q1.

Patient experience

Element	Details
Description	The Victorian healthcare experience survey (VHES) has been implemented in Victorian health services as a survey measuring patient experience since 2014.
Calculating performance for all questions	Indicators are measured at the health service level and mandatory participation is based on health services providing timely patient data to the contractor to enable surveying. Participation is based on health services providing patient data issued to the contractor by the 15th of each month and at least 30 responses per quarter being received to enable statistically significant analysis. Where data is not submitted in time, the measure is deemed not met. Some small rural health services will not be able to achieve the minimum 30 response rate per quarter. Small rural health services that can meet the minimum 30 response rate as cumulative over the course of the year will have the actual results from the overall patient experience reported annually. The 'experience score' is calculated by the survey contractor, **from the respective survey**, based on the positive response(s) to the identified questions from the VHES suite of information. Health service results analysed quarterly.
Frequency of reporting and data collection	Health services are required to submit the details of eligible patients to the survey contractor by the 15th of each month. Reported data is lagged by one quarter. Data is supplied at campus level and reported quarterly at health service level.
Improvement	For the purpose of the performance risk assessment, improvement is assessed against the previous quarter performance.

Overall experience

Indicator: Question 76 – Overall, how would you rate the care you received while in hospital?

Element	Details	
Description	This indicator measures the results of the 'very good' and 'good' response to the adult inpatient VHES survey question relating to 'overall experience'.	
Numerator	Weighted sum of 'good' and 'very good' responses to the question 'Overall, how would you rate the care you received while in hospital?'.	
Denominator	Weighted sum of valid responses to the question 'Overall, how would you rate the care you received while in hospital?'.	
Statewide target	Score equal to or above 95%	
Achievement	Overall experience score equal to or above 95%	Achieved
	Overall experience score below 95%	Not achieved

Key aspects of care questions that influence the overall experience

Indicator: Question 33 – How often did the doctors, nurses and other healthcare professionals caring for you explain things in a way you could understand?

Element	Details	
Description	Measures the results of the 'all of the time' and 'most of the time' responses to the adult inpatient VHES survey question relating to 'your care'.	
Numerator	Weighted sum of 'all of the time' and 'most of the time' responses to the question 'How often did the doctors, nurses and other healthcare professionals caring for you explain things in a way you could understand?'.	
Denominator	Weighted sum of valid responses to the question 'How often did the doctors, nurses and other healthcare professionals caring for you explain things in a way you could understand?'.	
Risk flag	< 90%	
Achievement	Equal to or above 90%	Achieved
	Below 90%	Not achieved

Indicator: Question 3 – Were you involved as much as you wanted to be in decisions about your care and treatment?

Element	Details	
Description	Measures the results of the 'yes definitely' response to the adult inpatient VHES survey question relating to 'your care'.	
Numerator	Weighted sum of 'yes definitely' responses to the question 'Were you involved as much as you wanted to be in decisions about your care and treatment?'.	
Denominator	Weighted sum of valid responses to the question 'Were you involved as much as you wanted to be in decisions about your care and treatment?'. Valid responses exclude 'I was not well enough or did not want to be involved in these decisions'.	
Risk flag	< 60%	
Achievement	Equal to or above 60%	Achieved
	Below 60%	Not achieved

Transition of care

Indicator: Transition index

Element	Details
Description	Measures the quality of patient reported discharge care.
Calculating Performance	This composite indicator captures the average sum of the very positive responses to the following four questions in the adult inpatient VHES relating to transfer of care: • Before leaving hospital, did the doctors and nurses give you sufficient information about managing your healthcare at home? • Did hospital staff take your family and home situation into account when planning your discharge? • Thinking about when you left hospital, were adequate arrangements made by the hospital for any services you needed? • If follow-up with your general practitioner was required, were they given all the necessary information about the treatment or advice you received while in hospital?
Numerator	Sum of (weighted) percent of 'yes, completely' responses to the first three transition questions plus number of 'yes' responses to the fourth transition question in the adult inpatient VHES.
Denominator	Weighted sum of valid responses to each of the four transition questions in the adult inpatient VHES. The denominator excludes: • Invalid responses to any question • Responses of 'it was not necessary' to the question 'Did hospital staff take your family and home situation into account when planning your discharge?' • Responses of 'I did not need any services' to the question 'Thinking about when you left hospital, were adequate arrangements made by the hospital for any services you needed?' • Responses of 'no information was needed by my GP' or 'there was no follow-up with my GP' to the question 'If follow-up with your general practitioner was required, was he or she given all the necessary information about the treatment or advice you received while in hospital?'
Statewide Target	≥ 75%
Achievement	Equal to or above 75% Achieved Below 75% Not achieved

Indicator: Question 69 – Before you left hospital, did the doctors and nurses give you sufficient information about managing your health and care at home?

Element	Details	
Description	This indicator measures the results of the 'yes completely' response to the adult inpatient VHES survey question relating to 'leaving hospital'.	
Numerator	Weighted sum of 'yes, completely' responses to the question 'Before you left hospital, did the doctors and nurses give you sufficient information about managing your health and care at home?'.	
Denominator	Weighted sum of valid responses to the question 'Before you left hospital, did the doctors and nurses give you sufficient information about managing your health and care at home?'.	
Risk flag	< 70%	
Achievement	Equal to or above 70%	Achieved
	Below 70%	Not achieved

Indicator: Question 70 – Did hospital staff take your family or home situation into account when planning your discharge?

Element	Details	
Description	This indicator measures the results of the 'yes completely' response to the adult inpatient VHES survey question relating to 'leaving hospital'.	
Numerator	Weighted sum of 'yes, completely' responses to the question 'Did hospital staff take your family and home situation into account when planning your discharge?'.	
Denominator	Weighted sum of valid responses to the question 'Did hospital staff take your family and home situation into account when planning your discharge?'. Valid responses exclude 'It was not necessary'.	
Risk flag	< 70%	
Achievement	Equal to or above 70%	Achieved
	Below 70%	Not achieved

Indicator: Question 71 – Thinking about when you left hospital, were adequate arrangements made by the hospital for any services you needed? (e.g. transport, meals, mobility aids)

Element	Details	
Description	This indicator measures the results of the 'yes completely' response to the adult inpatient VHES survey question relating to 'leaving hospital'.	
Numerator	Weighted sum of 'yes, completely' responses to the question 'Thinking about when you left hospital, were adequate arrangements made by the hospital for any services you needed?'.	
Denominator	Weighted sum of the valid responses to the question 'Thinking about when you left hospital, were adequate arrangements made by the hospital for any services you needed?'. Valid responses exclude 'I did not need any services'.	
Risk flag	< 65%	
Achievement	Equal to or above 65%	Achieved
	Below 65%	Not achieved

Perception of cleanliness

Indicator: Patient perception of hospital cleanliness

Element	Details	
Description	Measures the average sum of the very positive ('very clean') responses to the following two questions from the adult inpatient VHES relating to patient reported cleanliness: Question 12: In your opinion, how clean was the hospital room or ward that you were in? Question 13: How clean were the toilets and bathrooms that you used in hospital?	
Numerator	Sum of (weighted) percent of 'very clean' responses to the questions 'In your opinion, how clean was the hospital room or ward that you were in?' and 'How clean were the toilets and bathrooms that you used in hospital?'.	
Denominator	Sum of valid responses to the questions 'In your opinion, how clean was the hospital room or ward that you were in?' and 'How clean were the toilets and bathrooms that you used in hospital?'. The denominator excludes: • Invalid responses to either question • Responses of 'I did not use a toilet or bathroom' to the question 'How clean were the toilets and bathrooms that you used in hospital?'.	
Statewide target	≥ 70%	
Achievement	Equal to or above 70%	Achieved
	Below 70%	Not achieved

Forensicare patient experience

Indicator: Inpatient's overall experience at Thomas Embling Hospital (TEH)

Element	Details	
Description	This indicator measures the results of the 'excellent', 'very good' and 'good' responses to the question 'Overall, how would you rate your experience of care?' in the annual TEH consumer survey.	
Calculating performance	This indicator is measured at the health service level.	
Numerator	Total number of survey respondents who answered 'excellent', 'very good' and 'good' to the item.	
Denominator	Total number of survey respondents.	
Statewide target	≥ 90%	
Achievement	Equal to or above 90%	Achieved
	Below 90%	Not achieved
Improvement	For the purpose of the performance risk assessment, improvement is assessed against the previous survey results.	
Frequency of reporting and data collection	Results and participation will be reported annually in quarter 4. Data source: Forensicare quantitative survey results.	

Indicator: Patient's overall experience at community Forensicare mental health services

Element	Details	
Description	This indicator measures the results of the 'excellent', 'very good' and 'good' responses to the question 'Overall, how would you rate your experience of care?' in the annual Community Forensicare Mental Health Service consumer survey.	
Calculating performance	This indicator is measured at the health service level. Improvement will be compared to previous survey results.	
Numerator	Total number of survey respondents who answered 'excellent', 'very good' and 'good' to the item.	
Denominator	Total number of survey respondents.	
Statewide target	≥ 90%	
Achievement	Equal to or above 90%	Achieved
	Below 90%	Not achieved
Improvement	For the purpose of the performance risk assessment, improvement is assessed against the previous survey results.	
Frequency of reporting and data collection	Results and participation will be reported annually in quarter 4. Data source: Forensicare quantitative survey results.	

Healthcare-associated infections

Indicator: Rate of patients with surgical site infection

Element	Details
Description	Surgical site infection surveillance focuses on reducing the incidence of healthcare-associated infection among nominated surgical procedures.
Calculating performance	This indicator refers to a set of specific types of procedures:
	• coronary artery bypass grafts
	• hip arthroplasty
	• knee arthroplasty
	• caesarean section for nominated health services
	• colorectal surgery.
	Relevant procedures expressed as a crude rate per 100 procedures.
	For each procedure type, where a health service is found to have a statistically significantly higher infection rate than the state aggregate rate, they are deemed an outlier. Further information on the methodology for calculating outliers for surgical site infections can be obtained at VICNISS <http://www.vicniss.org.au>.
	Coronary artery bypass graft
	Campuses performing cardiac bypass surgery are required to conduct continuous surveillance.
	The list of hospitals for which this measure is applicable to is based on previously reported data and can be found at Attachment A.
	Hip and knee arthroplasty
	Campuses performing ≥ 50 hip or knee arthroplasty surgical procedures per annum are required to conduct continuous surveillance.
	The list of hospitals for which these measures are applicable to is based on previously reported data and can be found at Attachment B (Hip Arthroplasty) and Attachment C (Knee Arthroplasty).
	Caesarean section for nominated health services
	Health service campuses that manage ≥ 400 births are required to conduct six months of continuous surveillance of their c-section surgical site infections and report these to VICNISS. Health services are to nominate whether they will commence the six month surveillance period from the first, second or third quarter.
	The list of hospitals for which this measure is applicable to is based on previously reported data and can be found at Attachment D.
	Colorectal surgery
	Health services that undertake ≥ 50 relevant procedures a year will be required to conduct six months of continuous surveillance of their colorectal surgical site infections and report these to VICNISS. Health services are to nominate whether they will commence the six month surveillance period from the first, second or third quarter.
	The list of relevant procedures is available from VICNISS.
	The list of hospitals for which this measure is applicable to is available at Attachment E.

Element	Details
Frequency of reporting and data collection	Performance is monitored and assessed quarterly. Data reported is lagged. Data is analysed quarterly based on two quarters of data. Rates are calculated using the most recent six months of data in a rolling fashion. VICNISS collates and analyses data from health services and reports quarterly to participants and the department on aggregate, risk-adjusted, procedure-specific infection rates. Data is submitted to VICNISS and performance reported for the periods: • 1 January to 30 June in quarter 1 • 1 April to 30 September in quarter 2 • 1 July to 31 December in quarter 3 • 1 October to 31 March in quarter 4. This indicator is measured at the health service level. Where a health service has multiple campuses, an outlier at any campus will result in the health service not meeting the indicator. If data is not submitted at a campus level in any month, the entire quarter target will be deemed as not met by the health service. A result is generated annually. Where a health service does not achieve the indicator in a reporting period the annual result is not achieved.
Improvement	For the purpose of the performance risk assessment, the rate over a rolling six month period is compared to the six month rate of the previous quarter. SCV will also analyse performance over a longer period, taking trends as well as outlier status and absolute levels of performance into account.

Indicator: Rate of surgical site infection for all reported procedures

Element	Details
Numerator	The number of patients with a surgical site infection for all reported procedures.
Denominator	The total number of all reported procedures.
Statewide target	No outliers
Achievement	Achieved Not Achieved

Indicator: Rate of surgical site infection post coronary artery bypass grafts

Element	Details
Numerator	Number of surgical site infection post coronary artery bypass grafts.
Denominator	The total number of coronary artery bypass graft procedures.
Statewide target	No outliers
Achievement	Achieved Not achieved

Indicator: Rate of surgical site infection post hip arthroplasty

Element	Details
Numerator	Number of surgical site infection post hip arthroplasty.
Denominator	The total number of hip arthroplasties.
Statewide target	No outliers
Achievement	Achieved Not achieved

Indicator: Rate of surgical site infection post knee arthroplasty

Element	Details
Description	Number of surgical site infection post knee arthroplasty.
Denominator	The total number of knee arthroplasties.
Statewide target	No outliers
Achievement	Achieved Not Achieved

Indicator: Rate of surgical site infection post caesarean section delivery

Element	Details
Numerator	Number of surgical site infection post caesarean section delivery.
Denominator	The total number of caesarean section deliveries.
Statewide target	No outliers
Achievement	Achieved Not Achieved

Indicator: Rate of surgical site infection post colorectal surgery

Element	Details
Numerator	Number of surgical site infection post colorectal surgery.
Denominator	The total number of colorectal surgeries.
Statewide target	No outliers
Achievement	Achieved Not Achieved

Indicator: Intensive care unit central-line-associated bloodstream infection surveillance

Element	Details
Description	This surveillance measure focuses on reducing the incidence of central-line-associated bloodstream infection (CLABSI) for patients in intensive care unit (ICU). Neonatal intensive care units are excluded.
Calculating performance	Results are presented as rates calculated by the VICNISS on behalf of the department using the data collected from participating ICUs. Rates = numerator/denominator × 1,000
Numerator	The number of ICU CLABSIs.
Denominator	The total number of ICU central line days.
Statewide target	Nil
Achievement	Achieved Not achieved
Improvement	For the purpose of the performance risk assessment, improvement is assessed against the previous reporting period. SCV will also analyse performance over a longer period, taking trends as well as absolute levels of performance into account.
Frequency of reporting and data collection	This indicator is measured at the hospital level and is relevant to hospitals with an ICU. VICNISS collates and analyses data from health services and reports quarterly to participants and the department on aggregate, risk-adjusted infection rates. Data is submitted to VICNISS and performance reported for the periods: • 1 April to 30 June in quarter 1 • 1 July to 30 September in quarter 2 • 1 October to 31 December in quarter 3 • 1 January to 31 March in quarter 4. Performance is monitored and assessed quarterly. Data reported is lagged by one quarter. Annual performance is based on full year lagged data.

Indicator: Rate of patients with *Staphylococcus aureus* bacteraemia per occupied bed days

Element	Details
Description	This surveillance measure aims to reduce the rate of health care associated *Staphylococcus aureus* bacteraemia (SAB) for all patients admitted to a public hospital with a bacteraemia caused by either Methicillin-susceptible *S. aureus* (MSSA) or Methicillin-resistant *S. aureus* (MRSA).
Calculating performance	A patient episode of bacteraemia is defined as a positive blood culture for *S. aureus*. For surveillance purposes, only the first isolate per patient is counted, unless at least 14 days has passed without a positive blood culture, after which an additional episode is recorded.
	A SAB will be considered to be healthcare-associated either if:
	• the patient's first SAB blood culture was collected more than 48 hours after hospital admission or less than 48 hours after discharge, or
	• the patient's first SAB blood culture was collected less than or equal to 48 hours after hospital admission and one or more of the defined clinical criteria was met for the patient episode of SAB.
	Occupied bed days are defined as the total number of days for all patients who were admitted for an episode of care in the acute health facility, including psychiatric bed days.
	Further information on the SAB definition can be found at VICNISS <http://www.vicniss.org.au>.
	This indicator is expressed as the rate of infections per 10,000 occupied bed days. This indicator is expressed as a rate and rounded to one decimal place (0.05 is rounded down).
Numerator	Healthcare-associated SAB patient episodes.
Denominator	Number of occupied bed days for health services.
Statewide target	≤ 1.0 episodes per 10,000 occupied bed days.
Achievement	Equal to or below 1.0 Achieved Greater than 1.0 Not achieved
Improvement	For the purpose of the performance risk assessment, improvement is assessed against the previous reporting period. SCV will also analyse performance over a longer period, taking trends as well as absolute levels of performance into account.
Frequency of reporting and data collection	VICNISS collects and analyses data from health services and reports quarterly to participants and the department.
	Reporting periods are:
	• 1 April to 30 June reported in quarter 1
	• 1 July to 30 September in quarter 2
	• 1 October to 31 December in quarter 3
	• 1 January to 31 March in quarter 4.
	This indicator is measured at the health service level.
	Where a health service has multiple campuses, an aggregate for the health service result is produced.
	Data reported is lagged by one quarter.
	Performance is monitored and assessed quarterly.
	Performance result is generated annually based on full year lagged data.

Adverse events

Indicator: Sentinel events – root cause analysis reporting

Element	Details
Description	Sentinel events are a subset of adverse patient safety events that are wholly preventable and result in serious harm to, or death of, a patient. The purpose of sentinel event reporting is to ensure public accountability and transparency and drive national improvements in patient safety.[10]
	This indicator is a trigger for discussion regarding quality, safety and improvement in health services, as well as compliance with mandatory notification of sentinel events.
	The sentinel event program aims to improve health service system design and delivery through event review and shared learning from a defined range of adverse patient safety events (sentinel events).
	Notification of sentinel events are a sign of a healthy culture of reporting of incidents. Sentinel events also represent an important opportunity to review, learn and improve quality and safety. Too low numbers may be a sign of an under-reporting culture which is of concern, particularly in the context of other safety and quality risks. 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 sentinel event program for Victoria. All public and private health services are required to notify SCV within 3 business days of becoming aware of a sentinel event and undertake a review of the event using root cause analysis (RCA). Health services are required to provide a report outlining the review and a plan to prevent recurrence. Part A and B of the RCA report is to be submitted to SCV within 30 business days of the notification and part C of the RCA report to be submitted to SCV within 50 business days of the notification.

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[10] Australian sentinel events list – Australian Commission on Safety and Quality in Health Care
<https://www.safetyandquality.gov.au/our-work/indicators/australian-sentinel-events-list>

Element	Details
Calculating performance	This measure captures numbers of reportable sentinel events for which an RCA report (part A and B) is submitted within 30 business days[11] from notification of the event to SCV. Reportable sentinel events must meet one of the following specific criteria: 1. Surgery or other invasive procedure performed on the wrong site resulting in serious harm or death 2. Surgery or other invasive procedure performed on the wrong patient resulting in serious harm or death 3. Wrong surgical or other invasive procedure performed on a patient resulting in serious harm or death 4. Unintended retention of a foreign object in a patient after surgery or other invasive procedure resulting in serious harm or death 5. Haemolytic blood transfusion reaction resulting from ABO incompatibility resulting in serious harm or death 6. Suspected suicide of a patient in an acute psychiatric unit or acute psychiatric ward 7. Medication error resulting in serious harm or death 8. Use of physical or mechanical restraint resulting in serious harm or death 9. Discharge or release of an infant or child to an unauthorised person 10. Use of an incorrectly positioned oro- or naso-gastric tube resulting in serious harm or death 11. All other adverse patient safety events resulting in serious harm or death. Note: The above reflects an updated national sentinel event category list published by the Australian Commission on Safety and Quality in Health Care in 2019, which came into effect 1 July 2019.
Statewide target	All RCA reports (part A and B) submitted within a 30 business day timeframe.
Achievement	All RCA reports (part A and B) submitted within 30 business days[11] Achieved RCA report (part A and B) not submitted within 30 business days[11] Not Achieved
Improvement	For the purpose of the performance risk assessment, improvement is assessed against the previous quarter performance.
Frequency of reporting and data collection	Data for this measure is reported at health service level. Performance is assessed and reported quarterly. Annual results are also calculated.

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[11] Under special circumstances an extension beyond the 30 business days may be provided by SCV. In these instances, this measure will be assessed against the new agreed submission date.

Unplanned readmission

Element	Details
Description	Unplanned readmission refers to an unexpected readmission for treatment of the same condition, a related condition or a complication of the condition for which the patient was previously hospitalised.
	The unplanned readmission indicators for Acute Myocardial Infarction, Knee replacement, Hip replacement and Heart failure are part of a suite of core hospital-based outcome indicators focused on improving safety and quality of patient care.
Calculating performance	Results should fall within the expected range against statewide rates.
	Results above the 99.8% confidence limit are considered outliers.
	Results between the 95–99.8% confidence limit reflect higher or lower than expected rates.
	High rates should be seen as a prompt to further investigation. Investigation should consider a comprehensive range of possible explanations including: case mix, structural or resource issues, changes in treatment protocols, professional practice.
Frequency of reporting and data collection	Quarterly (lagged by a quarter), representing a quarterly rate and an annual (preceding twelve months) rate. Outliers are calculated based on the annual rate.
	For quarterly results, campus level rates will be reported when the number of in scope separations for the quarter is at least 15 or where 2 or more readmissions are reported for two consecutive quarters.
	For annual results, campus level rates will be reported when the number of in-scope separations is 50 or more in the twelve months up to and including the reporting quarter.
	Data collection: VAED. Results are collected and reported at campus level.
Improvement	For the purpose of the performance risk assessment, the annual rate is compared to the annual rate of the previous quarter. SCV will also analyse performance over a longer period, taking trends as well as absolute levels of performance into account.

Indicator: Unplanned readmission for Acute Myocardial Infarction

Element	Details
Description	Unplanned readmissions to the same hospital within 30 days of patients' separation, for management of Acute Myocardial Infarction.
Numerator	Includes all separations with a separation date which is within the reference period and which satisfy all of the following: • the separation is a readmission to the same hospital campus following a separation which is in scope of the denominator (either for the reference period or the previous period) • has an ICD-10-AM principal diagnosis code (i.e. the readmission) of either I21.x or I22.x • occurs within 30 days of the previous date of separation • the readmission is an acute admission (Care Type = '4') • Admission type of the readmission is 'Emergency' ('O' or 'C') • excludes transfers from other campuses (Admission Source = 'T').
Denominator	Includes all separations with a separation date which is within the reference period and which satisfy all of the following: • has an ICD-10-AM principal diagnosis code of I21.x or I22.x • is an acute separation (Care Type = '4') • patient age is between 30–89 years (inclusive) • Admission Type of admission is 'Emergency' ('O', 'C') • excludes transfers in and transfers out (Admission Source or Separation Mode = 'T') • LOS is between 4–30 patient days (inclusive) • excludes in-hospital deaths (Separation Mode = 'D').
Statewide target	No outliers
Achievement	Achieved Not achieved
Improvement	For the purpose of the performance risk assessment, the annual rate is compared to the annual rate of the previous quarter. SCV will also analyse performance over a longer period, taking trends as well as absolute levels of performance into account.

Indicator: Unplanned readmission for knee replacement

Element	Details
Description	Unplanned readmissions to the same hospital within 60 days of patients' separation from acute care for knee replacement surgery.
Numerator	Includes all separations with a separation date which is within the reference period and which satisfy all of the following: • the separation is a readmission to the same hospital campus following a separation which is in scope of the denominator (either for the reference period or the previous period) • the ICD-10-AM principal diagnosis code (i.e. of the readmission) is in ('I21.x','I26.x','I50.x','I74.x','M17.x','M23.x','N13.x','R33','S89.x','T81.x',' T84.x','I80.1','I80.2.x','I97.8.x','J15.1','J18.0','J18.9','J95.8x','L89.2x', 'M24.66','M25.66','N39.0','S82.0','T88.7', L03.13, L03.14, 'S72.10','S83.44','T85.78','T85.88') • the readmission occurs within 60 days of the previous date of separation • the readmission is an acute admission (Care Type = '4').
Denominator	Includes all separations with a separation date which is within the reference period and which satisfy all of the following: • has any of the following procedure codes: 49518-00 [1518], 49519-00 [1518], 49521-02 [1519] • is an acute separation (Care Type = '4') • patient age is at least 20 years • LOS is greater than or equal to 4 days • excludes in-hospital deaths (Separation Mode = 'D').
Statewide target	No outliers
Achievement	Achieved Not achieved
Improvement	For the purpose of the performance risk assessment, the annual rate is compared to the annual rate of the previous quarter. SCV will also analyse performance over a longer period, taking trends as well as absolute levels of performance into account.

Indicator: Unplanned readmission for heart failure

Element	Details
Description	Unplanned readmissions to the same hospital within 30 days of patients' separation, for management of heart failure.
Numerator	Includes all separations with a separation date which is within the reference period and which satisfy all of the following: • the separation is a readmission to the same hospital campus following a separation which is in scope of the denominator (either for the reference period or the previous period) • has a principal diagnosis code (i.e. the readmission) of I50 • the readmission occurs within 30 days of the previous date of separation • the readmission is an acute admission (Care Type = '4') • Admission Type of admission is 'emergency' ('O', 'C') • excludes transfers from other campuses (Admission Source = 'T').
Denominator	Includes all separations with a separation date which is within the reference period and which satisfy all of the following: • has an ICD-10-AM principal diagnosis code of I50 • is an acute separation (Care Type = '4') • patient age is between 30–89 years (inclusive) • Admission Type of admission is 'emergency' ('O', 'C') • excludes transfers in and transfers out (Admission Source or Separation Mode = 'T') • LOS is between 1–30 patient days (inclusive) • excludes in-hospital deaths (Separation Mode = 'D') • patient must have spent at least one night in hospital (i.e. non-same day patient).
Statewide target	No outliers
Achievement	Achieved Not achieved
Improvement	For the purpose of the performance risk assessment, the annual rate is compared to the annual rate of the previous quarter. SCV will also analyse performance over a longer period, taking trends as well as absolute levels of performance into account.

Indicator: Unplanned and potentially preventable readmission of mother within 28 days of discharge from a birthing admission

Element	Details
Description	This indicator measures the rate of unplanned and potentially preventable readmissions of women within 28 days of discharge from hospital following a birthing admission.
	High quality and coordinated care means most women and babies do not return to hospital as an inpatient during the postnatal period. Unplanned and preventable hospital stays during this period reflect a deviation from the normal course of postnatal recovery.
	Evidence suggests higher readmission rates are associated with inconsistent discharge procedures, poor postnatal care and limited support in the community.
	The intersection of hospital-based maternity and newborn services and the community-based maternal and child health service system is a key point of transition within the first six weeks after the birth of a child.
Calculating performance	Readmissions that meet the criteria for inclusion are attributed to the health service that provided admitted postnatal care to the mother prior to discharge.
	Women transferred to another health service following a birth separation are excluded from the numerator total, as are women who are readmitted as part of a planned follow-up plan after their birth episode.
	Women who present to an emergency department or urgent care centre but are not admitted, are excluded from the numerator total.
	Maternal deaths are excluded from the denominator.
	Data is lagged by one quarter.
	Reporting thresholds ≥10 cases in the denominator.
	Results are assessed and reported quarterly and expressed as percentage.
	Outlier status (above 99.7% confidence limit) assessed against state-wide rates.

Element	Details
Numerator	The number of women readmitted to any health service with a potentially preventable readmission diagnosis code within 28 days of a birthing admission.
	Women who are readmitted and have a primary diagnosis related to their pregnancy or birth are included in the numerator total. However, diagnosis codes that are associated with a complexity that cannot be prevented (or managed) through postnatal care or that are associated with a condition that manifests after discharge from hospital, without any indication of its presence prior to this time, are excluded.
	Potentially preventable readmission primary diagnosis codes are limited to the following:
	• delayed and secondary postpartum haemorrhage (ICD10 Code O722)
	• infection of obstetric surgical wound (ICD10 Code O860)
	• puerperal sepsis (ICD10 Code O85)
	• non-purulent mastitis without attachment difficulty (ICD10 Code O9120)
	• fitting and adjustment of urinary device (ICD10 Code Z466)
	• spinal epidural headache during puerperium (ICD10 Code O894)
	• disruption of perineal obstetric wound (ICD 10 Code O901)
	• pre-eclampsia unspecified (ICD10 Code O149)
	• unspecified maternal hypertension (ICD10 Code O16)
	• anaemia complicating birth and puerperium (ICD10 Code O9903)
	• retained portion placenta and membrane without haemorrhage (ICD10 Code O731)
	• other immediate postpartum haemorrhage (ICD10 Code O721)
	• haematoma of obstetric wound (ICD10 Code O902)
	• urinary tract infection following delivery (ICD10 Code O862)
	• disruption of caesarean section wound (ICD10 Code O900)
	• care and examination of lactating mother (ICD10 Code Z391)
	• gestational hypertension (ICD10 Code O13)
	• urinary tract infection site not specified (ICD10 Code N390)
	• non-purulent mastitis with attachment difficulty (ICD10 Code O9121)
	• severe mental and behavioural disorder associated with puerperium not elsewhere classified (ICD10 Code F531)
	• mild mental and behavioural disorder associated with puerperium not elsewhere classified (ICD10 Code F530)
	• other reaction to spinal and lumbar puncture (ICD10 Code G971)
	• fever unspecified (ICD10 Code R509)
	• retention of urine (ICD10 Code R33)
	• eclampsia in the puerperium (ICD10 Code O152)
	• third-stage haemorrhage (ICD10 Code O720)

Element	Details
Denominator	The number of women provided admitted postnatal care prior to discharge.
Statewide target	No outliers
Achievement	Achieved Not achieved
Improvement	For the purpose of the performance risk assessment, improvement is compared to previous quarter performance and based on the state-wide rate (outlier status).

Indicator: Potentially preventable readmission of a neonate within 28 days of discharge from a birthing admission

Element	Details
Description	This indicator measures the rate of unplanned and potentially preventable readmissions of babies within 28 days of discharge from hospital following a birthing admission.
	High quality and coordinated care means most women and babies do not return to hospital as an inpatient during the postnatal period. Unplanned and preventable hospital stays during this period reflect a deviation from the normal course of postnatal recovery.
	Evidence suggests higher readmission rates are associated with inconsistent discharge procedures, poor postnatal care and limited support in the community.
Calculating performance	Calculated for the hospital that discharged the newborn episode.
	Includes admissions to any Victorian health service after birth, not just a readmission to the birthing hospital.
	Reporting thresholds ≥ 10 cases in the denominator.
	Results are analysed, reported quarterly and expressed as a percentage.
	Outlier status (above 99.7% CI) assessed against state-wide rates.
	Data lagged by two quarters.

Element	Details
Numerator	The number of babies readmitted to any health service with a potentially preventable readmission diagnosis code within 28 days of discharge.
	Babies transferred to another health service following a birth separation are excluded from the numerator total, as are babies who are readmitted as part of a planned follow-up after their birth episode.
	Babies who present to an emergency department or urgent care centre but are not admitted are excluded from the numerator total.
	Babies who are admitted and have a primary diagnosis related to their pregnancy or birth are included in the numerator total. However, diagnosis codes that are associated with a complexity that cannot be prevented (or managed) through postnatal care or that are associated with a condition(s) that manifests after discharge from hospital without any indication of its presence prior to this time, are excluded. Potentially preventable readmissions are limited to the cohort of primary diagnoses listed below.
	Neonate readmission diagnosis codes: • neonatal jaundice unspecified (ICD10 Code P599) • abnormal weight loss (ICD10 Code R634) • feeding problem of newborn unspecified (ICD10 Code P929) • other lack of normal physiological development (ICD10 Code R628) • bacterial sepsis of newborn unspecified (ICD10 Code P369) • other feeding problems of newborn (ICD10 Code P928) • neonatal jaundice with preterm delivery (ICD10 Code P590) • neonatal jaundice from other specified causes (ICD10 Code P598) • other preterm infant ≥ 32 but <37 completed weeks (ICD10 Code P0732) • ABO isoimmunisation of foetus and newborn (ICD10 Code P551) • observation of newborn for suspected infectious condition (ICD10 Code Z0371) • apnoea of newborn, unspecified (ICD10 Code P2840) • cyanotic attacks of newborn (ICD10 Code P282) • enteroviral meningitis (ICD10 Code A870) • omphalitis newborn with or without mild haemorrhage (ICD10 Code P38) • dehydration of newborn (ICD10 Code P741) • hypothermia of newborn unspecified (ICD10 Code P809) • convulsions of newborn (ICD10 Code P90)
Denominator	The denominator includes the total number of babies discharged from a health service.
	Qualified and unqualified babies are included – irrespective of their accommodation type during the birth episode (if they spent time in a neonatal intensive care unit or special care nursery).
	Exclusions: • Stillbirths and neonatal deaths prior to discharge are excluded. • Babies who are readmitted on the same day of discharge are also excluded. This is because it is not possible to determine whether these are genuine readmissions or a new separation following planned transfer of care.

Element	Details
Statewide target	No outliers
Achievement	Achieved Not achieved
Improvement	For the purpose of the performance risk assessment, improvement is compared to previous quarter performance and based on the state-wide rate (outlier status).

Indicator: Unplanned readmission for hip replacement

Element	Details
Description	Unplanned readmissions to the same hospital within 60 days of patients' separation from acute care, for hip replacement surgery.
Frequency of reporting and data collection	Quarterly (lagged by a quarter), representing an annual (preceding twelve months) rate.
	Campus level rates will be reported when the number of in-scope separations is 50 or more in the twelve months up to and including the reporting quarter.
	Data collection: VAED. Results are collected and reported at campus level.
Numerator	Includes all separations with a separation date which is within the reference period and which satisfy all of the following:
	• the separation is a readmission to the same hospital campus following a separation which is in scope of the denominator (either for the reference period or the previous period)
	• the ICD-10-AM principal diagnosis code (i.e. of the readmission) is in ('G46','I21.x','I26.x','I50.x','I74.x','I80.x','J15.x','L89.x','N13.x','N30.x',' R33','S73.x','T84.x','T89.x','I62.1','I63.3','I97.8x','J18.0','J18.9','J95.8x' ,'L03.9','M25.65','M96.8','N39.0','T81.1','T81.3','T81.5','T81.6','T81.8x', 'T81.9','T85.9','T88.7', 'L03.13, L03.14,'S72.00','S72.08','T85.788','T85.88')
	• the readmission occurs within 60 days of the previous date of separation
	• the readmission is an acute admission (Care Type = '4').
Denominator	Includes all separations with a separation date which is within the reference period and which satisfy all of the following:
	• has any of the following procedure codes: 49318-00 [1489],49319-00 [1489]
	• is an acute separation (Care Type = '4')
	• patient age is at least 20 years
	• LOS is greater than or equal to 3 days
	• excludes in-hospital deaths (Separation Mode = 'D').
Statewide target	Annual rate = ≤ 2.5%
Achievement	Achieved = ≤ 2.5%
	Not achieved = > 2.5%
Improvement	For the purpose of the performance risk assessment, the annual rate is compared to the annual rate of the previous quarter. SCV will also analyse performance over a longer period, taking trends as well as absolute levels of performance into account.

Mental health

Indicator: Percentage of adult mental health inpatients who are readmitted within 28 days of discharge

Element	Details
Description	Adult specialist mental health services are aimed primarily at people with a serious mental illness or mental disorder who have associated significant levels of disturbance and psychosocial disability due to their illness or disorder. Readmission rates for adult mental health patients can reflect the quality of care, effectiveness of discharge planning and level of support provided to patients after discharge, as well as other factors.
Calculating performance	This indicator includes adult mental health patients who are admitted overnight or longer in hospital.
	Exclusions are overnight separations for electroconvulsive therapy, transfers to other acute hospitals or to residential aged care, and patients who leave against medical advice or abscond.
	This indicator is expressed as a percentage and rounded to the nearest whole number.
Numerator	Non-same day separations from adult general acute psychiatric inpatient units that result in a non-same-day readmission to the same or to another public sector acute psychiatric inpatient unit within 28 days of discharge.
Denominator	Number of non-same-day separations from adult general acute psychiatric inpatient units.
Statewide target	≤ 14%
Achievement	Less than or equal to 14% Achieved
	Greater than 14% Not achieved
Improvement	For the purpose of the performance risk assessment, improvement is compared to previous quarter performance.
Frequency of reporting and data collection	Performance is monitored and assessed quarterly. In addition to quarterly monitoring, a performance result is generated annually based on the full year data.
	The 28-day lag inherent in the indicator means that reporting is lagged by one month. For example, quarter 2 will report the mental health results for separations occurring in the period September to November.
	Performance is reported for the periods:
	• 1 June to 31 August in quarter 1
	• 1 September to 30 November in quarter 2
	• 1 December to 28 February in quarter 3
	• 1 March to 31 May in quarter 4.
	The data source for this indicator is the Client Management Interface (CMI), which is the local client information system used by each public mental health service. It also uses the Operational Data Store (ODS), which manages a set of select data items from each CMI. The initialism used for this data source is CMI/ODS.

Indicator: Rate of seclusion events relating to a child and adolescent acute mental health admission

Element	Details
Description	Reducing restraint and seclusion is a national safety priority, and incorporating this indicator ensures appropriate monitoring of seclusion use in child and adolescent mental health service (CAMHS) acute inpatient units in Victoria.
	This indicator is to measure any period of seclusion relating to a child or adolescent acute admission.
Calculating performance	This indicator comprises CAMHS acute inpatient services provided by public mental health services and includes all CAMHS acute admissions.
	Occupied bed days are calculated where the admission event type is one of the following:
	• SA (statistical admission)
	• R (return from leave)
	• A (admission – formal)
	• T (ward transfer).
	Leave events within an admission are excluded.
	Admission events that do not have any temporal overlap with the reporting period are excluded. Only the minutes of the admission events that overlap with the reporting period are counted. The minutes for each CAMHS acute admission event are then summed and divided by 1,440 to give the total occupied bed days for the campus for the reporting period.
	Any period of seclusion relating to a CAMHS acute admission ending in the reporting period is counted. The number of seclusions is divided by the number of occupied bed days. The quotient is then multiplied by 1,000.
	CAMHS clients are identified by program type.
Numerator	CAMHS acute seclusion events during the reference period.
Denominator	Total CAMHS acute occupied bed days during the reference period.
Statewide target	≤ 15 seclusions per 1,000 bed days (< 15/1,000).
Achievement	Less than or equal to < 15/1,000 Achieved
	Greater than > 15/1,000 Not achieved
Improvement	For the purpose of the performance risk assessment, improvement is compared to previous quarter performance.
Frequency of reporting and data collection	Performance is monitored and assessed quarterly 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.
	In addition to quarterly monitoring, a performance result is generated annually based on the full year data.
	The data source for this indicator is the Client Management Interface (CMI), which is the local client information system used by each public mental health service. It also uses the Operational Data Store (ODS), which manages a set of select data items from each CMI. The data source is CMI/ODS.

Indicator: Rate of seclusion events relating to an adult acute mental health admission

Element	Details
Description	Reducing restraint and seclusion is a national safety priority, and incorporating this indicator ensures appropriate monitoring of seclusion use in adult acute inpatient units in Victoria. This indicator is to measure any period of seclusion relating to an adult acute admission.
Calculating performance	This indicator comprises adult acute inpatient services provided by public mental health services and includes adult acute admissions as well as patients at ORYGEN Youth Health Melbourne Clinic campus. Occupied bed days are calculated where the admission event type is one of the following: • SA (statistical admission) • R (return from leave) • A (admission – formal) • T (ward transfer). Leave events within an admission are excluded. Admission events that do not have any temporal overlap with the reporting period are excluded. Only the minutes of the admission events that overlap with the reporting period are counted. The minutes for each adult acute admission event are then summed and divided by 1,440 to give the total occupied bed days for the campus for the reporting period. Any period of seclusion relating to an adult acute admission ending in the reporting period is counted. The number of seclusions is divided by the number of occupied bed days. The quotient is then multiplied by 1,000. Improvement is compared to previous quarter performance.
Numerator	Adult acute seclusion events during the reference period.
Denominator	Total adult acute occupied bed days during the reference period.
Statewide target	≤ 15 seclusions per 1,000 bed days (< 15/1,000).
Achievement	Less than or equal to 15/1,000 — Achieved Greater than > 15/1,000 — Not achieved
Improvement	For the purpose of the performance risk assessment, improvement is compared to previous quarter performance.
Frequency of reporting and data collection	Performance is monitored and assessed quarterly 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. In addition to quarterly monitoring, a performance result is generated annually based on the full year data. The data source for this indicator is the Client Management Interface (CMI), which is the local client information system used by each public mental health service. It also uses the Operational Data Store (ODS), which manages a set of select data items from each CMI. The initialism used for this data source is CMI/ODS.

Indicator: Rate of seclusion events relating to an aged acute mental health admission

Element	Details
Description	Reducing restraint and seclusion is a national safety priority, and incorporating this indicator ensures appropriate monitoring of seclusion use in aged acute inpatient units in Victoria.
	This indicator is to measure any period of seclusion relating to an aged acute admission.
Calculating performance	This indicator comprises aged acute inpatient services provided by public mental health services and includes all aged acute admissions.
	Occupied bed days are calculated where the admission event type is one of the following:
	• SA (statistical admission)
	• R (return from leave)
	• A (admission – formal)
	• T (ward transfer).
	Leave events within an admission are excluded.
	Admission events that do not have any temporal overlap with the reporting period are excluded. Only the minutes of the admission events that overlap with the reporting period are counted. The minutes for each aged acute admission event are then summed and divided by 1,440 to give the total occupied bed days for the campus for the reporting period.
	Any period of seclusion relating to an aged acute admission ending in the reporting period is counted. The number of seclusions is divided by the number of occupied bed days. The quotient is then multiplied by 1,000.
	Aged clients are identified by the type of admission.
Numerator	Aged acute seclusion events during the reference period.
Denominator	Total aged acute occupied bed days during the reference period.
Statewide target	≤ 15 seclusions per 1,000 bed days (< 15/1,000).
Achievement	Less than or equal to < 15/1,000 Achieved
	Greater than > 15/1,000 Not achieved
Improvement	For the purpose of the performance risk assessment, improvement is compared to previous quarter performance.
Frequency of reporting and data collection	Performance is monitored and assessed quarterly 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.
	In addition to quarterly monitoring, a performance result is generated annually based on the full year data.
	The data source for this indicator is the Client Management Interface (CMI), which is the local client information system used by each public mental health service. It also uses the Operational Data Store (ODS), which manages a set of select data items from each CMI. The initialism used for this data source is CMI/ODS.

Indicator: Percentage of child and adolescent mental health inpatients with post-discharge follow-up within seven days

Element	Details
Description	Timely post-discharge follow-up is an important component of client care. Monitoring the proportion of discharges that are followed up within seven days is a good measure of the timeliness of this care. This indicator reflects the effectiveness of the interface between admitted care and non-admitted care. It is also monitored at a national level.
Calculating performance	Where one or more contacts fall in the seven days after the separation date, the separation is considered to have received post-discharge community care.
	Separations are counted against the mental health area (catchment campus) of the client, rather than the campus of separation. The separation type is 'home' and patients must be admitted overnight or longer in hospital.
	Contacts on the day of separation are excluded. Contacts can be of any duration, in any location for any type of recipient, whether by the local mental health service or another mental health service.
	Child and adolescent mental health service (CAMHS) clients are identified by admission type in the Client Management Interface (CMI) system.
	This indicator is expressed as a percentage and rounded to the nearest whole number.
Numerator	Number of post-discharge follow-ups within seven days.
Denominator	Total non-same-day acute mental health CAMHS separations to a private residence.
Statewide target	≥ 80%
Achievement	Greater than or equal to 80% Achieved
	Less than 80% Not achieved
Improvement	For the purpose of the performance risk assessment, improvement is compared to previous quarter performance.
Frequency of reporting and data collection	Performance is monitored and assessed quarterly. In addition to quarterly monitoring, a performance result is generated annually based on the full year data.
	The separation date is between the start of the reporting period (minus seven days) and the end of the reporting period (minus seven days). Separations are lagged by seven days to allow all post-discharge follow-up in the reporting period to be captured. For example, if the reporting period is from 1 July to 30 September, then separations from 24 June to 24 September are included.
	Results are 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.
	The data source for this indicator is the CMI, which is the local client information system used by each public mental health service. It also uses the Operational Data Store (ODS), which manages a set of select data items from each CMI. The initialism used for this data source is CMI/ODS.

Indicator: Percentage of adult mental health patients who have post-discharge follow-up within seven days

Element	Details
Description	Timely post-discharge follow-up is an important component of client care. Monitoring the proportion of discharges that are followed up within seven days is a good measure of the timeliness of this care. This indicator reflects the effectiveness of the interface between admitted care and non-admitted care. It is also monitored at the Commonwealth level.
Calculating performance	Where one or more contacts fall in the seven days after the separation date, the separation is considered to have received post-discharge community care.
	The separation type is home and patients must be admitted overnight or longer in hospital.
	Contacts on the day of separation are excluded. Contacts can be of any duration, in any location for any type of recipient, whether by the local mental health service or another mental health service.
	This indicator is expressed as a percentage of post-discharge follow-ups on the total number of non-same-day acute adult separations.
	This indicator is rounded to the nearest whole number.
Numerator	Number of post-discharge follow-ups within seven days.
Denominator	Total non-same-day acute mental health adult separation to a private residence or accommodation.
Statewide target	≥ 80%
Achievement	Greater than or equal to 80% — Achieved
	Less than 80% — Not achieved
Improvement	For the purpose of the performance risk assessment, improvement is compared to previous quarter performance.
Frequency of reporting and data collection	Performance is monitored and assessed quarterly. In addition to quarterly monitoring, a performance result is generated annually based on the full year data.
	The separation date is between the start of the reporting period (minus seven days) and the end of the reporting period (minus seven days). Separations are lagged by seven days to allow all post-discharge follow-up in the reporting period to be captured. For example, if the reporting period is from 1 July to 30 September, then separations from 24 June to 24 September are included.
	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.
	The data source for this indicator is the Client Management Interface (CMI), which is the local client information system used by each public mental health service. It also uses the Operational Data Store (ODS), which manages a set of select data items from each CMI. The initialism used for this data source is CMI/ODS.

Indicator: Percentage of aged mental health inpatients who have post-discharge follow-up within seven days

Element	Details
Description	Timely post-discharge follow-up is an important component of client care. Monitoring the proportion of discharges that are followed up within seven days is a good measure of the timeliness of this care. This indicator reflects the effectiveness of the interface between admitted care and non-admitted care. It is also monitored at the Commonwealth level.
Calculating performance	Where one or more contacts fall in the seven days after the separation date, the separation is considered to have received post-discharge community care.
	The separation type is home or residential aged care and patients must be admitted overnight or longer in hospital.
	Contacts on the day of separation are excluded. Contacts can be of any duration, in any location for any type of recipient, whether by the local mental health service or another mental health service.
	This indicator is expressed as a percentage of post-discharge follow-ups on the total number of non-same-day acute aged separations.
	Aged clients are identified by the type of admission.
	This indicator is expressed as a percentage and rounded to the nearest whole number.
Numerator	Number of post-discharge follow-ups within seven days.
Denominator	Total non-same-day acute mental health aged separations to a private residence or accommodation.
Statewide target	≥ 80%
Achievement	Greater than or equal to 80% Achieved
	Less than 80% Not achieved
Improvement	For the purpose of the performance risk assessment, improvement is compared to previous quarter performance.
Frequency of reporting and data collection	Performance is monitored and assessed quarterly. In addition to quarterly monitoring, a performance result is generated annually based on the full year data.
	The separation date is between the start of the reporting period (minus seven days) and the end of the reporting period (minus seven days). Separations are lagged by seven days to allow all post-discharge follow-up in the reporting period to be captured. For example, if the reporting period is from 1 July to 30 September then separations from 24 June to 24 September are included.
	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.
	The data source for this indicator is the Client Management Interface (CMI), which is the local client information system used by each public mental health service. It also uses the Operational Data Store (ODS), which manages a set of select data items from each CMI. The initialism used for this data source is CMI/ODS.

Maternity and newborn

Indicator: Rate of singleton term infants without birth anomalies with Apgar score < 7 to 5 minutes

Element	Details	
Description	This indicator measures the wellbeing of babies at birth. It is used as a proxy for the quality of intrapartum care and neonatal resuscitation, where necessary, following birth.	
	Singleton infants who are more than 37 weeks gestation and without congenital anomalies are expected to be born in good condition, show healthy physiological adaption to birth and not require significant resuscitation measures.	
	The Apgar score is an assessment of a newborn's wellbeing at birth based on five physiological attributes at one and five minutes (and longer if applicable): Colour (circulation), breathing, heart rate, muscle tone and reflexes.	
	The Apgar score is a verified measure of adverse long-term outcomes.	
	An Apgar score < 7 at five minutes indicates an infant who requires significant or ongoing resuscitation measures or additional care that may be due to avoidable factors during labour and childbirth and/or the immediate resuscitation measures at birth. It may also indicate sub-optimal triaging and/or management of higher complexity pregnancies.	
	All cases of infants born with a low Apgar score (< 7) at five minutes should undergo a clinical review to determine whether appropriate management and monitoring of the pregnancy was provided and whether the case was avoidable. The review can also highlight opportunities for improvement.	
Calculating performance	This indicator excludes all terminations of pregnancy, babies born at less than 37 weeks' gestation, birthweight <150 grams, babies born with congenital anomalies, multiple births, stillbirths and babies born before arrival at hospital.	
Numerator	The number of singleton, liveborn, term infants without congenital anomalies with an Apgar score < 7 at five minutes.	
Denominator	The number of inborn singleton, liveborn term babies without congenital anomalies.	
Statewide target	≤ 1.4%	
Achievement	Less than or equal to 1.4%	Achieved
	Greater than 1.4%	Not achieved
Improvement	For the purpose of the performance risk assessment, the annual rate is compared to the annual rate of the previous quarter. SCV will also analyse performance over a longer period, taking trends as well as absolute levels of performance into account.	

Element	Details
Frequency of reporting and data collection	Data for this indicator is derived from the Victorian Perinatal Data Collection (VPDC) and lagged by one quarter.
	Due to low numbers of births at some health services, this measure is calculated using a 12 month rolling average over the reporting period.
	Results are reported quarterly at campus level, using four quarters rolling data, with one quarter lag time. Results are not reported where minimum threshold of ≥10 case in denominator is not achieved.
	Data is required to be submitted by health services monthly. All data reported to the VPDC is due within 30 days.
	Health services are required to submit VPDC data for the previous month by the end of the following month. (This may mean that a birth may take up to 60 days to be reported by a health service if it occurred at the start of the month).

Indicator: Rate of severe fetal growth restriction (FGR) in singleton pregnancy undelivered by 40 weeks

Element	Details
Description	This indicator measures the proportion of severely growth-restricted singleton babies who were not born by 40 weeks' gestation. For this indicator, a baby is considered to be **severely** growth restricted when their birthweight is below the third centile for gestation, sex and plurality.
	Severe fetal growth restriction is associated with an increased risk of perinatal mortality and morbidity, admission to a special care nursery or neonatal intensive care unit, and long term health consequences. The risk of mortality for a severely growth-restricted baby increases as the pregnancy advances. FGR should therefore be identified early in pregnancy for appropriate medical management and delivery before 40 weeks' gestation.
	Severe fetal growth restriction closely correlates with adverse outcomes at one year of age.
	The rate of severe FGR in singleton babies who were not born by 40 weeks' gestation has been chosen as the performance indicator for quality of antenatal care.
	FGR can be difficult to diagnose and health services should monitor their rates at regular intervals and aim to review these cases to understand why they had not been detected or managed.
Calculating performance	Severe FGR is defined as birthweight less than the third centile for gestation, sex and plurality, whether liveborn or stillborn.
	This indicator excludes all terminations of pregnancy, babies without severe FGR, multiple births and births at earlier gestations (less than 32 weeks).
Numerator	Birth at 40 or more weeks gestation of a singleton baby with severe FGR.
Denominator	All singleton births (live and stillborn) with severe FGR born at and beyond 32 weeks gestation.
Statewide target	≤ 28.6%
Achievement	Equal to or less than 28.6% Achieved
	Greater than 28.6% Not achieved
Improvement	For the purpose of the performance risk assessment, the annual rate is compared to the annual rate of the previous quarter. SCV will also analyse performance over a longer period, taking trends as well as absolute levels of performance into account.
Frequency of reporting and data collection	Data for this indicator will be derived from the VPDC. Data is lagged by one quarter.
	This indicator is reported quarterly at campus level, with one quarter lag
	Results are reported quarterly at campus level, using 12 months (four quarters) rolling data, with one quarter lag time.
	Results are not reported where minimum threshold of ≥10 case in denominator is not achieved over the 12 month period.
	Data is required to be submitted by health services monthly.
	All data reported to the VPDC is due within 30 days.
	Health services are required to submit VPDC data for the previous month by the end of the following month. (This may mean that a birth may take up to 60 days to be reported by a health service if it occurred at the start of the month).

Continuing care

Indicator: Functional Independence Measure (FIM™) efficiency

Element	Details
Description	The FIM™ instrument is a basic indicator of patient disability. FIM™ is used to track the changes in the functional ability of a patient during an episode of hospital rehabilitation or Geriatric Evaluation and Management (GEM) care.
	FIM™ is comprised of 18 items, grouped into 2 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 is able to perform the tasks assessed by that item. Total scores range from 18 to 126.
	A low FIM™ score is a good indicator of need for subacute bed based care due to reduced function.
	Equally, a higher FIM™ admission 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 indicator applies to all health services providing subacute care (rehabilitation and/or GEM). Excludes palliative care, non-acute care and paediatric rehabilitation.
	Performance is calculated separately as individual scores for GEM and rehabilitation.
Improvement	Improvement is compared to previous quarter performance.
Frequency of reporting and data collection	Data extracted from VAED and reported quarterly with a one quarter lag. Results are reported at health service level.

Indicator: Rehabilitation

Element	Details	
Numerator	Total FIM™ score on discharge minus total FIM™ score on rehabilitation admission	
Denominator	Length of episode stay per rehabilitation stream	
Statewide target	≥ 0.645	
Achievement	Equal to or above 0.645	Achieved
	Below 0.645	Not achieved

Ambulance services

Element	Details
Description	The VHES Ambulance Emergency questionnaire seeks to discover the experience of people who were transported by an emergency ambulance, treated at the scene by an ambulance service however, not transported, or received advice over the phone from a referral service after calling triple zero.
Calculating performance for all questions	Indicators are measured at the organisation level and mandatory participation is based on Ambulance Victoria providing timely patient data to the contractor to enable surveying.
	Participation is based on Ambulance Victoria providing patient data to the contractor and at least 1300 (Code 1 and 2) responses being received to enable statistically significant analysis.
	Exclude where there is a 'nil' or 'don't know' response.
	Where data is not submitted in time, the measure is deemed not met.
	The 'experience score' is calculated by the survey contractor, from the respective survey, based on the positive response(s) to the identified questions from the VHES suite of information.
Frequency of reporting and data collection	Ambulance Victoria is required to submit the details of eligible patients, who interacted with Ambulance Victoria in February and March, to the survey contractor by 16th of April and 16th May respectively.
	Data is lagged and reported annually at an organisation level in Q1.
Improvement	For the purpose of the performance risk assessment improvement is assessed against the previous performance.

Indicator: Question 72 – Overall, how would you rate the care you received from the ambulance service?

Element	Details	
Description	This indicator measures the results of the 'very good' and 'good' response to the Ambulance Emergency VHES survey question relating to 'overall experience'.	
Numerator	Weighted sum of 'very good' and 'good' responses to the question: 'Overall, how would you rate the care you received from the ambulance service?'.	
Denominator	Weighted sum of valid responses to the question: 'Overall, how would you rate the care you received from the ambulance service?'.	
Statewide target	Score equal to or above 95%	
Achievement	Overall experience score equal to or above 95%	Achieved
	Overall experience score below 95%	Not achieved

Indicator: Question 55 – Overall, how would you rate the care and treatment you received from your paramedics?

Element	Details	
Description	This indicator measures the results of the 'very good' and 'good' response to the Ambulance Emergency VHES survey question relating to 'overall experience of the care and treatment received from the paramedics'.	
Numerator	Weighted sum of 'very good' and 'good' responses to the question: 'Overall, how would you rate the care and treatment you received from your paramedics?'.	
Denominator	Weighted sum of valid responses to the question: 'Overall, how would you rate the care and treatment you received from your paramedics?'.	
Statewide target	Score equal to or above 95%	
Achievement	Overall experience score equal to or above 95%	Achieved
	Overall experience score below 95%	Not achieved

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

Element	Details
Description	Adequate relief of pain is one of a series of key measures of the clinical effectiveness of interventions by paramedics. The indicator of the proportion of patients experiencing severe cardiac or traumatic pain, whose level of pain is significantly reduced, focuses the attention of the organisation on the effectiveness of clinical interventions in two common areas of service provision – cardiac care and trauma care.
	Assessment of pain severity and the extent of relief that paramedics can provide is central to the provision of appropriate care.
	This indicator applies to patients of all ages experiencing traumatic pain and patients who are 15 years old or older with cardiac pain.
Calculating performance	This indicator measures the difference between the initial pain score and the final pain score according to Ambulance Victoria (clinical practice guidelines. Patients experiencing severe pain are defined as those having an initial pain score of 8 or more, with pain measured out of 10.
	A patient is deemed to have had a significant reduction in pain if the difference between their initial and final pain score is 2 or more.
	This indicator excludes:
	• patients with a Glasgow Coma Score < 9
	• intubated patients
	• patients unable to rate pain
	• patients who have < 2 recorded pain scores and
	• patients who refuse analgesia.
	This indicator is expressed as a percentage to one decimal place.
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%
Achievement	Equal to or greater than 90% Achieved
	Less than 90% Not achieved
Improvement	Improvement is compared to previous quarter performance.
Frequency of reporting and data collection	Performance is monitored quarterly.
	Data is submitted to the department quarterly from Ambulance Victoria.

Indicator: Percentage of acute adult stroke patients transported to definitive care within 60 minutes

Element	Details	
Description	The early recognition of stroke symptoms and the timing and the destination to which patients are transported are critical to ensuring optimal outcomes for stroke patients.	
	This indicator is a measure of ambulance response to adult patients (15 years or older) suspected of having a stroke within the last six hours, who are transported within 60 minutes to a health service with the capability to deliver intravenous thrombolysis.	
	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>	
Calculating performance	This indicator excludes inter-hospital transfers, patients with an estimated stroke onset of greater than six hours, patients with significant pre-existing disability or dependent on others for daily living.	
	This indicator 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%	
Achievement	Equal to or greater than 90%	Achieved
	Less than 90%	Not achieved
Improvement	Improvement is compared to previous quarter performance.	
Frequency of reporting and data collection	Performance is monitored quarterly.	
	Data is submitted to the department quarterly from Ambulance Victoria.	

Indicator: Percentage of major trauma patients that meet destination compliance

Element	Details
Description	Mortality and morbidity can be reduced by effective field triage, treatment and transport of severely injured patients to specialised trauma hospitals.
	This indicator is a measure of ambulance response to patients defined as 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.
	Major trauma patients are defined by the Victorian State Trauma Registry, and this process relies on hospital diagnostic procedures, and in hospital treatment data which causes a lag of one quarter for all data.
Calculating performance	This indicator excludes inter-hospital transports and patients not meeting the Ambulance Victoria Trauma Triage Guidelines.
	This indicator is expressed as a percentage to one decimal place.
Numerator	Total 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).
Denominator	Number of patients defined as major trauma.
Statewide target	85%
Achievement	Equal to or greater than 85% Achieved
	Less than 85% Not achieved
Improvement	Improvement is compared to previous quarter performance.
Frequency of reporting and data collection	Performance is monitored quarterly.
	Data reported is lagged by one quarter.
	Data is submitted to the department quarterly from Ambulance Victoria.

Indicator: Percentage of adult cardiac arrest patients surviving to hospital

Element	Details
Description	Cardiac arrest survival is strongly impacted by Emergency Medical Services (EMS) response times, clinical interventions and treatments.
	The cardiac arrest survival to hospital rate describes the percentage of adult patients in out-of-hospital cardiac arrest, that 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.
	Data is collected and reported according to the internationally recognised Utstein template and definitions. The Victorian Ambulance Cardiac Arrest Registry captures data on all out-of-hospital cardiac arrest patients attended by EMS in Victoria.
	This indicator applies to adult patients (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.
Calculating performance	This indicator applies to adult patients who are in VF/VT on EMS arrival for whom resuscitation is commenced by EMS or patients defibrillated by PAD.
	Excludes cardiac arrests witnessed by EMS and patients where vital signs at hospital are unknown.
	This indicator is expressed as a percentage to one decimal place.
Numerator	The number of adult VF/VT cardiac arrest patients with a palpable pulse on arrival at hospital.
Denominator	The total number of adult VF/VT cardiac arrest patients meeting the criteria.
Statewide target	50%
Achievement	Equal to or greater than 50%　　　　　　　　　　Achieved
	Less than 50%　　　　　　　　　　　　　　　　Not achieved
Improvement	Improvement is compared to previous quarter performance.
Frequency of reporting and data collection	Performance is monitored quarterly using 12 months rolling percentages due to small sample sizes.
	Data is submitted to the department quarterly from Ambulance Victoria.

Indicator: Percentage of adult cardiac arrest patients surviving to hospital

Element	Details
Description	Cardiac arrest survival is strongly impacted by Emergency Medical Services (EMS) response times, clinical interventions and treatments.
	Data is collected and reported according to the internationally recognised Utstein template. The Victorian Ambulance Cardiac Arrest Registry captures data on all out-of-hospital cardiac arrest patients attended by EMS in Victoria.
	This indicator applies to adult patients (15 years or older) who were in ventricular fibrillation or pulseless ventricular tachycardia (VF/VT) on EMS arrival for whom resuscitation was commenced by EMS or who were defibrillated via public access defibrillator (PAD).
Calculating performance	This indicator applies to adult patients who were in VF/VT on EMS arrival for whom resuscitation was commenced by EMS or patients defibrillated by PAD.
	Excludes cardiac arrests witnessed by EMS and patients where discharge status is unknown.
	This indicator is expressed as a percentage to one decimal place.
Numerator	The number of adult VF/VT cardiac arrest patients discharged alive from hospital.
Denominator	The total number of adult VF/VT cardiac arrest patients meeting the criteria.
Statewide target	25%
Achievement	Equal to or greater than 25% · Achieved
	Less than 25% · Not achieved
Improvement	Improvement is compared to previous quarter performance.
Frequency of reporting and data collection	Performance is monitored quarterly using 12 month rolling percentages.
	Data is submitted to the department quarterly from Ambulance Victoria.

Strong governance, leadership and culture

Organisational culture

Element	Details
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.
	While staff participation in the survey is voluntary, low participation rates can generate misleading results or signal staff engagement concerns.
Calculating performance	The survey includes eight questions that specifically assess health service staff perspectives about the safety culture of the organisation.
	For the overall response measure, performance is based on a composite score of the eight safety culture agreement questions and expressed as the percentage of staff responses that either 'agree' or 'strongly agree' with each question.
	Performance against each of the eight individual safety questions is also measured by assessing the percentage of staff responses that either 'agree' or 'strongly agree' with each question.
	Denominator excludes 'Neither agree or disagree' and 'Don't know' responses.
Improvement	Improvement for any of the People Matter Survey related measures is assessed against the previous year result.
Frequency of reporting and data collection	Performance is monitored and assessed annually.
	These indicators measure performance at the health service level.
	The data source for this measure is the Victorian Public Sector Commission.
	Health services receive a report on their results and are also benchmarked against other like healthcare organisations.
	Data is submitted to the department by 31 August and reported in quarter 1.

Indicator: Percentage of staff with an overall positive response to safety culture question in People Matter survey

Element	Details	
Numerator	The number of 'agree' or 'strongly agree' responses to each of the eight safety culture questions in the health service's People Matter Survey.	
Denominator	The total number of 'agree', 'strongly agree', 'disagree' or 'strongly disagree' responses to each of the eight safety culture questions in the health service's People Matter Survey.	
Statewide target	80%	
Achievement	Equal to or greater than 80%	Achieved
	Less than 80%	Not achieved

Indicator: I am encouraged by my colleagues to report any patient safety concerns I may have

Element	Details	
Numerator	The number of 'agree' or 'strongly agree' responses to the People Matter Survey question: 'I am encouraged by my colleagues to report any patient safety concerns I may have'.	
Denominator	The total number of 'agree', 'strongly agree', 'disagree' or 'strongly disagree' responses to the assessed question.	
Statewide target	80%	
Achievement	Equal to or greater than 80%	Achieved
	Less than 80%	Not achieved

Indicator: Patient care errors are handled appropriately in my work area

Element	Details	
Numerator	The number of 'agree' or 'strongly agree' responses to the People Matter Survey question: 'Patient care errors are handled appropriately in my work area'.	
Denominator	The total number of 'agree', 'strongly agree', 'disagree' or 'strongly disagree' responses to the assessed question.	
Statewide target	80%	
Achievement	Equal to or greater than 80%	Achieved
	Less than 80%	Not achieved

Indicator: My suggestions about patient safety would be acted upon if I expressed them to my manager

Element	Details	
Numerator	The number of 'agree' or 'strongly agree' responses to the People Matter survey question: 'My suggestions about patient safety would be acted upon if I expressed them to my manager'.	
Denominator	The total number of 'agree', 'strongly agree', 'disagree' or 'strongly disagree' responses to the assessed question.	
Statewide target	80%	
Achievement	Equal to or greater than 80%	Achieved
	Less than 80%	Not achieved

Indicator: Management is driving us to be a safety-centred organisation

Element	Details	
Numerator	Percentage of staff with a positive response to the question: 'Management is driving us to be a safety-centred organisation'.	
Denominator	The total number of 'agree', 'strongly agree', 'disagree' or 'strongly disagree' responses to the assessed question.	
Statewide target	80%	
Achievement	Equal to or greater than 80%	Achieved
	Less than 80%	Not achieved

Indicator: The culture in my work area makes it easy to learn from the errors of others

Element	Details	
Numerator	The number of 'agree' or 'strongly agree' responses to the People Matter survey question: 'The culture in my work area makes it easy to learn from the errors of others'.	
Denominator	The total number of 'agree', 'strongly agree', 'disagree' or 'strongly disagree' responses to the assessed question.	
Statewide target	80%	
Achievement	Equal to or greater than 80%	Achieved
	Less than 80%	Not achieved

Indicator: This health service does a good job of training new and existing staff

Element	Details	
Numerator	Percentage of staff with a positive response to the safety culture question: 'This health service does a good job of training new and existing staff'.	
Denominator	The total number of 'agree', 'strongly agree', 'disagree' or 'strongly disagree' responses to the assessed question.	
Statewide target	80%	
Achievement	Equal to or greater than 80%	Achieved
	Less than 80%	Not achieved

Indicator: Trainees in my discipline are adequately supervised

Element	Details	
Numerator	Percentage of staff with a positive response to the safety culture question: 'Trainees in my discipline are adequately supervised'.	
Denominator	The total number of 'agree', 'strongly agree', 'disagree' or 'strongly disagree' responses to the assessed question.	
Statewide target	80%	
Achievement	Equal to or greater than 80%	Achieved
	Less than 80%	Not achieved

Indicator: I would recommend a friend or relative to be treated as a patient here

Element	Details	
Numerator	Percentage of staff with a positive response to the safety culture question: 'I would recommend a friend or relative to be treated as a patient here'.	
Denominator	The total number of 'agree', 'strongly agree', 'disagree' or 'strongly disagree' responses to the assessed question.	
Statewide target	80%	
Achievement	Equal to or greater than 80%	Achieved
	Less than 80%	Not achieved

Key Performance Measures and Underlying Risk Factors 2019–20

Indicator: Percentage of staff who responded to the People Matter Survey

Element	Details	
Numerator	Number of staff who responded to the People Matter Survey	
Denominator	Total number of staff who could have participated in the People Matter Survey	
Statewide target	30%	
Achievement	Equal to or greater than 30%	Achieved
	Less than 30%	Not achieved

Indicator: Bullying

Element	Details	
Description	Relates to the People Matter survey question: 'Have you personally experienced bullying at work in the last 12 months?'.	
	This measure aims to identify bullying risks within the organisation.	
	A target is not applied as no staff should be experiencing bullying.	
	The risk flag should trigger further attention to potential bullying concerns within the organisation.	
Numerator	The responses 'yes but not currently experiencing it' and 'yes and currently experiencing it' are counted for the numerator.	
Denominator	All responses to the People Matter Survey are included in denominator	
Risk Flag	17%	
Achievement	Less than 17%	Achieved
	Equal to or over 17%	Not achieved

Indicator: Learner's experience

Element	Details
Description	Learner perceptions about their feeling of safety and wellbeing as identified through the Best Practice Clinical Learning Environment (BPCLE) Framework.
Calculating performance	The BPCLE Framework is a guide for health and human services organisations, in partnership with education providers, to coordinate and deliver high-quality training for learners.
	The BPCLE Framework and supplementary resources are available from [HealthVic Best Practice Clinical Learning Environment (BPCLE)](https://www2.health.vic.gov.au/health-workforce/education-and-training/building-a-quality-health-workforce/bpcle-framework) <https://www2.health.vic.gov.au/health-workforce/education-and-training/building-a-quality-health-workforce/bpcle-framework>
	Results obtained through BPCLE Framework can provide additional context to potential safety culture or bullying concerns within the organisation.
	The *Victorian health services Performance Monitoring Framework* prescribes no specific performance targets for BPCLE Framework related measures. Health service performance will however be assessed against key risk flags associated with the three components of the BPCLE Framework (Indicator 23):
	• learner perceptions of their safety
	• learner perceptions of their own wellbeing
	• learner experience/awareness of bullying.
	Each of these components will be assessed as individual measures to ascertain if there are potential safety and wellbeing vulnerabilities pertaining to students and other learners employed by health services.
	Each of these measures apply to four learner levels:
	• professional entry (formerly 'undergraduate') – defined as learners enrolled in a higher education course of study leading to initial registration for, or qualification to, practice as a health professional.
	• early graduate – An individual who has completed their entry-level professional qualification within the last one or two years. For example, this will encompass:
	– junior doctors employed in pre-vocational positions for postgraduate years 1 and 2 (PGY1 and PGY2) (also referred to as Hospital Medical Officers).
	– registered Nurses and Midwives in Graduate Nurse (or Midwifery) Programs (GNP/GMP).
	– enrolled Nurses (formerly 'Division 2') in their first year post-qualification.
	• allied health professionals in their first two years post-qualification (generally employed at Grade 1 level). Where internship programs exist (e.g. Pharmacy), this would include the internship year and the first year post-internship.
	• vocational/postgraduate – defined as learners enrolled in formal programs of study, usually undertaken to enable specialty practice. Examples include registrars in specialist medical training programs; nurses and allied health professionals enrolled in Graduate Certificate, Graduate Diploma or Masters courses.
Improvement	For the purpose of the performance risk assessment, improvement is calculated annually compared to previous year's survey results.

Element	Details
Frequency of reporting and data collection	Performance is assessed throughout the calendar year and reported annually at health service level. Data is submitted by health service as per the BPCLE Framework reporting requirements associated with the Training and Development Grant.

Indicator: Percentage of learners feeling safe at the organisation

Element	Details	
Numerator	The number of learners that rated their feeling of safety favourably (i.e. agree or strongly agree on the 5-point Likert scale of: strongly disagree – disagree – neither agree nor disagree – agree – strongly agree) to the statement: 'I feel safe at this organisation'.	
Denominator	The total number of learners that responded to the statement.	
Risk Flag	80%	
Achievement	Over 80%	Achieved
	Equal to or under 80%	Not achieved

Indicator: Percentage of learners having a sense of wellbeing at the organisation

Element	Details	
Numerator	The number of learners that rate their sense of personal wellbeing favourably (i.e. agree or strongly agree on a 5-point Likert scale of strongly disagree – disagree – neither agree nor disagree – agree – strongly agree) to the statement: 'I had an overall sense of wellbeing while in this organisation'.	
Denominator	The total number of learners that responded to the statement.	
Risk Flag	80%	
Achievement	Over 80%	Achieved
	Equal to or under 80%	Not achieved

Indicator: Percentage of learners who reported experiencing or witnessing bullying at the organisation

Element	Details	
Numerator	The number of learners that indicate a 'yes' answer to the statement: 'I personally experienced bullying or witnessed bullying of others in this organisation'.	
Denominator	The total number of learners that responded to the statement.	
Risk Flag	20%	
Achievement	Under 20%	Achieved
	Equal to or over 20%	Not achieved

Timely access to care

Emergency care

Indicator: Percentage of patients transferred from ambulance to an emergency department (ED) within 40 minutes

Element	Details
Description	Timely reception of ambulance patients in EDs is essential to delivering responsive and safe emergency care, and good performance impacts positively on patient outcomes, patient flow in the ED and ambulance response times. This indicator monitors the percentage of patients who were transferred from paramedic care to hospital emergency care within 40 minutes of ambulance arrival.
Calculating performance	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'). This indicator captures the percentage of cases where ambulance patient transfer time is less than or equal to 40 minutes. This indicator includes patients who arrive by ambulance to the ED but excludes patients arriving by Non-Emergency Patient Transport. This indicator is expressed as a percentage and rounded to the nearest whole number (0.5 is rounded up).
Numerator	Patients arriving by emergency ambulance who are transferred within 40 minutes to the ED.
Denominator	All patients arriving by emergency ambulance who are transferred to the ED.
Statewide target	90%
Achievement	Greater than or equal to 90%　　　　　　　　　　　　　Achieved Less than 90%　　　　　　　　　　　　　　　　　　　Not achieved
Improvement	Improvement is calculated based on same time last year performance.
Frequency of reporting and data collection	This indicator is measured at the campus level. Performance is monitored and assessed monthly. Quarterly and annual results are also generated. This indicator is calculated using data submitted by health services via the Victorian Emergency Minimum Dataset (VEMD). Refer to the *Policy and Funding Guidelines* for further information on VEMD data submission timelines.

Indicator: Percentage of triage category 1 emergency patients seen immediately

Element	Details
Description	Triage category 1 patients have a condition that is clinically assessed as immediately life threatening and requires immediate intervention. The clinical benchmark is 100 per cent due to the high clinical needs of patients.
	The aim of this indicator is to ensure the treatment of patients occurs within appropriate clinical benchmark times.
	All patients attending EDs are triaged or assessed for urgency. The Australasian College of Emergency Medicine has identified five triage categories and defines the desirable time by when treatment should commence for patients in each category.
Calculating performance	A patient is categorised as having been seen immediately if the time to treatment, as defined in the VEMD manual, is less than or equal to one minute.
	Time to treatment equals b – a, where:
	• 'a' is arrival date and time
	• 'b' is the date and time of the initiation of patient management (either by a doctor, a mental health practitioner or a nurse, whichever is earliest).
	This indicator excludes those presentations with a departure status code of:
	• 10 – left after advice regarding treatment options
	• 11 – left at own risk without treatment
	• 30 – referred to collocated clinic.
	This indicator is expressed as a percentage and rounded to the nearest whole number (0.5 is rounded up).
	Improvement is calculated based on same time last year performance.
	Performance breach notification
	If a category 1 ED patient was not seen immediately 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 triage category 1 emergency patients seen immediately.
Denominator	Total number of triage category 1 emergency patients.
Statewide target	100%
Achievement	Equal to 100% — Achieved Less than 100% — Not achieved
Frequency of reporting and data collection	Performance is monitored and assessed monthly.
	Quarterly and annual results are also generated.
	Data is submitted by health services via the VEMD. Refer to the *Policy and Funding Guidelines* for further information on VEMD data submission timelines.
	This indicator is measured at the campus level.

Indicator: Percentage of triage category 1 to 5 emergency patients seen within clinically recommended time

Element	Details
Description	All patients attending EDs are triaged or assessed for urgency. The Australasian College of Emergency Medicine has identified five triage categories and defines the desirable time by when treatment should commence for patients in each category.
	The aim of this indicator is to ensure the treatment of patients occurs within appropriate clinical benchmark times.
Calculating performance	A patient is categorised as having been seen within clinically appropriate time where the time to treatment is as defined in the VEMD manual.
	Time to treatment equals b – a, where:
	• 'a' is arrival date and time
	• 'b' is the date and time of the initiation of patient management (either by a doctor, a mental health practitioner or a nurse, whichever is earliest).
	This indicator excludes those presentations with a departure status code of:
	• 10 – left after advice regarding treatment options
	• 11 – left at own risk without treatment
	• 30 – referred to collocated clinic.
	This indicator is expressed as a percentage and rounded to the nearest whole number (0.5 is rounded up).
Numerator	Number of triage category 1 to 5 emergency patients seen within desirable times.
Denominator	Total number of triage category 1 to 5 emergency patients.
Statewide target	80%
Achievement	Greater than or equal to 80% Achieved
	Less than 80% Not achieved
Improvement	Improvement is calculated based on same time last year performance.
Frequency of reporting and data collection	Performance is monitored and assessed monthly.
	Quarterly and annual results are also generated.
	Data is expected to be submitted by health services via the VEMD. Refer to the *Policy and Funding Guidelines* for further information on VEMD data submission timelines.
	This indicator is measured at the campus level.

Indicator: Percentage of emergency patients with a length of stay in the ED of less than four hours

Element	Details
Description	This indicator measures the effectiveness of hospital processes and patient flow. The measure aims to encourage more timely management of ED patients who are admitted to the hospital, referred to another hospital or discharged within four hours.
Calculating performance	This indicator is measured at the campus level and excludes patients referred to a collocated clinic. This indicator is expressed as a percentage and rounded to the nearest whole number (0.5 is rounded up).
Numerator	Number of patients with an ED length of stay of less than or equal to four hours (240 minutes).
Denominator	Total number of patients presenting to the ED.
Statewide target	81%
Achievement	Greater than or equal to 81% Achieved Less than 81% Not achieved
Improvement	Improvement is calculated based on same time last year performance.
Frequency of reporting and data collection	Performance is monitored and assessed monthly. Quarterly and annual results are also generated. Data is submitted by health services via the VEMD. Refer to the *Policy and Funding Guidelines* for further information on VEMD data submission timelines.

Indicator: Number of patients with a length of stay in the ED greater than 24 hours

Element	Details
Description	This indicator measures the timely transfer of emergency patients to an inpatient bed or discharge from the ED. It reflects the effectiveness of hospital patient flow processes and discharge planning.
Calculating performance	This indicator is measured at the campus level and excludes patients whose status is dead on arrival. **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 patients with an ED length of stay of greater than 24 hours (1,440 minutes), regardless of departure status code.
Statewide target	0 patients
Achievement	0 patients — Achieved Greater than or equal to 1 patient — Not achieved
Improvement	Improvement is calculated based on same time last year performance.
Frequency of reporting and data collection	Performance is monitored and assessed monthly. Quarterly and annual results are also generated. Data is submitted by health services via the VEMD. Refer to the *Policy and Funding Guidelines* for further information on VEMD data submission timelines.

Elective surgery

Elective surgery performance indicators aim to encourage improved performance in managing healthcare for elective surgery patients. Elective surgery services should be provided in accordance with the *Elective surgery access policy* (2015). HealthVic Surgical services <http://www.health.vic.gov.au/surgery/policies>.

Indicator: Percentage of elective surgery patients admitted within clinically recommended time

Element	Details	
Description	All elective surgery patients are allocated an urgency category that indicates the desirable timeframe for admissions due to their clinical condition.	
	There are three urgency categories:	
	• urgency category 1 patients – admission within 30 days is desirable	
	• urgency category 2 patients – admission within 90 days is desirable	
	• urgency category 3 patients – admission within 365 days is desirable.	
	This indicator is measured at the health service level. Where a health service has multiple campuses, the aggregate for all campuses is used.	
Calculating performance	Only records assigned an intended procedure code[12] and with a readiness status of R (ready for surgery) are used to assess this indicator.	
	A removal in the Elective Surgery Information System (ESIS) is counted when 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 Elective 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	
	• Y – procedure received at intended campus, not planned at admission (excludes emergency admission)	
	• M – admitted to the intended campus or any campus with the health service and has received the awaited procedure as an emergency admission.	
	A broader range of removal codes is used for this indicator compared with the indicator that measures the number of patients admitted.	
	This indicator is expressed as a percentage and rounded to one decimal place (0.05 is rounded up).	
Numerator	Number of patients admitted within clinically recommended timeframes, aggregated across all urgency categories.	
Denominator	Total number of patients admitted.	
Statewide target	94%	
Achievement	Greater than or equal to 94%	Achieved
	Less than 94%	Not achieved
Improvement	For the purpose of the performance risk assessment, improvement is compared to same time last year performance.	

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[12] Principal Prescribed Procedure (PPP) codes of less than 500 are accepted for episodes that were registered before 1 July 2019.

Element	Details
Frequency of reporting and data collection	Performance is monitored and assessed monthly. Data is submitted by health services via ESIS. Refer to *Policy and Funding Guidelines* for further information on ESIS data submission timelines.

Indicator: Percentage of urgency category 1 elective surgery patients admitted within 30 days

Element	Details
Description	Urgency category 1 elective surgery patients are patients 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	Only records assigned an intended procedure[13] and with a readiness status of R (ready for surgery) are used to assess this indicator. A removal in ESIS is counted when 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 • Y – procedure received at intended campus, not planned at admission (excludes emergency admission) • M – admitted to the intended campus or any campus with the health service and has received the awaited procedure as an emergency admission. A broader range of removal codes is used for this indicator compared with the indicator that measures the number of patients admitted. This indicator is expressed as a percentage and rounded to one decimal place (0.05 is rounded up). This indicator is measured at the health service level. Where a health service has multiple campuses, the aggregate for all campuses is used. **Performance breach notification** If a category 1 elective 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%
Achievement	Equal to 100% Achieved Less than 100% Not achieved
Improvement	For the purpose of the performance risk assessment, improvement is compared to same time last year performance.

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[13] Principal Prescribed Procedure (PPP) codes of less than 500 are accepted for episodes that were registered before 1 July 2019.

Element	Details
Frequency of reporting and data collection	Performance is monitored and assessed monthly.
	Data is submitted by health services via ESIS. Refer to the *Policy and Funding Guidelines* for further information on ESIS data submission timelines.

Indicator: Number of patients on the elective surgery waiting list

Element	Details
Description	Elective surgery performance indicators aim to encourage improved performance in managing healthcare for elective surgery patients.
	This indicator measures the number of patients waiting for elective surgery as at the end of the reporting period and is measured at the health service level. Where health services have multiple campuses, the aggregate for all campuses is used.
Calculating performance	Only records assigned an intended procedure[14] and with a readiness status of R (ready for care) are used to assess this indicator.
	This indicator is expressed as a whole number.
	Agreed individual health service quarterly targets consider external factors impacting on service capacity such as peaks in emergency demand and seasonal fluctuations. Notional monthly targets are used to assist with monitoring performance.
Numerator	Number of patients, for all urgency categories, waiting for elective surgery at the end of the reporting period.
Specific health service target	As agreed in the SOP.
Achievement	Target achieved Achieved
	Target not achieved Not achieved
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	Performance is monitored and assessed monthly.
	Data is submitted by health services via ESIS. Refer to the *Policy and Funding Guidelines* for further information on ESIS data submission timelines.

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[14] Principal Prescribed Procedure (PPP) codes of less than 500 are accepted for episodes that were registered before 1 July 2019.

Indicator: Reduce long waiting elective surgery patients

Element	Details
Description	Percentage of patients on the waiting list who have waited longer than clinically recommended time for their respective triage category.
Calculating performance	Only records assigned an intended procedure[15] are used to assess this indicator.
	The measure considers the 'total' waiting list at a health service, not only patients who are 'ready for surgery'. 'Total number of patients on the waiting list' means all patients with readiness status of R, S, F, C or P.
	Proportional improvement (under the Achievement section below) denotes the incremental performance improvement required to achieve the indicator should the statewide target not be achieved at 30 June.
	This indicator is measured at the health service level. Where a health service has multiple campuses, the aggregate for all campuses is used.
	Example
	At 30 June (Year 1), Health Service A has:
	• 100 patients on the Elective 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 Elective Surgery Waiting List (regardless of readiness status).
	Therefore, 10 per cent of patients had waited longer than clinically recommended time.
	At 30 June (Year 2), Health Service A has:
	• 85 patients on the Elective 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 Elective Surgery Waiting List (regardless of readiness status).
	Therefore, Health Service A had 8.5 per cent of patients who had waited longer than clinically recommended time at this time
	Health Service A did not achieve the state-wide target (less than 5 per cent), however did achieve a 15 per cent proportional improvement (10 per cent vs 8.5 per cent), therefore meeting this indicator.
Numerator	Total number of patients on the Elective Surgery Waiting List (regardless of readiness status) who have waited longer than clinically recommended times (> 30 'ready for care days' for category 1, > 90 'ready for care days' for category 2, > 365 'ready for care days' for category 3).
Denominator	Total number of patients on the Elective Surgery Waiting List (regardless of readiness status).
Statewide target	5%
Achievement	Less than or equal to 5% <u>OR</u> if state wide target not met, at least 15% proportional improvement from prior year as calculated at 30 June. Achieved
	Greater than 5% <u>AND</u> less than 15% proportional improvement from prior year as calculated at 30 June. Not achieved

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[15] Principal Prescribed Procedure (PPP) codes of less than 500 are accepted for episodes that were registered before 1 July 2019.

Element	Details
Improvement	The 15 per cent proportional improvement from prior year (as indicated under the achievement section) is different to improvement achieved for the purpose of the risk assessment.
	The former denotes an alternative level of achievement calculated at the end of year and reflected in the Annual Report against the SOP targets.
	Quarterly improvement for the purpose of the performance risk assessment is the proportional reduction in overdue patients compared to previous quarter. As such, for Q1 (Year 2) this will be compared to Q4 (Year 1); Q2 (Year 2) to Q1 (Year 2) and so on.
Frequency of reporting and data collection	Performance is monitored and assessed quarterly.
	Data is submitted by health services via ESIS.

Indicator: Number of patients admitted from the elective surgery waiting list

Element	Details
Description	This indicator measures the stocks and flows of elective surgery patients and assists the understanding of the demand management of elective surgery patients.
	Individual targets are negotiated with each health service. Targets for the number of patients admitted from the waiting list during each month are set at the health service level, rather than individual hospital level.
	The phased targets set for individual health services reflect peaks in emergency demand and seasonal capacity limitations. To enable this indicator to be monitored on a monthly basis health services provide the department with phased monthly targets.
Calculating performance	The number of patients during the reporting period who have been admitted for the awaited procedure, or related procedure, that addresses the clinical condition for which they were added to the elective surgery waiting list.
	Only records assigned an ESIS intended procedure[16] are used to assess this indicator.
	Within ESIS data, a removal is counted as a planned admission if the removal date falls within the quarter being reported and the reason for removal is either:
	• W – admitted to 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.
	Planned admissions have a narrower range of removal codes than the codes used for the indicators dealing with the percentage of patients removed within time.
	This indicator is expressed as a whole number.
Numerator	Number of admitted patients.
Target	Specific health service target as agreed in the SOP.
Achievement	Achieved
	Not achieved
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	Performance is monitored and assessed monthly. In addition to monthly monitoring, a performance result is generated annually based on the full year data.
	Data is submitted by health services via ESIS. Refer to the *Policy and Funding Guidelines* for further information on ESIS data submission timelines.

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[16] Principal Prescribed Procedure (PPP) codes of less than 500 are accepted for episodes that were registered before 1 July 2019.

Indicator: Number of hospital-initiated postponements made within 28 days of a scheduled elective surgery admissions per 100

Element	Details
Description	This indicator measures the number of hospital-initiated postponements (HiPs) that occur within 28 days of a scheduled elective surgery admission experienced by elective surgery patients during a quarter.
Calculating performance	Only records assigned an intended procedure[17] code used to assess this indicator. All HiPs that occur within 28 days of a scheduled elective surgery admission within the quarter will impact on performance regardless of whether the patient is 'ready for surgery', 'not ready for surgery – staged patients', 'not ready for surgery – pending improvement of clinical condition', 'not ready for surgery – deferred for personal reasons' or has been removed from the waiting list. HiPs are counted for the quarter in which they actually occur, even if the procedure being postponed was scheduled for a different quarter. A postponement is hospital-initiated if the reason for the scheduled admission date change in ESIS is recorded as: • 100 – surgeon unavailable • 101 – surgical unit initiated • 102 – hospital staff unavailable • 103 – ward bed unavailable • 104 – critical care bed unavailable • 105 – equipment unavailable • 106 – theatre overbooked • 108 – emergency priority • 109 – elective priority • 110 – hospital or surgeon has not prepared patient • 111 – clerical or booking error. This indicator is rounded to one decimal place (0.05 is rounded up).
Numerator	Number of HiPs that occur within 28 days of a scheduled elective surgery admission within the quarter.
Denominator	Number of procedures scheduled to occur in the quarter, regardless of whether the procedure actually takes place.
State-wide target	7 per 100 scheduled admissions.
Achievement	Less than or equal to 7 per 100 scheduled admissions Achieved Greater than 7 per 100 scheduled admissions Not Achieved
Frequency of reporting and data collection	Performance is monitored and assessed quarterly. In addition to the monthly monitoring, a performance result is generated annually based on full year data. This indicator is measured at the health service level. Where a health service has multiple campuses, the aggregate for all campuses is used. Data is submitted by health services via ESIS. Refer to the *Policy and Funding Guidelines* for further information on ESIS data submission timelines.

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[17] Principal Prescribed Procedure (PPP) codes of less than 500 are accepted for episodes that were registered before 1 July 2019.

Specialist clinics

Specialist clinic performance indicators aim to encourage improved performance in managing access for patients who are referred to a specialist clinic by a general practitioner (GP) or external specialist. Management of patient referrals to specialist clinics, including allocation of appointments, should be provided in accordance with the *Specialist clinics in Victorian public hospitals: access policy* (2013).[18]

Indicator: Proportion of urgent patients referred by a GP or external specialist who attended a first appointment within 30 days

Element	Details
Description	The indicator monitors the proportion of urgent patients referred by a GP or external specialist who attended a first appointment within 30 days of the referral.
Calculating performance	Specialist clinic referrals that have been clinically prioritised as urgent are used to assess this indicator.
	The indicator includes all patients referred from either a GP or external specialist who attended a first appointment during or had a first appointment booked date before the end of the reporting period.
	This indicator includes those patients with a scheduled appointment but failed to attend.
	The waiting time for a first appointment is the number of days between the Referral in Received Date and the Contact Date/Time or First Appointment Booked Date, whichever occurs first.
Numerator	The number of urgent patients referred by a GP or external specialist, who waited 30 calendar days or less for a first appointment, or first appointment booked date before the end of the reporting period.
Denominator	The number of all urgent patients referred by a GP or external Specialist, who attended a first appointment, or had a first appointment booked date, before the end of the reporting period.
Statewide target	100%
Achievement	Equal to 100% — Achieved
	Less than 100% — Not achieved
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 monitored and assessed monthly.
	Data is submitted by health services via VINAH.
	Submission date: Health services are encouraged to submit data as often as desired, so long as a minimum of one submission is made for each reference month no later than 5pm on the 10th day of the following reference month.
	Clean date: All errors are to be cleared by the 14th day of the following month, or the preceding working day if the 14th falls on a weekend or public holiday.
	End of financial year consolidation: All errors for the financial year must be corrected and resubmitted before consolidation of the VINAH database on the date advised in the *Policy and Funding Guidelines*.

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[18] This policy is currently being refreshed.

Indicator: Proportion of routine patients referred by a GP or external specialist who attended a first appointment within 365 days

Element	Details
Description	The indicator monitors the proportion of routine patients referred by a GP or external specialist who attended a first appointment within 365 days of referral.
Calculating performance	Specialist clinic referrals that have been clinically prioritised as routine are used to assess this indicator.
	The indicator includes all patients referred from either a GP or external specialist, who attended a first appointment during, or had a first appointment booked date before the end of the reporting period.
	This indicator includes those patients with a scheduled appointment but did not attend.
	The waiting time for a first appointment is the number of days between the Referral in Received Date and the Contact Date/Time or First Appointment Booked Date, whichever occurs first.
Numerator	The number of routine patients referred by a GP or external specialist, who waited 365 calendar days or less for a first appointment, or first appointment booked date before the end of the reporting period.
Denominator	The number of all routine patients referred by a GP or external specialist, who attended a first appointment or had a first appointment booked date before the end of the reporting period.
Statewide target	90%
Achievement	Equal to or above 90% Achieved Less than 90% Not achieved
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 monitored and assessed monthly.
	Data is submitted by health services via VINAH.
	Submission date: Health services are encouraged to submit data as often as desired, so long as a minimum of one submission is made for each reference month no later than 5pm on the 10th day of the following reference month.
	Clean date: All errors are to be cleared by the 14th day of the following month, or the preceding working day if the 14th falls on a weekend or public holiday.
	End of financial year consolidation: All errors for the financial year must be corrected and resubmitted before consolidation of the VINAH database on the date advised in the *Policy and Funding Guidelines*.

Indicator: Proportion of urgent maternity patients referred for obstetric care to a level 4, 5 or 6 maternity service who were booked for an appointment within 30 days of accepted referral

Element	Details
Description	The indicator monitors the proportion of urgent maternity patients referred to level 4, 5 or 6 maternity service, who attended a first appointment within 30 days of accepted referral.
Calculating performance	The waiting time represents the number of days between the Referral in Received Date and the First Appointment Booked Date.
	Applies to health services determined by the department to provide level 4, 5 or 6 maternity capability. For details of the maternity capability levels for all public services, go to the Policy and Funding Guidelines <https://www2.health.vic.gov.au/about/policy-and-funding-guidelines>.
	Data for this indicator is derived from the Victorian Integrated Non-Admitted Health (VINAH) dataset.
	The *VINAH user manual*, including data elements and business rules can be found at the VINAH webpage <https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/data-collections/vinah>
Numerator	The number of urgent maternity patient contacts scheduled within the reporting period for an appointment within 30 days of referral to clinic.
Denominator	The number of urgent maternity patient contacts scheduled within the reporting period for an appointment.
Statewide target	100%
Achievement	Equal to 100% Achieved
	Less than 100% Not achieved
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 monitored and assessed quarterly for contacts scheduled within the reporting period.
	Data for this indicator is derived from VINAH.
	Submission date: health services are encouraged to submit data as often as desired, so long as a minimum of one submission is made for each reference month no later than 5pm on the 10th day of the following reference month.
	Clean date: all errors are to be cleared by the 14th day of the following month, or the preceding working day if the 14th falls on a weekend or public holiday.
	End of financial year consolidation: all errors for the year must be corrected and resubmitted before consolidation of the VINAH database on the date advised in the *Policy and Funding Guidelines*.

Key Performance Measures and Underlying Risk Factors 2019–20

Timely response (Ambulance Victoria only)

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

Element	Details	
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.	
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 of the first arrival at the incident scene of an Ambulance Victoria paramedic, a community emergency response team or an ambulance community officer. This indicator applies to all emergency road Code 1 incidents responded to statewide. This indicator excludes: • incidents for which the response time was recorded as > 2 hours or where there are missing time stamps • responses to ambulance incidents by the Metropolitan Fire Brigade, the Country Fire Authority, NSW Ambulance Service and remote area nurses • responses by air ambulance resources. This indicator is expressed as a percentage to one decimal place.	
Numerator	The sum of all first arrival responses from each emergency road Code 1 incident responded to within 15 minutes.	
Denominator	Total number of emergency road Code 1 incidents responded to in that same reporting period.	
Statewide target	85%	
Achievement	Equal to or greater than 85%	Achieved
	Less than 85%	Not achieved
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 monitored and assessed monthly. Ambulance Victoria submits data to the department monthly.	

Indicator: Percentage of emergency (Priority Zero) incidents responded to within 13 minutes

Element	Details
Description	Percentage of emergency (Priority Zero) cases attended within 13 minutes of the triple zero (000) call.
	Statewide response times are an indicator 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 measures the time from a triple zero (000) call being answered by ESTA to the time of the first arrival at the incident scene of an Ambulance Victoria paramedic, a community emergency response team or an ambulance community officer.
	This indicator applies to all emergency road Priority Zero incidents responded to statewide.
	This indicator excludes:
	• incidents for which the response time was recorded as > 2 hours or where there are missing time stamps
	• responses to ambulance incidents by the Metropolitan Fire Brigade, the Country Fire Authority, NSW Ambulance Service and remote area nurses
	• responses by air ambulance resources.
	This indicator 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.
Risk flag	85%
Achievement	Equal to or above 85% Achieved
	Below 85% Not achieved
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 monitored and assessed monthly.
	Ambulance Victoria submits data to the department monthly.

Indicator: Percentage of emergency Code 1 incidents responded to within 15 minutes in centres with a population greater than 7,500

Element	Details
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.
Calculating performance	Response time measures the time from a triple zero (000) call being answered by ESTA to the time of the first arrival at the incident scene of an Ambulance Victoria paramedic, a community emergency response team or an ambulance community officer.
	Urban response times are emergency (Code 1) incidents responded to within 15 minutes in centres with a population > 7,500. Urban centres with a population > 7,500 are identified using the Australian Bureau of Statistics resident population statistics and Urban Centre Locality (UCL) boundaries.
	This indicator applies to all emergency road Code 1 incidents responded to in centres with a population > 7,500.
	The locations of Code 1 incidents are identified using the x and y coordinates generated by the ESTA Computer Aided Dispatch (CAD) system. These coordinates are mapped to UCL boundaries to identify those events that fall within the UCLs where the population exceeds 7,500.
	This indicator excludes:
	• incidents for which the response time was recorded as > 2 hours or where there are missing time stamps
	• responses to ambulance incidents by the Metropolitan Fire Brigade, the Country Fire Authority, NSW Ambulance Service and remote area nurse
	• responses by air ambulance resources.
	This indicator is expressed as a percentage to one decimal place.
Numerator	Number of emergency Code 1 incidents aggregated across all the UCLs with a population > 7,500 responded to within (≤) 15 minutes.
Denominator	Total number of emergency Code 1 incidents across all the UCLs with a population > 7,500 responded to in that same reporting period.
Statewide target	90%
Achievement	Equal to or greater than 90% Achieved
	Less than 90% Not achieved
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 monitored and assessed monthly.
	Ambulance Victoria submits data to the department monthly.

Indicator: Percentage of triple zero (000) cases where the caller receives advice or service from another health provider as an alternative to an emergency ambulance response – statewide

Element	Details
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 (000) 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 ESTA call-taker.
	This indicator applies to all 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 indicator is expressed as a percentage to one decimal place.
	Improvement is compared to same time last year performance
Numerator	Total number of cases managed by the Referral Service that did not result in an emergency response.
Denominator	Total number of emergency cases + total number of Referral Service managed cases that did not result in an emergency response.
Statewide target	15%
Achievement	Equal to or greater than 15% Achieved
	Less than 15% Not achieved
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 monitored and assessed monthly.
	Ambulance Victoria submits data to the department monthly.

Indicator: Average ambulance hospital clearing time

Element	Details
Description	Clearing time is a key component of total paramedic hospital time that is directly attributable to Ambulance Victoria.
	This indicator measures the elapsed time from the handover of an emergency patient at a hospital emergency department to completion of all tasks to ensure the ambulance crew is available to respond to another incident.
	Handover involves a patient being physically transferred to a hospital trolley, bed, chair or waiting area. The 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 indicator applies to all emergency transports to a hospital emergency department statewide.

Element	Details
Calculating performance	The average time for the given period. Off-stretcher time and clearing time are sourced from the PCR. This indicator excludes: • hospital transports where the clearing time was recorded as > 3 hours or where there are missing time stamps • transports by air ambulance resources • non-emergency hospital transports • inter-hospital transports. This indicator is expressed as either minutes to one decimal place or in the following format: MM:SS. Improvement is compared to same time last year performance
Numerator	The sum of emergency road clearing times.
Denominator	The total number of emergency road clearing times in that same reporting period.
Statewide target	20 minutes
Achievement	Less than or equal to 20 minutes Achieved Greater than 20 minutes Not achieved
Improvement	For the purpose of the performance risk assessment, improvement is compared to previous quarter performance.
Frequency of reporting and data collection	Performance is monitored and assessed monthly. Data is lagged by one month. Ambulance Victoria submits data to the department monthly.

Forensicare: Admissions to Thomas Embling Hospital (TEH)

Indicator: Number of male security patients admitted to acute units in TEH

Element	Details
Description	Number of security patients admitted to male acute units at TEH.
Calculating performance	The number of admissions to TEH acute units where the client is male and on a security order at the time of admission. Performance is measured as an integer. Performance is assessed quarterly.
Numerator	Admissions to TEH acute units in the applicable time period, where the client is male, and is on a security order (order codes 105 and 202) at the time of admission.
Denominator	N/A
Statewide target	80
Achievement	Equal to or greater than 80 Achieved Less than 80 Not achieved
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 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. The data source for this indicator is the Client Management Interface (CMI), which is the local client information system used by each public mental health service. It also uses the Operational Data Store (ODS), which manages a set of select data items from each CMI. The initialism used for this data source is CMI/ODS.

Indicator: Percentage of male security patients admitted to TEH within 14 days of certification

Element	Details
Description	Percentage of male security patients admitted to TEH within 14 days of being certified as requiring compulsory treatment.
Calculating performance	Percentage of male clients admitted to TEH within 14 days after being placed on a court secure treatment order or a secure treatment order (order codes 105 and 202) within the applicable time period.
	Performance is assessed quarterly.
Numerator	Total number of male security patients who were certified as requiring compulsory treatment, and who were transferred to TEH within 14 days.
	Patient is counted when the number of days between certification and transfer to TEH is within 14 days.
Denominator	Total number of male clients placed on a court secure treatment order or a secure treatment order (order codes 105 and 202) within the applicable time period.
Statewide target	100%
Achievement	Equal to 100% Achieved
	Less than 100% Not achieved
Improvement	For the purpose of the performance risk assessment, improvement is compared to previous quarter performance.
Frequency of reporting and data collection	Indicator is reported quarterly.
	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.
	The data source for this indicator is the Client Management Interface (CMI), which is the local client information system used by each public mental health service. It also uses the Operational Data Store (ODS), which manages a set of select data items from each CMI. The initialism used for this data source is CMI/ODS.

Forensicare: Length of stay – male security patients

Indicator: Percentage of male security patients discharged to prison within 80 days

Element	Details
Description	Percentage of male security patients within TEH discharged to a correctional centre within 80 days.
Calculating performance	Performance is assessed quarterly.
Numerator	Total number of discharges within 80 days from TEH acute units in the applicable time period, where the client was male and on a security order. Exclude same day stays.
	Calculating numerator:
	1. Select discharges from TEH acute units in the applicable time period, where the client was on a security order (order codes 105 and 202) at the time of discharge.
	a. This is based on episode end date, except in instances where a client was discharged whilst in leave, then take the date sent on leave.
	b. Calculate length of stay by taking the difference in minutes between the episode start date & time and the end date & time. Convert time difference to days by multiplying by *0.000694444444 (1/60mins/24hrs).
	c. Exclude those instances where the length of stay is greater than 80.
	d. Exclude same day stays.
	2. Count the number of discharges per team.
Denominator	Total number of occupants in the TEH acute units in the applicable time period, where the client was male and was on a security order (at discharge/end of reporting period). Exclude same day stays.
	Calculating denominator:
	1. Select all male clients in TEH acute units in the applicable time period. Exclude same day stays.
	a. Include only those clients on a security order (order codes 105 and 202) at the end of the reporting period, or for those clients that were discharged within the reporting period, at the time of discharge.
	b. For those clients not discharged within the applicable time period, exclude those clients that have length of stay less than 80 days.
	2. Count the number of episodes per team.
Statewide target	75%
Achievement	Equal to or greater than 75% Achieved
	Less than 75% Not achieved
Improvement	For the purpose of the performance risk assessment, improvement is compared to previous quarter performance.

Element	Details
Frequency of reporting and data collection	CMI/ODS (Mental Health Client Management Information / Operational Data Store). Indicator is reported quarterly. 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. The data source for this indicator is the Client Management Interface (CMI), which is the local client information system used by each public mental health service. It also uses the Operational Data Store (ODS), which manages a set of select data items from each CMI. The initialism used for this data source is CMI/ODS.

Indicator: Percentage of male security patients at TEH discharged within 21 days of becoming a civil patient

Element	Details
Description	Percentage of male security patients at TEH whose security order expired, who were discharged to community or a Designated Mental Health Service within 21 days.
Calculating performance	Performance is assessed quarterly.
Numerator	Total number of male security patients at TEH whose security order expired during the reference period, and were subsequently discharged to the community or an area mental health service within 21 days. Numerator calculation: 1. Obtain male clients admitted to TEH acute units who had a security order (code 105 & 202) expire during the reporting period. Include only those clients that were discharged from Forensicare Thomas Embling Hospital within 21 days after the security order expired. a. Obtain all TEH acute clients who had a security order expire (order codes 105 & 202) during the reporting period b. Exclude those who have had an extension with a subsequent security order or who have returned to MAP Exclude those who are still in TEH 21 days after their security order expired 2. Count the number.
Denominator	Total number of male TEH acute unit clients whose security order expired during the reference period. Denominator calculation: 1. Obtain male clients admitted to TEH acute units who had a security order (code 105 & 202) expire during the reporting period. a. Obtain all TEH acute unit clients who had a security order expire (order codes 105 & 202) during the reporting period. b. Include only those who had a civil order to follow. Exclude those who have had an extension with a subsequent security order or who have returned to MAP. 2. Count the number.
Statewide target	75%
Achievement	Equal to or greater than 75%　　　　　　　　　　Achieved Less than 75%　　　　　　　　　　　　　　　　　Not achieved
Improvement	For the purpose of the performance risk assessment, improvement is compared to previous quarter performance.

Element	Details
Frequency of reporting and data collection	CMI/ODS (Mental Health Client Management Information / Operational Data Store). Indicator is reported quarterly. 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. The data source for this indicator is the Client Management Interface (CMI), which is the local client information system used by each public mental health service. It also uses the Operational Data Store (ODS), which manages a set of select data items from each CMI. The initialism used for this data source is CMI/ODS.

Effective financial management

Indicator: Operating result as a percentage of revenue

Element	Details
Description	This indicator is a measure of financial sustainability.
	The agreed SOP target should achieve an operating surplus necessary to maintain or, where necessary, improve the current operating cash position. This requirement aligns with the department's reform priority to increase the financial sustainability and productivity of the health system.
Calculating performance	This indicator is predicated on the year-to-date (YTD) operating result in the SOP. The variance between the actual YTD result reported in the Agency Information Management System (AIMS) F1 and the target, which is the YTD budget loaded in the F1 (based on the agreed SOP outcome) is the measured outcome. It is expressed as a percentage and rounded to two decimal places.
	The indicator excludes consolidated entities (with the exception of Monash Health, which includes Jessie McPherson Private Hospital and Western Health which includes Western Health Foundation).
	Phased monthly targets are based on the September AIMS F1 submission for the financial year. Changes thereafter are only reported on agreement between the department and the health service regardless of the data submitted in the AIMS F1.
	The opportunity to prospectively re-phase monthly targets tracking to the agreed annual operating result should be negotiated with the department. Should the phasings require adjusting; these changes will be considered on a quarterly basis and, where agreed, submitted in the F1 by the health service.
	Note that the department does not support retrospective changes to phased targets.
Numerator	YTD operating result before capital and depreciation.
Denominator	YTD total revenue.
Target	As agreed in the SOP for each health service.
Achievement	Actual F1 YTD operating as % of revenue is greater than Budgeted F1 YTD operating as % of revenue — Achieved
	Actual F1 YTD operating as % of revenue is less than Budgeted F1 YTD operating as % of revenue — Not achieved
Improvement	For the purpose of the performance risk assessment, improvement is assessed against phased target result, except for Q1 (no change).
Frequency of reporting and data collection	Performance is monitored and assessed monthly.
	The annual result is generated on receipt of audited financial data submitted in the AIMS F1.
	Data is submitted by health services monthly via AIMS F1. Refer to the *Guidelines for completing the F1 (finance return)* for further information on completing the F1.
	Refer to the *Policy and Funding Guidelines* for further information about funding policy changes.

Indicator: Trade creditors

Element	Details
Description	This indicator is a short-term liquidity indicator. It represents the average number of days a health service takes to pay creditors. Increasing days beyond the 60-day target may indicate significant cash liquidity issues.
	Note: in response to feedback from health services, and consistent with outcomes from the benchmarking group, an adjustment to the calculation of this indicator has been made to include account codes related to inter hospital and accrual expenses.
Calculating performance	Average trade creditors divided by the average daily non-salary costs.
	Trade creditors are defined as account codes between:
	• 80101 to 80199: trade creditors – system generated
	• 80600 to 80649: creditors – inter hospital
	• 81001 to 81099: accrual expenses.
	Non-salary costs are defined as account codes in the ranges:
	• 20001 to 38900 (excludes accounts 37036–37040: PPP interest expense)
	• 12501 to 13211.
	This indicator is calculated at a health service level and calculation of the indicator does not include controlled entities cost range Z9002–Z9101 and Z9502–Z9655 (with the exception of Monash Health, which includes Jessie McPherson Private Hospital and Western Health which includes the Western Health Foundation).
	The indicator is expressed as a number of whole days, therefore rounded to the nearest whole number (0.5 is rounded up).
Numerator	The sum of trade creditors at the end of the previous financial year and trade creditors at the end of the reporting month divided by two.
Denominator	YTD non-salary costs divided by the YTD number of days.
Statewide target	60 days
Achievement	Less than or equal to 60 days Achieved
	Greater than 61 days Not achieved
Improvement	For the purpose of the performance risk assessment, improvement is assessed against prior year's results for the same period.
Frequency of reporting and data collection	Performance is monitored and assessed monthly.
	The annual result is generated on receipt of audited financial data submitted in the AIMS F1.
	Data is expected to be submitted by health services monthly via AIMS F1. Refer to the *Guidelines for completing the F1 (finance return)* for further information on completing the F1.

Indicator: Patient fee debtors

Element	Details
Description	This indicator is a short-term liquidity indicator. It represents the average number of days a health service takes to collect debts in relation to patient fees. The length of time it takes for private health funds and statutory bodies (such as the TAC) to settle their accounts will influence the result. A fall in days indicates more effective collection.
Calculating performance	Average patient fees receivable divided by the average daily patient fee revenue. Patient fees receivable are defined as the following account codes: • 71001 to 71049: debtors – private inpatients • 71071 to 71075: debtors – private inpatients (uninsured overseas visitors) • 71100 to 71149: debtors – private outpatients • 71200 to 71249: debtors – nursing home / hostel • 71300 to 71349: debtors diagnostic billing • 71401 to 71449: other patient debtors – for example: day hospital. Patient fees revenue are defined as the following account codes: • 50001 to 50040: admitted patient fees – acute • 50041 to 50043: admitted patient fees uninsured debtors • 50051 to 50396: admitted patient fees – other • 50401 to 50730: non-admitted patient fees • 50751 to 50756: transport fees – Ambulance Victoria • 50901 to 50960: private practice fees • 59111 to 59149: private practice fees. This indicator is calculated at a health service level and calculation of the indicator does not include controlled entities cost range Z9002–Z9101 and Z9502–Z9655 (with the exception of Monash Health, which includes Jessie McPherson Private Hospital and Western Health, which includes the Western Health Foundation). The indicator is expressed as a number of whole days, therefore rounded to the nearest whole number (0.5 is rounded up).
Numerator	The sum of patient fees receivable at the end of the previous financial year and the patient fees receivable at the end of the reporting month divided by two.
Denominator	YTD patient fee revenue divided by the YTD number of days.
Statewide target	60 days
Achievement	Less than or equal to 60 days Achieved Greater than 61 days Not achieved
Improvement	For the purpose of the performance risk assessment, improvement is assessed against prior year's results for the same period.
Frequency of reporting and data collection	Performance is monitored and assessed monthly. The annual result is generated on receipt of audited financial data submitted in the AIMS F1. Data is expected to be submitted by health services monthly via AIMS F1. Refer to the *Guidelines for completing the F1 (finance return)* for further information on completing the F1.

Indicator: Public and Private Weighted Inlier Equivalent Separation (WIES)

Element	Details
Description	The year-to-date (YTD) public and private (PP) WIES indicator aims to reinforce the need for health services to manage their activity in line with the published recall policy.
Calculating performance	In assessing performance, the department recognises that there may be circumstances whereby a health service falls outside the KPI tolerance levels without significantly impacting financial viability. These cases are assessed on a case-by-case basis.
	Phased monthly targets are based on the September F1 submission for the financial year. Changes thereafter are only reported on agreement between the department and the health service regardless of data submitted in the AIMS F1.
	The phased end-of-year targets (as reported for the F1 activity budget) should reflect the agreed activity targets.
	YTD activity performance against the target is expressed as a percentage and rounded to two decimal places (0.055 is rounded up).
Numerator	YTD actual PP WIES.
Denominator	YTD PP WIES target.
Statewide target	100%
Achievement	Between 98% and102% Achieved
	Less than 98% or over 102% Not achieved
Improvement	For the purpose of the performance risk assessment improvement is assessed against the YTD phased target results, except for Q1 which is assessed against same time last year performance.
Frequency of reporting and data collection	Performance is monitored and assessed monthly.
	An annual result is generated based on the YTD result at 30 June (following final consolidation of VAED).
	Data is submitted by health services monthly via the AIMS F1. Refer to the *Guidelines for completing the F1 (finance return)* for further information on completing the F1.
	For further information on the funding policy changes and recall policy please refer to the *Policy and Funding Guidelines.*

Indicator: Adjusted current asset ratio (ACAR)

Element	Details
Description	This indicator is a measure of financial liquidity.
	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. It compares an organisation's current assets to its current liabilities.
	The CAR for hospital performance has been adjusted to include 'Long-Term Investments: Other financial assets' (which excludes Land and Buildings). This recognises 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 the traditional CAR calculations. Further, the Long Service Leave (LSL) liability will be adjusted so that only the current portion of the liability is included. This will utilise a factor based on the previous year's full year balances.
	Additionally, the SOP targets will be established. These will 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	The variance between the actual ACAR based on the audited 30 June result and the target/benchmark is the measured outcome. Targets are based on a health service's final audited ACAR result for the previous financial year, which will form the 'base' upon which health services will be measured.
	Health services that have 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 the indicator 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' in order to be recognised as having improved from their base point.
Numerator	Current asset and long-term investment are defined as:
	• 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	All short-term liabilities are defined as accounts 80000 to 86699.
	Excludes the non-current portion of LSL liability, based on previous year's % of total LSL balance for each health service.
Statewide target	0.7
Achievement	Statewide target achieved OR 3% improvement from health service base target.
	Statewide target not achieved OR less than 3% 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.

Element	Details
Frequency of reporting and data collection	Performance is monitored and assessed monthly.
	The annual result is generated on receipt of audited financial data submitted in the AIMS F1.
	Data is submitted by health services monthly via AIMS F1. Refer to the *Guidelines for completing the F1 (finance return)* for further information on completing the F1.
	Refer to the *Policy and Funding Guidelines* for further information about funding policy changes.

Indicator: Forecast days of available cash

Element	Details
Description	This measure presents the number of days a health service can maintain its operations with unrestricted available cash, **projected as at 30 June**. Ideally, health services will project, at the end of the financial year, to have sufficient cash and cash equivalents to cover tied funding obligations and also meet their daily working capital requirements for a period of at least 14 days.
Calculating performance	The results are derived by dividing the numerator by the denominator and rounded to one decimal place. Health service will be measured against the targets stipulated in the 'Achievement' section below. However, for health services that have finished the previous financial year (June 30) below the targeted 14 days, the 30 June result from the previous year will become a 'base' target upon which health service will assessed against for improvement.
Numerator	'Total available funds': unrestricted cash at the end of June, which is all short- and long-term financial assets less committed funding to present the net available cash (total unrestricted funds) that is available to the health service for its operations. Exclude both short-term and long-term: • 'committed obligations for internally managed specific purpose funds' • 'prior year recall' • 'other commitments'.
Denominator	'Working capital' – this is equal to total operating expenditure excluding controlled entities as reported in the *F1 Budget Income – SOP* worksheet. This is then divided by 365 (total days in year) to arrive at the average daily working capital requirement.
Statewide target	14.0 days
Achievement	June End of Year Forecast is equal to or above 14.0 days Achieved June End of Year Forecast is less than 14.0 days Not achieved
Improvement	For the purpose of the performance risk assessment improvement is assessed against the 30 June base.
Frequency of reporting and data collection	Projected cash at 30 June is based on the AIMS F1 submission (*Actual cashflow worksheet*) for the financial year. If the *Actual cashflow worksheet* does not provide forecast (out-months) cashflow data through to the end of year, the target will be assessed as not achieved. Performance is monitored and assessed monthly. The annual result is generated on receipt of audited financial data submitted in the AIMS F1. Data is submitted by health services monthly via AIMS F1. Refer to the *Guidelines for completing the F1 (finance return)* for further information on completing the F1. Refer to the *Policy and Funding Guidelines* for further information about funding policy changes.

Indicator: Days of available cash (monthly)

Element	Details
Description	This measure presents the number of days a health service can maintain its operations with unrestricted available cash, measured on the last day of each month. Ideally, health services will report sufficient cash and cash equivalents to cover funding obligations and also meet their daily working capital requirements for a period of at least 14 days.
Calculating performance	The results are derived by dividing the numerator by the denominator and rounded to one decimal place. Health services will be measured against the targets stipulated in the 'Achievement' section below.
Numerator	'Total available funds': unrestricted cash at the end of each month, which is all short- and long-term financial assets less committed funding to present the net available cash (total unrestricted funds) that is available to the health service for its operations. Exclude both short-term and long-term: • 'committed obligations for internally managed specific purpose funds' • 'prior year recall' • 'other commitments'.
Denominator	'Working capital' – this is equal to total operating expenditure excluding controlled entities as reported in the *F1 Budget Income – SOP* worksheet. This is then divided by 365 (total days in year) to arrive at the average daily working capital requirement.
Statewide target	14.0 Days available cash is attained each month 10 or more months of 14.0 Days available cash are attained annually
Achievement	At least 14.0 Days available cash is attained Achieved Less than 14.0 Days available cash is attained Not achieved
Improvement	For the purpose of the performance risk assessment, improvement is assessed against the 30 June base.
Frequency of reporting and data collection	For the purpose of annual reporting, achievement will be assessed as 10 or more months (during the financial year) for which 14 days of available cash has been attained. Days available cash (monthly) is based on the monthly AIMS F1 submission (*Actual cashflow worksheet)* for the financial year. If the *Actual cashflow worksheet* does not provide cashflow data for the relevant month, the target will be assessed as not achieved. Performance is monitored and assessed monthly. Data is submitted by health services monthly via AIMS F1. Refer to the *Guidelines for completing the F1 (finance return)* for further information on completing the F1. Refer to the *Policy and Funding Guidelines* for further information about funding policy changes.

Indicator: Net result from transactions

Element	Details
Description	This measure presents the accuracy of forecasting the *Net result from transactions (NRFT)* for the current financial year ending 30 June.
	Ideally, health services will report this result with sufficient accuracy to be within a $250,000 acceptable variance.
Calculating performance	The result compares the consolidated forecast *NRFT* as reported to the department in the current financial year, in the *Revised Estimates* F1 submission, with the consolidated actual *NRFT* reported in the Comprehensive Operating Statement in the Audited Financial Statements. This comparison is expressed as a numerical variance.
	It is expected that the final F1 consolidated trial balance will accurately reflect the NRFT as reported in the audited financial statements.
	The NRFT 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*.
	The calculation will be the variance expressed in absolute dollars.
Numerator	*Actual NRFT* as reported in the audited financial statements, subtract *Forecast NRFT* as reported in the final Revised Estimates F1 submission to the department by 7 June[19] for the current financial year.
Statewide target	$250,000
Achievement	Variance less than or equal to $250,000 Achieved
	Variance greater than $250,000 Not achieved
Improvement	Reduced variance from the previous year.
Frequency of reporting and data collection	Annually.
	The *Revised Estimates* are updated and provided to the Department of Treasury and Finance (DTF) 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 DTF are provided in June.[19]
	These estimates assist the Treasurer in determining the State's final financial result.
	Performance is monitored and assessed annually.
	Data is submitted by health services monthly via AIMS F1. Refer to the *Guidelines for completing the F1 (finance return)* for further information on completing the F1.

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[19] The final submission date will be dependent on timelines published by DTF for the 2019–20 financial year.

Underlying Risk Factors (performance input category 2)

The Underlying Risk Factors (performance input category 2) of the Framework are those indicators that provide the underlying contextual element to a health service's performance. These indicators are intended to set out and assess various qualitative aspects of performance for each health service. Namely governance, culture, and other complex assessments of the health service's performance management capability.

The corresponding detailed considerations provide supporting deliberations and further information as against each Underlying Risk Factor. This assists the department and health services in assessing the contextual elements and risks underpinning the environment in which each health service operates, as well as the subsequent impacts on its overarching performance.

Domain	Underlying Performance Risk Factor	Detailed considerations
High quality and safe care	Workforce availability, capacity and capability	Inability to attract or retain suitably qualified and experienced clinicians
		Lack of clinician back-up in the event of unexpected absences or complex care requirements
		Professionally isolated practitioners
		Difficulties managing clinician performance (e.g. due to high reliance or lack of senior clinical oversight)
		High reliance on locums to maintain staffing levels
		High reliance on international medical graduates requiring supervision or on provisional registration
	Ability to respond to changes in community needs	Significant increase in catchment population / demand beyond physical and operational capacity
		Flow-on impact from significant local industry changes
		Limited capacity to redesign services in line with changes in community profile or mix of services (up or down)
	Clinical leadership	Lack of senior clinical leadership (Director of Nursing/ Director of Clinical Services/Director of Medical Services roles unfilled or sessional/part-time)
		Prolonged vacancies and high turnover in senior clinical roles
		Lack of supervision capacity commensurate to the number of junior staff on limited or provisional registration
	Management of complex care or changes in capability	Lack of appropriate infrastructure/staffing to maintain capability and manage complexity (i.e. for low volume activity or procedures)
		Recent increases or decreases in clinical capability (including workforce or support services)
		Inadequate clinical back-up/support arrangements for local care of complex patients
		Significant increase or decrease in volume of specific activity or procedures

Domain	Underlying Performance Risk Factor	Detailed considerations
Strong governance, leadership and culture	Board governance	Inability to attract appropriate skill mix across board directors Lack of quorum or long-standing gaps Lack of clinical or clinical governance expertise General inexperience across the board Lack of a current and department-endorsed Strategic Plan
	Leadership	Long executive tenure Recent turnover of executive staff Lack of capability, engagement and succession planning of leadership and senior clinical teams
	Competing strategic priorities	Major capital or information technology works underway Service continuity risks during works, transition and/or commissioning Insufficient expertise in project management and/or change management
	Safety culture	Evidence of bullying Poor management of complaints Poor reporting culture of patient and/or staff safety incidents High levels of staff disengagement, sick leave and/or turnover rates Limited mechanisms for engaging consumers and their families, including poor handling of complaints Occupational Health & Safety issues
Timely access to care	Workforce sustainability	Ongoing vacancies within clinical areas No evidence of current workforce plan Workforce profile that does not match projected future needs (e.g. ageing workforce, changing community needs)
	Service sustainability	Interruption to service delivery Public profile / reputation impacting on service utilisation Changes in service volume impacting on service viability Inability to adjust local service offerings to respond to changes in community needs
Effective financial management	Financial sustainability	Prolonged history of financial problems Deteriorating operating result and cash position Inherent high costs structure to maintain service delivery Lack of responsiveness to resolve emerging financial issues Financial issues not recognised and/or escalated in a timely manner Quality and timeliness of financial reporting and processes reflecting regular discrepancies/inaccuracies leading to a general lack of confidence in the data submitted Presence of a current loan with the department with limited resources to repay loan within contracted term Requirement for additional cash during financial year

Specific events: Breaches

The below events are considered a performance breach and require immediate escalation to the department.

Health services are required to notify the department (via the Director, Commissioning, Performance and Regulation, or the Director, Rural and Regional Health for rural and regional health services) within 24 hours of a breach or becoming aware of a breach. Notification will set out the circumstances and response to the breach, including whether patient safety has been compromised.

Details for breaches of the following specific events have been outlined above in the relevant Key Performance Measure:

* Emergency Care Triage Category 1 failure
* Emergency Department 24 hours waiting time failure
* Elective Surgery Category 1 admissions
* Compliance with Aged Care Standards.

Details for breaches of the following specific events are outlined below:

* Compliance with the National Safety and Quality Health Service standards
* Colonoscopy Category 1 not treated within recommended time.

Accreditation breach

Compliance with the National Safety and Quality Health Service standards

Consistent with the Australian Health Service Safety and Quality Accreditation Scheme (the Scheme), health services are required to be accredited against the National Safety and Quality Health Service Standards (NSQHS standards).

This scheme applies to all public health services. It includes contracted/outsourced services as if they are being provided by the health service.

Under the Scheme, the department, as the jurisdictional regulator, has responsibility for verifying the accreditation status of Victorian public health services.

In the event of an identified significant patient risk or 'not met' core action item, health services are required to immediately notify the department and submit an action plan to them addressing the issues. The *Accreditation – Performance monitoring and regulatory approach business rules* outline the department's approach to monitoring performance of public health services against the NSQHS standards. Further details on the accreditation requirements can be found at HealthVic public hospital accreditation <https://www2.health.vic.gov.au/hospitals-and-health-services/quality-safety-service/hospital-accreditation>.

For Ambulance Victoria, ISO 9001:2008 (quality management system) certification applies.

Performance breach

A 'not met' criteria for accreditation is considered a performance breach.

Under accountability and funding requirements within the SOP, a health service must comply with the requirements for accreditation consistent with the Scheme.

Colonoscopy Category 1 breach

Colonoscopy Category 1 not treated within recommended time

In 2018, Victoria introduced statewide risk stratified guidelines for the categorisation of colonoscopy procedures for all public hospitals. Patients who are considered a category 1 (the most urgent category) patient against the guidelines are those most at risk of having a suspected colorectal cancer.

Category 1 colonoscopy patients are patients that require treatment within 30 days.

Colonoscopy categorisation guidelines are available from the [Specialist clinics – resources webpage](https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/specialist-clinics/specialist-clinics-program/specialist-clinics-resources) <https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/specialist-clinics/specialist-clinics-program/specialist-clinics-resources>.

Performance breach

A category 1 colonoscopy patient is overdue when the number of days since the patient was accepted by the health service for an urgent colonoscopy has exceeded 30 days, and the event has been verified and confirmed as accurate. The patient will then be regarded as a performance breach and a departmental notification procedure must be initiated by the health service.

It is acknowledged there are currently no agreed data standards for procedural waiting list management. Until that work is completed, the following is to be used by health services:

1. Date of registration for urgent category 1 procedure: the date the health service agrees the procedure is required and the patient is confirmed as a category 1 patient (as per the colonoscopy categorisation guidelines) and

2. Date of admission: Date on which an admitted patient commences an episode of care during which the patient receives the awaited procedure.

A breach is when the difference between (1) and (2) is 31 days or more.

Attachment A: List of health services/campuses required to report Coronary Artery Bypass Graft surgical site infections

The Alfred – Alfred Health

Royal Melbourne Hospital – Melbourne Health

St Vincent's Hospital

The Austin – Austin Health

Monash Medical Centre [Clayton] – Monash Health

University Hospital Geelong – Barwon Health

Attachment B: List of health services/campuses required to report Hip Replacement surgical site infections

Ballarat Health

Bendigo Hospital, The

Box Hill Hospital – Eastern Health

Dandenong Hospital – Monash Health

Echuca Regional Health

Footscray Hospital – Western Health

Frankston Hospital – Peninsula Health

Hamilton Base Hospital

Heidelberg Repatriation Hospital – Austin Health

Latrobe Regional Hospital

Maroondah Hospital – Eastern Health

Mildura Base Hospital

Monash Medical Centre [Moorabbin] – Monash Health

Royal Melbourne Hospital – Melbourne Health

Sandringham & District Memorial – The Alfred

Shepparton – Goulburn Valley Health

St Vincent's Hospital

The Alfred – Alfred Health

The Austin – Austin Health

The Northern – Northern Health

University Hospital Geelong – Barwon Health

Wangaratta – Northeast Health

Warragul – West Gippsland Health

Warrnambool – South West Healthcare

Williamstown Hospital – Western Health

Attachment C: List of health services/campuses required to report Knee Replacement surgical site infections

Bacchus Marsh – Djerriwarrh Health Service

Ballarat Health

Bendigo Hospital, The

Box Hill Hospital – Eastern Health

Dandenong Hospital – Monash Health

Echuca Regional Health

Footscray Hospital – Western Health

Frankston Hospital – Peninsula Health

Hamilton Base Hospital

Heidelberg Repatriation Hospital – Austin Health

Horsham – Wimmera Health Care

Latrobe Regional Hospital

Mildura Base Hospital

Monash Medical Centre [Moorabbin] – Monash Health

Portland District Health

Royal Melbourne Hospital – Melbourne Health

Sandringham & District Memorial – The Alfred

Shepparton – Goulburn Valley Health

St Vincent's Hospital

Stawell Regional Health

The Alfred – Alfred Health

The Austin – Austin Health

The Northern – Northern Health

University Hospital Geelong – Barwon Health

Wangaratta – Northeast Health

Warragul – West Gippsland Health

Warrnambool – South West Healthcare

Williamstown Hospital – Western Health

Attachment D: List of health services/campuses required to report Caesarean sections surgical site infections

Angliss – Eastern Health

Bacchus Marsh – Djerriwarrh Health

Ballarat Health

Bendigo Health Care Group

Box Hill – Eastern Health

Casey – Monash Health

Clayton – Monash Health

Dandenong – Monash Health

Echuca Regional Health

Frankston – Peninsula Health

Heidelberg Women's – Mercy Health

Latrobe Regional Hospital

Mildura Base Hospital

The Northern – Northern Health

Royal Women's Hospital (Carlton)

Sale – Central Gippsland Health

Sandringham – Royal Women' Hospital

Shepparton – Goulburn Valley Health

Sunshine – Western Health

Wangaratta – Northeast Health

Warragul – West Gippsland Health

Warrnambool – South West Health

Werribee – Mercy Health

Wodonga – Albury/Wodonga Health

University Hospital Geelong – Barwon Health

Key Performance Measures and Underlying Risk Factors 2019–20

Attachment E: List of health services/campuses required to report Colorectal surgical site infections

The Alfred – Alfred Health

Austin Hospital – Austin Health

Ballarat Health

Bendigo Health Care Group

Box Hill – Eastern Health

Clayton – Monash Health

Dandenong – Monash Health

Footscray – Western Health

Frankston – Peninsula Health

Latrobe Regional Hospital

Mildura Base Hospital

Wangaratta – Northeast Health

The Northern – Northern Health

Peter MacCallum Cancer Institute

Royal Children's Hospital [Parkville]

Royal Melbourne Hospital

Shepparton – Goulburn Valley Health

Warrnambool – South West Health

St Vincent's Hospital

University Hospital Geelong – Barwon Health