Victorian Health Services

Performance Monitoring Framework Indicator Business Rules 2022-23

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Please provide feedback to:

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Introduction

This document complements the Performance Monitoring Framework by outlining individual business rules for each performance measure.

Changes to performance monitoring framework measures in 2022–23

This section summarises key changes to the performance monitoring framework related measures including updated targets and reporting requirements.

* High quality and safe care

There has been a target change to the rate of patients with S. aureus bloodstream infection (SAB) from 1.0 to 0.7 to align to the national benchmark.

Two new mental health patient experience measures have been included that are also reported in the BP3 and as recommended by the Royal Commission into Victoria’s Mental Health System. A further patient experience measure has been included, Percentage of adult patients who reported they were involved as much as they wanted to be in making decisions about their care, identified as a driver contributing towards patient experience.

Target changes have been applied to several mental health seclusion and readmission measures to align them to BP3 reporting.

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 has been retained but reclassified as a PMF measure.

Two new Aboriginal cultural safety measures have been elevated from PRISM: percentage of Aboriginal patients in emergency that did not wait for treatment and percentage of admitted Aboriginal patients who left against medical advice.

* Strong governance, leadership, and culture

No changes for PMF 2022-23 to the measures reported in this domain.

* Timely access to care

Three Forensicare measures have been amended and received target changes. These are, Percentage of male Security Patients admitted to Thomas Embling Hospital within 7 days of certification, Percentage of male security patients discharged from Thomas Embling Hospital to a correctional centre within 21 days and Percentage of male security patients discharged within 7 days of becoming a civil client.

Additional measure to support elective surgery priorities for 2022/23 was added in V1.1 to reflect health service specific targets for additional activity as ‘Number of patients (in addition to base) admitted from the elective surgery waitlist.’

* Effective financial management

No changes for PMF 2022-23 to the measures reported in this domain.

More detailed information about these changes is included in Table 1 below.

Table 2 provides a breakdown of the Statement of Priority and Non-Statement of Priority measures.

**Table 1**: Summary of changes to Key Performance Measures for reporting year 2022-23

| Key performance measure | KPI | Change | Commentary |
| --- | --- | --- | --- |
| **Target changes** | | | |
| Rate of patients with SAB (S. aureus bloodstream infection) per 10,000 occupied bed days​ | Healthcare-associate infections​ | Target change | Reduction in target from 1.0 to 0.7 to align with national benchmark. |
| Rate of seclusion episodes per 1,000 occupied bed days – Inpatient (CAMHS) ​ | Mental health | Target change | Reduction in target from ≤ 10 to ≤ 5​ to align with BP reporting. |
| Rate of seclusion episodes per 1,000 occupied bed days – Inpatient (adult) | Mental health | Target change | Reduction in target from ≤ 10 to ≤ 8​ to align with BP reporting. |
| Percentage of consumers re-admitted within 28 days of separation – Inpatient (CAMHS) | Mental health | Target change | Reduction in target from < 22% to < 14%​​ to align with BP reporting. |
| Percentage of consumers re-admitted within 28 days of discharge separation – Inpatient (older persons) | Mental health | Target change | Reduction from < 14% to < 7%​​ to align with BP reporting. |
| **Measure change** | | | |
| 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​ | Maternity and newborn | Reduce to non-SOP | Retained in the PMF but as a non-SOP measure. No change to target of 100%. |
| Percentage of male Security Patients admitted to Thomas Embling Hospital within 7 days of certification | Forensicare | Measure and Target Change | Measure changed from 14 to 7 days of certification to promote early intervention, timely access to service with better outcomes with reduced waiting times. Target change from 100% to 80% to support transition as Forensicare reduced target wait times by 50%. |
| Percentage of male security patients discharged from Thomas Embling Hospital to a correctional centre within 21 days | Forensicare | Measure and Target Change | Measure changed from 80 to 21 days to improve discharge planning and increase access to Thomas Embling Hospital. Along with reduced discharge planning days, target was increased from 75% to 80%. |
| Percentage of male security patients discharged within 7 days of becoming a civil client | Forensicare | Measure and Target Change | Measure changed from 21 to 7 days with target increased from 75% to 80% to promote least restrictive intervention and reduce consumer days in a secure facility. |
| **Removal** | | | |
| Percentage of adult patients who reported that hospital staff took their family or home situation into account when planning their discharge​ | Patient experience | Removal |  |
| **New** |  |  |  |
| Percentage of families/carers reporting a positive experience of the service​ | Mental health | Addition | New SOP measure with a target of 80%​ to align with BP reporting |
| Percentage of adult patients who reported they were involved as much as they wanted to be in making decisions about their care​ | Patient experience | Addition | New SOP measure with a target of 75% |
| Percentage of families/carers who report they were ‘always’ or ‘usually’ felt their opinions as a carer were respected​ | Mental health | Addition | New SOP measure with a target of 90%​ to align with BP reporting |
| Percentage of patients that did not wait for treatment for Aboriginal and non-Aboriginal patients presenting to hospital emergency departments​ | Cultural safety | Addition | Target reduction of 25% in the gap between Aboriginal and non-Aboriginal rates based on 2021/22 annual rates​ |
| Percentage of admitted patients who left against medical advice  [[1]](#footnote-2) for Aboriginal and non-Aboriginal patients​ | Cultural safety | Addition | Target reduction of 25% in the gap between Aboriginal and non-Aboriginal rates based on 2021/22 annual rates​ |
| Number of patients (in addition to base) admitted from the elective surgery waitlist | Timely Access – elective surgery waiting list | Addition | Health Service specific target, dependant on base target |
| **Amendments to 2022/23 V1.1** |  |  |  |
| Inclusion of new cultural safety measures in table 2 | Table 2 | Amendment | Inconsistency |
| “Actual number of days available cash, measured on the last day of each month” reflected accurately in table 2 | Table 2 | Amendment | Inconsistency |
| Forecast days of available cash measure name amended to include the word 'forecast' to distinguish from 'actual days of available cash' | Effective financial management | Amendment | Accuracy of measure name |
| removal of word 'adult' from measure 'overall patient experience' to remain consistent with previous versions of PMF and include paediatric data from RCH | Patient experience | Amendment | Accuracy of measure name |
| “Operating result” reinstated as separate measure and edited description of measure “Operating result as a percentage of revenue” to non SoP | Effective financial management | Amendment | Inconsistency |
| Alternative measure name “Functional independence gain from an episode of rehabilitation admission to discharge relative to length of stay" to be included under description for "Average change in the functional independence measure (FIM) score per day of care for rehabilitation separations" | Continuing Care | Amendment | Inconsistency |
| Status of new Aboriginal Health - cultural safety measures corrected to non SoP | Cultural Safety | Amendment | Minor error |
| Four Cash Management measures in table 2 corrected to reflect SoP status  Trade creditors Patient fee debtors Adjusted current asset ratio Current days of available cash | Effective financial management | Amendment | Minor error |
| Aligned SoP status for measure "number of patients ON surgery waiting list" between Table 2 and Monitor | Elective Surgery | Amendment | Minor error |

**Table 2**: List of Key Performance Measures – SOP and Non-SOP

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Statement of priority measure |  |  | Non-Statement of priority measure |

**High quality and safe care**

| Program | KPI | | Key performance measure | Target |
| --- | --- | --- | --- | --- |
| Accreditation | | Residential aged care accreditation | Compliance with the commonwealth’s Aged Care Accreditation Standards | Accredited |
| Infection prevention and control | | Hand hygiene | Compliance with the Hand Hygiene Australia program | 85%[[2]](#footnote-3) |
| Health care worker immunisation | Percentage of healthcare workers immunised for influenza | 92%[[3]](#footnote-4) |
| Patient experience | | Overall experience | Percentage of patients who reported positive experiences of their hospital stay | 95% |
| Percentage of adult patients who reported positive experiences of their discharge from hospital | 75% |
| Percentage of adult patients who reported they were involved as much as they wanted to be in making decisions about their care | 75% |
| Mental health | Percentage of consumers who rated their overall experience of care with a service in the last 3 months as positive | 80% |
| Percentage of mental health consumers reporting they ‘usually’ or ‘always’ felt safe using this service | 90% |
| Percentage of families/carers reporting a ‘very good’ or ‘excellent’ overall experience of the service | 80% |
| Percentage of families/carers who report they were ‘always’ or ‘usually’ felt their opinions as a carer were respected | 90% |
| Healthcare associated infections (HAI’s) | | Surgical site infection (SSI) | Rate of surgical site infections for selected procedures (aggregate) | No outliers |
| Rate of surgical site infections for hip prosthesis, per 100 procedures | No outliers |
| Rate of surgical site infections for knee prosthesis, per 100 procedures |
| Rate of surgical site infections for cardiac bypass, per 100 procedures |
| Rate of surgical site infections for caesarean section, per 100 procedures |
| Rate of surgical site infections for colorectal surgery, per 100 procedures |
| ICU CLABSI | Rate of central line (catheter) associated blood stream infections (CLABSI) in intensive care units, per 1,000 central line days | Zero |
| SAB | Rate of healthcare-associated S. aureus bloodstream infections per 10,000 bed days | ≤ 0.7 |
| Adverse events | | Sentinel events | Percentage of notified sentinel events for which a sentinel event report was submitted within 30 business days from notification | All sentinel event reports submitted within 30 business days from notification |
| Readmission | Unplanned readmissions to any hospital following treatment for a hip replacement | ≤ 6% |
| Unplanned readmissions to any hospital following treatment for a knee replacement | ≤ 5.5% |
| Unplanned readmissions to any hospital following treatment for acute myocardial infarction | ≤ 4% |
| Unplanned readmissions to any hospital following treatment for heart failure | ≤ 11.3% |
| Unplanned readmissions to any hospital following treatment for paediatric tonsillectomy and adenoidectomy | ≤ 3.7% |
| Unplanned maternity readmissions within 28 days of discharge from birth episode (mother) | No outliers |
| Unplanned newborn readmissions within 28 days of discharge from birth episode (baby) |
| Mental health | | Closed community cases | Percentage of closed community cases re-referred within six months (adult) | < 25% |
| Percentage of closed community cases re-referred within six months (older persons) | < 25% |
| Percentage of closed community cases re-referred within six months (CAMHS/CYMHS) | < 25% |
| Seclusion | Rate of seclusion episodes per 1,000 occupied bed days - Inpatient (CAMHS) | ≤ 5 |
| Rate of seclusion episodes per 1,000 occupied bed days - Inpatient (adult) | ≤ 83 |
| Rate of seclusion episodes per 1,000 occupied bed days - Inpatient (older persons) | ≤ 5 |
| Post-discharge follow-up | Percentage of consumers followed up within 7 days of separation – Inpatient (CAMHS) | 88% |
| Percentage of consumers followed up within 7 days of separation – Inpatient (adult) | 88%3 |
| Percentage of consumers followed up within 7 days of separation - Inpatient (older persons) | 88% |
| Readmission | Percentage of consumers re-admitted within 28 days of separation - Inpatient (CAMHS) | < 14% |
| Percentage of consumers re-admitted within 28 days of separation - Inpatient (adult) | < 14% |
| Percentage of consumers re-admitted within 28 days of separation - Inpatient (older persons) | < 7% |
| Maternity and newborn | | APGAR | Percentage of full-term babies (without congenital anomalies) who are considered in poor condition shortly after birth (Apgar) | ≤ 1.4% |
| FGR | Percentage of singleton babies with severe fetal growth restriction (FGR) delivered at 40 or more weeks gestation | ≤ 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 | | FIM™ efficiency | Average change in the functional independence measure (FIM) score per day of care for rehabilitation separations | ≥ 0.645 |
| Aboriginal Health | | Cultural Safety – Left against medical advice | Difference in percentage of admitted patients who left against medical advice  [[4]](#footnote-5) for Aboriginal and non-Aboriginal patients​ | 25% reduction in gap based on 2021/22 rate |
| Cultural Safety – Did not wait to be seen | Percentage of patients that did not wait for treatment for Aboriginal and non-Aboriginal patients presenting to hospital emergency departments​ | 25% reduction in gap based on 2021/22 rate |
| Ambulance Victoria | | Patient experience | Percentage of respondents who rated care, treatment, advice and /or transport received from the ambulance service as good or very good | 95% |
| Percentage of respondents who rated care and treatment received from paramedics as good or very good | 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**

| Program | KPI | | Key performance measure | | Target |
| --- | --- | --- | --- | --- | --- |
| Organisational culture | | Safety culture | | People matter survey – Percentage of staff with an overall positive response to safety culture survey questions | 62%[[5]](#footnote-6),[[6]](#footnote-7) |
| Staff encouraged to report patient safety concerns | 62%5,6 |
| Patient care errors are handled appropriately | 62%5,6 |
| Suggestions about patient safety are acted upon | 62%5,6 |
| Management driving safety centred organisation | 62%5,6 |
| Culture conducive to learning from errors | 62%5,6 |
| Training new and existing staff | 62%5,6 |
| Trainees are adequately supervised | 62%5,6 |
| Would staff recommend a friend or relative to be treated as a patient there | 62%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 | ≥ 17%5,6 |
| Learner’s experience | | Safety | | Percentage learners feeling safe at the organisation / total number of respondents | ≤ 80% |
| Wellbeing | | Percentage learners having a sense of wellbeing at the organisation /total number of respondents | ≤ 80% |
| Bullying | | Percentage who reported experiencing or witnessing bullying at the organisation/total number of respondents | ≥ 20% |

**Timely access to care**

| Program | | KPI | | Key performance measure | | Target |
| --- | --- | --- | --- | --- | --- | --- |
| Emergency care | | 40-minute transfer | | Percentage of patients transferred from ambulance to emergency department within 40 minutes | 90%[[7]](#footnote-8) |
| 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 emergency department of less than four hours | 81% |
| ED > 24 hours | | Number of patients with a length of stay in the emergency department greater than 24 hours | 0 |
| Mental health | | Percentage of triage episodes requiring an urgent response (triage scale C) where a face-to-face response was provided by the mental health service within 8 hours | 80% |
| Percentage of mental health-related emergency department presentations with a length of stay of less than 4 hours | 81% |
| Elective surgery | | Category 1 admissions | | Percentage of urgency category 1 elective surgery patients admitted within 30 days | 100% |
| Cat 1, 2 and 3 admissions | | Percentage of urgency category 1, 2 and 3 elective surgery patients admitted within clinically recommended time | 94% |
| ESWL | | Number of patients on the elective surgery waiting list | Health service specific |
| ESWL | | Number of patients admitted from the elective surgery waiting list | (base)  Health service specific |
| ESWL | | Number of patients (in addition to base) admitted from the elective surgery waiting list | Health service specific |
| Reducing long waiting elective surgery patients | | Percentage 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 |
| HiPS | | Number of hospital-initiated postponements per 100 scheduled elective surgery admissions | ≤ 7 |
| Specialist clinics | | Waiting time | | Percentage of urgent patients referred by a GP or external specialist who attended a first appointment within 30 days | 100% |
| Waiting time | | Percentage of routine patients referred by GP or external specialist who attended a first appointment within 365 days | 90% |
| Ambulance Victoria | | 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 | | Admissions to Thomas Embling Hospital | | Number of male security patients admitted to Thomas Embling Hospital (TEH) Male Acute Units – Security | 20 |
| Percentage of male Security Patients admitted to Thomas Embling Hospital within 7 days of certification | 80% |
| Male security patient acute length of stay: Thomas Embling Hospital | | Percentage of male security patients discharged from Thomas Embling Hospital to a correctional centre within 21 days | 80% |
| Percentage of male security patients discharged within 7 days of becoming a civil client | 80% |

**Effective financial management**

| Program | KPI | | Key performance measure | | Target |
| --- | --- | --- | --- | --- | --- |
| Effective financial management | | Budget | | Operating result ($M) | Health service specific[[8]](#footnote-9),[[9]](#footnote-10) |
| Budget Management | | Operating result as a percentage of total operating revenue | Health service specific[[10]](#footnote-11),[[11]](#footnote-12) |
| Creditors | | Average number of days to paying trade creditors | 60 days4,5 |
| Debtors | | Average number of days to receiving patient fee debtors | 60 days4,5 |
| Adjusted current asset ratio | | Variance between actual ACAR and target, including performance improvement over time or maintaining actual performance | 0.7 or 3% improvement from health service base target 4,5 |
| Current Days Available Cash | | Actual number of days of available cash, measured on the last day of each month | 14 days4,5 |
| Forecast Days Available Cash | | Forecast days available cash | 14 days 4, 5 |
| NRFT Variance | | Variance between forecast and actual Net result from transactions (NRFT) for the current financial year ending 30 June | Variance ≤ $250,000 4,5 |

Business Rules

The Business rules 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 the Commonwealth’s Aged Care Accreditation Standards |
| --- | --- |
| Description | It is a requirement that all residential aged care facilities are accredited and maintain full compliance with the relevant accreditation standards.  The Commonwealth Government has primary responsibility for funding and regulating the residential aged care sector. In Victoria, a number of residential aged care services are provided by public health services and are subject to the Commonwealth’s Aged Care Accreditation Standards. |
| Calculating performance | This indicator is assessed at the health service level. Where a health service has multiple facilities, all facilities are required to meet the expected outcomes.  Full compliance with accreditation standards will be referred to as ‘achieved’.  Where a health service has not met accreditation standards they will be referred to as ‘not achieved’.  To achieve this indicator all residential aged care services must be fully compliant with all 44 expected outcomes of the Aged Care Accreditation Standards, at all times.  All episodes where expected outcomes are not met during the reporting period will be assessed as ‘not achieved’. Any breaches require health services to meet a timetable for improvements set by the Aged Care Standards and Accreditation Agency (ACSAA), usually within a three-month period, which includes submitting action plans and follow-up visits during and after this period.  **Performance breach**  As not met criteria for accreditation is considered a performance breach.  The department’s Aged Care team should also be notified of any instances of noncompliance as soon as the ACSAA have identified them. |
| Statewide target | Full compliance |
| Achievement | Achieved  Not achieved |
| Improvement | For the purpose of the performance risk assessment improvement is assessed against the previous accreditation result. |
| 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.  The accreditation status as at the end of the quarter for the health service is to be reported for the periods:  1 July to 30 September 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 Accreditation Standards during the relevant quarter will be obtained. |

**Infection prevention and control**

| Indicator | Compliance with the Hand Hygiene Australia program | |
| --- | --- | --- |
| 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 in their data submission to Hand Hygiene Australia (HHA).  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 are 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) <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 SCV and the relevant health services. | |
| Statewide target | ≥ 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 previous reporting 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 | |
| --- | --- | --- |
| 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) <http://www.vicniss.org.au>. | |
| Calculating performance | The period used to calculate the rate of HCW immunisation is 11 April to 15 August 2022. | |
| Numerator | Number of category A, B and C HCW vaccinated as at 15 August. | |
| Denominator | Number of category A, B and C HCW employed who worked one or more shifts during the influenza vaccination campaign (11 April to 15 August). | |
| Statewide target | ≥ 92% | |
| Achievement | Equal to or above 92% | Achieved |
| Below 92% | 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 31 August 2022. 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 assessed annually and reported in Q1. | |

**Patient experience**

| Indicator | Percentage of patients who reported positive experiences of their hospital stay | |
| --- | --- | --- |
| Description | Patient experience measures provide a patient-centred perspective on interactions with health-care providers. Monitoring insights from these measures contributes to improving the provision of care and strengthens the relationship between patients and care providers. These measures contribute to overall safety and quality monitoring within the health system. | |
| Calculating performance | The percentage of patients who respond, 'Very good' or 'Good' to question   1. 'Overall, how would you rate the care you received from the in hospital?' in the adult inpatient section of the Victorian Healthcare Experience Survey (VHES) collected at all health services with exception of Royal Childrens Hospital   *or to the question*   1. ‘Overall, how would you rate the care your child received from the hospital?’ in the inpatient section of the Victorian Paediatric Inpatient Survey collected at Royal Childrens Hospital only | |
| Numerator | Weighted sum of '‘Good’ or ‘Very good’ responses to the question: 'Overall, how would you rate the care you received while in hospital? *Or the question* ‘Overall, how would you rate the care your child received from the hospital?’ | |
| Denominator | Weighted sum of valid responses to the question 'Overall, how would you rate the care you received while in hospital?' *Or the question* ‘Overall, how would you rate the care your child received from the hospital?’  The denominator excludes:   * Invalid responses to any question | |
| Statewide target | ≥ 95% | |
| Achievement | Equal to or above 95% | Achieved |
| Below 95% | 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 | Reported data is lagged by one quarter.  Data is supplied and reported quarterly at health service level. | |

| Indicator | Percentage of adult patients who reported positive experiences of their discharge from hospital | |
| --- | --- | --- |
| Description | Patient experience measures provide a patient-centred perspective on interactions with health-care providers. Monitoring insights from these measures contributes to improving the provision of care and strengthens the relationship between patients and care providers. These measures contribute to overall safety and quality monitoring within the health system. | |
| Calculating performance | An index which is calculated from the responses to three questions about the patient's transition from hospital to home. Included are the percentage of 'Yes, completely' responses to the first three transition questions:   * Before you left hospital, did staff give you or to someone close to you useful information about managing your health and care at home? * Did hospital staff take your family, home and health situation into account when planning your return to home? * Were you involved, as much as you wanted to be, in decisions about leaving hospital?   from the adult inpatient Victorian Healthcare Experience Survey (VHES) | |
| Numerator | Sum of (weighted) percent of 'Yes, completely' responses to the first three transition questions in the adult inpatient VHES. | |
| Denominator | Sum of valid responses to each of the three transition questions in the VHES.  The denominator excludes:   * Invalid responses to any question | |
| Statewide target | ≥ 75% | |
| Achievement | Equal to or above 75% | Achieved |
| Below 75% | 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 | Reported data is lagged by one quarter.  Data is supplied and reported quarterly at health service level. | |

| Indicator | Percentage of adult patients who reported they were involved as much as they wanted to be in making decisions about their care | |
| --- | --- | --- |
| Description | Patient experience measures provide a patient-centred perspective on interactions with health-care providers. Monitoring insights from these measures contributes to improving the provision of care and strengthens the relationship between patients and care providers. These measures contribute to overall safety and quality monitoring within the health system. | |
| Calculating performance | The percentage of patients who responded ‘Yes, definitely’ to the question ‘Were you involved as much as you wanted to be in making decisions about your care?’ in the adult inpatient Victorian Healthcare Experience Survey (VHES). | |
| Numerator | The percentage of patients who responded ‘Yes, definitely’ to the question ‘Were you involved as much as you wanted to be in making decisions about your care?’ | |
| Denominator | Weighted sum of valid responses to the question ‘they were involved as much as they wanted to be in making decisions about their care’  The denominator excludes:   * Invalid responses to any question | |
| Statewide target | 75% | |
| Achievement | Equal to or above 75% | Achieved |
| Below 75% | 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 | Reported data is lagged by one quarter.  Data is supplied and reported quarterly at health service level. | |

| Indicator | Percentage of consumers who rated their overall experience of care with a service in the last 3 months as positive | |
| --- | --- | --- |
| Description | Personalised care and support is one of three national mental health and suicide prevention information priorities. It includes collecting and publishing consumer experience data at a range of levels to embed consumer experience of care at the heart of discussions about mental health services. Consumer and carer experience surveys are a key part of efforts to embed and amplify the voices of mental health consumers and carers in service improvement. | |
| Calculating performance | Percentage of Your Experience of Service (YES) survey respondents reporting a positive overall experience of care in the last 3 months with a clinical mental health service provider. | |
| Numerator | Total score of responses to questions 1-22.  The numerator excludes:  Invalid responses, YES surveys where <12 of questions 1-22 were completed and where a service has completed less than 10 questionnaires during the survey period. | |
| Denominator | Number of valid question responses to questions 1-22 of the YES survey.  The denominator excludes:  Invalid responses, YES questionnaires where <12 of questions 1-22 were completed and where a service has completed less than 10 questionnaires during the survey period. | |
| Statewide target | 80% | |
| Achievement | Equal to or above 80% | Achieved |
| Below 80% | Not achieved |
| Improvement | For the purpose of the performance risk assessment, improvement is compared to previous period performance | |
| Frequency of reporting and data collection | Data is supplied and reported annually at health service level.  Participation is based on health services providing the questionnaire to in-scope consumers and at least 30 responses being received by the contractor to enable statistically significant analysis | |

| Indicator | Percentage of consumers who reporting they ‘usually’ or ‘always’ felt safe using this service | |
| --- | --- | --- |
| Description | Patient safety is the prevention of harm to patients from the care that is intended to help them. Safety is an essential part of delivering quality care and a fundamental principle of person-centred care. Patients may be the most reliable reporters of some aspects of healthcare processes; their perspectives should be considered when pursuing changes to improve patient safety.2 | |
| Calculating performance | Percentage of Your Experience of Service (YES) survey respondents reporting that in the last 3 months they ‘usually’ or ‘always’ felt safe using this service. | |
| Numerator | Number of consumers responding with a result of ‘Always’ or ‘Usually’ to the prompt (3): ‘You felt safe using the service’ | |
| Denominator | Number of consumers completing YES surveys with a valid response.  The denominator excludes:   * Invalid responses to any question, ‘not completed’ and ‘not needed’ | |
| 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 compared to previous period performance | |
| Frequency of reporting and data collection | Data is supplied and reported annually at health service level.  Participation is based on health services providing the questionnaire to in-scope consumers and at least 30 responses being received by the contractor to enable statistically significant analysis | |

2. Hincapie, A; Slack, M; Malone, D; MacKinnon, N; Warholak, T. Relationship between patients’ perceptions of care, quality and health care errors in 11 countries: A secondary data analysis; Quality Management in Health Care, 25 (1); 2016

| Indicator | Percentage of families/ carers reporting a ‘very good’ or ‘excellent’ overall experience of service | |
| --- | --- | --- |
| Description | The principles of the *Mental Health Act 2014* outline a vision for services that protect human rights and promote hope, recovery, capacity and autonomy. These principles recognise the importance of the wellbeing of carers and children, promoting and encouraging communication between health practitioners, consumers, their families and carers. While paying regard to consumers' preferences, families and carers must be meaningfully included in consumers' treatment and care.  Clinical best practice requires identification, recognition, and involvement of families and carers, including children, across the service continuum. Clinicians need to actively engage with families and carers as an essential part of mental health service delivery and acknowledge that some consumers may not want their families involved and that some families may not want to be involved1 | |
| Calculating performance | The percentage of carers who responded with 'Very good' or 'Excellent' to the question, '‘Overall, how would you rate your experience as a carer with this mental health service over the last 3 months?’. | |
| Numerator | Number of '‘Excellent’ or ‘Very good’ responses to the question: ‘Overall, how would you rate your experience as a carer with this mental health service over the last 3 months?’. | |
| Denominator | Number of valid responses to the question ‘Overall, how would you rate your experience as a carer with this mental health service over the last 3 months?’.  The denominator excludes:   * Invalid responses to any question, ‘not completed’ and ‘not applicable’ | |
| Statewide target | 80% | |
| Achievement | Equal to or above 80% | Achieved |
| Below 80% | Not achieved |
| Improvement | For the purpose of the performance risk assessment, improvement is compared to previous period performance | |
| Frequency of reporting and data collection | Data is supplied and reported annually at health service level.  Participation is based on health services providing the questionnaire to in-scope consumers and at least 30 responses being received by the contractor to enable statistically significant analysis | |

Working together with families and carers: Chief Psychiatrist’s Guideline <https://www2.health.vic.gov.au/about/key-staff/chief-psychiatrist/chief-psychiatrist-guidelines/working-together-with-families-and-carers>

| Indicator | Percentage of families/ carers reporting they ‘usually’ or ‘always’ felt their opinions as a carer were respected | |
| --- | --- | --- |
| Description | A key principle under the department’s *Mental Health Lived Experience Framework* includes valuing the experience and opinions of all those involved by providing meaningful opportunities and support to enable participation of consumers and families/carers. | |
| Calculating performance | The percentage of carers who responded with ‘Usually’ or 'always' to the question, ‘Your opinion as a carer was respected’. | |
| Numerator | Number of ‘Usually’ or ‘always’ responses to the question: ‘Your opinion as a carer was respected’. | |
| Denominator | Number of valid responses to the question ‘Overall, how would you rate your experience as a carer with this mental health service over the last 3 months?’.  The denominator excludes:   * Invalid responses to any question, ‘not completed’ and ‘not needed’ | |
| 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 compared to previous period performance | |
| Frequency of reporting and data collection | Data is supplied and reported annually at health service level.  Participation is based on health services providing the questionnaire to in-scope consumers and at least 30 responses being received by the contractor to enable statistically significant analysis | |

**Forensicare patient experience**

| **Indicator** | **Inpatient’s overall experience at Thomas Embling Hospital** | |
| --- | --- | --- |
| 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 Thomas Embling Hospital 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** | |
| --- | --- | --- |
| 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 |
| --- | --- |
| 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 obtained from at [VICNISS](http://www.vicniss.org.au) <http://www.vicniss.org.au>.  **Coronary artery bypass graft**  Campuses performing cardiac bypass surgery are required to conduct continuous surveillance of surgical site infections associated with the procedure and report them to VICNISS. The list of hospitals/campuses 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 hip and knee arthroplasty surgical procedures are required to conduct continuous surveillance of surgical site infections associated with these procedures and report them to VICNISS.. The list of hospitals/campuses for which this measure is applicable to is based on previously reported data and can be found at Attachment B (Hip) Attachment C (knee).  **Caesarean section for nominated health services**  Campuses providing a birthing service are required to conduct continuous surveillance of their c-section surgical site infections and report these to VICNISS.  The list of hospitals/campuses for which this measure is applicable to is based on previously reported data and can be found at Attachment D.  **Colorectal surgery**  Campuses that perform colorectal procedures are required to undertake surveillance for a continuous six-month period during the period 1 July to 30 June.  List of relevant procedures is available from VICNISS.  The list of hospitals/campuses for which this measure is applicable to is available at Attachment E. |
| 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. |
| Reporting requirements | It is acknowledged that Attachments A to E, that are based on reported activity levels prior to the COVID-19 pandemic period, have not been reviewed recently.  Activity levels during 2022-23 will inform a review of the lists to be applicable for 2023-24.  For 2022-23, the current lists remain current and applicable to the surgical site infection surveillance requirements of health services and hospitals. |
| Improvement | For the purpose of the performance risk assessment, improvement is assessed against the previous reporting period. |

| Indicator | Rate of surgical site infection for all reported procedures |
| --- | --- |
| 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 |
| --- | --- |
| 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 |
| --- | --- |
| 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 |
| --- | --- |
| 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 |
| --- | --- |
| 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 |
| --- | --- |
| 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 |
| --- | --- |
| 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 CLABSIs |
| Denominator | The total number of central line days |
| Statewide target | Zero |
| Achievement | Achieved  Not achieved |
| Improvement | For the purpose of the performance risk assessment improvement is assessed against the previous reporting period. |
| 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 | |
| --- | --- | --- |
| 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) <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 | ≤ 0.7 | |
| Achievement | Equal to or below 0.7 | Achieved |
| Greater than 0.7 | 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 | 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 –reporting | |
| --- | --- | --- |
| Description | Sentinel events are serious and unexpected adverse patient safety events that often result in significant or permanent harm or death.  This indicator is a trigger for discussion regarding quality, safety and improvement in health services, as well as compliance with mandatory reporting of sentinel events.  The sentinel event program aims to improve health service system design and delivery through shared learning from a defined range of serious adverse events (sentinel events).  Increasing numbers of sentinel events are concerning particularly in the context of other safety and quality risks. Too low numbers may be a sign of an under-reporting culture. Of most importance is the timeliness of the response and effectiveness of the action taken to prevent re-occurrence.  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 and provide a report outlining a plan to prevent recurrence. A copy of the sentinel event report must be submitted to SCV within 30 business days of the notification. | |
| Calculating performance | This measure captures numbers of notifiable sentinel events for which a sentinel event report is submitted within 30 business days\* from notification of the event to SCV.  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, including:  * Clinical process or procedure * Falls * Deteriorating patients * Self-harm (behaviour) * Communication of clinical information * Medical device or equipment * Nutrition * Resource or organisational management * Healthcare associated infection * Patient accidents.   Further details on the sentinel events program, including reporting requirements is outlined < https://www.safercare.vic.gov.au/notify-us/sentinel-events>  \* 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. | |
| Statewide target | All sentinel event reports submitted within a 30-business day timeframe | |
| Achievement | All sentinel event reports submitted within 30 business days\* | Achieved |
| Sentinel event report not submitted within 30 business days\* | 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. | |

**Unplanned re-admission**

| Indicator | Rate of unplanned readmissions to any hospital following a hip replacement procedure, per 100 periods of care |
| --- | --- |
| Description | Unplanned readmissions to any hospital within 60 days of patients’ separation from acute care, for hip replacement surgery. |
| Calculating performance | Hospital-based outcome indicators for unplanned / unexpected readmissions are focused on improving safety and quality of patient care. High rates should be seen as a prompt to further investigation. Learnings may be applied from low rates.  Unplanned and unexpected readmissions to any hospital where the principal diagnosis and readmission interval indicate that the readmission may be related to the care provided by the hospital during the patient’s period of care for the hip replacement procedure. |
| Numerator | For the numerator, the period of care is a readmission to any hospital following a period of care for hip replacement procedure and the principal diagnosis of the readmission having a principal diagnosis code listed in the numerator computation.  Number of unplanned readmissions to the any hospital following a hip replacement procedure.  Principal diagnosis code in ('A40', 'A41', 'A49', 'E87', 'F05', 'I21', 'I50', 'I74', 'I62', 'I63', 'J13', 'J15', 'J16', 'J17', 'J18', 'L89', 'M05', 'M06', 'R33', 'R26', 'R27', 'R28', 'R29', 'S73', 'T84', 'S72', 'Z47', 'Z48', 'S30', 'S31', 'S32', 'S33', 'S34', 'S35', 'S36', 'S37', 'S38', 'S39', 'S40', 'S41', 'S42', 'S43', 'S44', 'S45', 'S46', 'S47', 'S48', 'S49', 'S50', 'S51', 'S52', 'S70', 'S71', 'S72', 'S73', 'S74', 'S75', 'S76', 'S77', 'S78', 'S79', 'S80', 'S81', 'S82', 'S83', 'S84', 'S85', 'S86', 'S87', 'S88', 'S89',  'G577', 'G578', 'G579', 'I269', 'I800', 'I801', 'I802', 'I803', 'I978', 'K919', 'L039', 'L033', 'M968', 'M706', 'M707', 'M966', 'N390', 'R073', 'R074', 'T811', 'T813', 'T815', 'T816', 'T818', 'T887', 'T799', 'T810', 'T814',  'G5812', 'K9189', 'L0312', 'L0313', 'M2565', 'M2566', 'M2567', 'M2555', 'M2556', 'M2557', 'M2545', 'M2546', 'M2547', 'M0005', 'M0006', 'M0007', 'M7965', 'M7966', 'M7967', 'M7985', 'M7986', 'M8405', 'M8435', 'M8445', 'T8588', 'S7203', 'S7205', 'S7210', 'S7310', 'T8578')  And  Care Type = '4-Acute' |
| Denominator | The denominator includes acute periods of care for hip replacement procedure, defined as having a procedure code listed in the denominator computation but excluding periods of care in which the separation mode was death or left against medical advice. The patient must be 18 years of age or older.  Number of periods of care for hip replacement procedure.  Procedure code in (49318-00, 49319-00, 90607-00, 90607-01)  And Care Type = '4-Acute'  And Age is >= 18 years  And Separation Mode NOT IN ('D-Death', 'Z-Left against medical advice')  Excludes:   * Patients whose principal reason for admission was revision arthroplasty of hip:   + Hemiarthroplasty of femur (47522-00)   + Excision arthroplasty of hip (49312-00)   + Partial arthroplasty of hip (49315-00) * Patients that underwent a hip replacement as a direct result of a fracture and classified by:   + Fracture of femur, lumbar spine and pelvis (S72, S32)   + Pathological fracture (M805, M8445)   + Stress fracture, malunion of fracture, non-union of fracture (M8435, M8405, M8415)   + Mechanical complications of prosthesis (T840 – T844)   + Admissions with principal diagnosis for malignant neoplasm (C414, C402, C419, C763, C765, C795, C800) |
| Statewide target | ≤ 6% |
| Achievement | Less than or equal to 6% - Achieved  Greater than 6% - Not achieved |
| Improvement | For the purpose of the performance risk assessment, improvement is compared to previous quarter performance and based on the annual rate. |

| Indicator | Rate of unplanned readmissions to any hospital following management of acute myocardial infarction, per 100 periods of care |
| --- | --- |
| Description | Unplanned readmissions to any hospital within 30 days of patients’ separation, for management of Acute Myocardial Infarction. |
| Calculating performance | Hospital-based outcome indicators for unplanned / unexpected readmissions are focused on improving safety and quality of patient care. High rates should be seen as a prompt to further investigation. Learnings may be applied from low rates.  Unplanned and unexpected readmissions to any hospital where the principal diagnosis and readmission interval indicate that the readmission may be related to the care provided by the hospital during the patient’s period of care for the management of acute myocardial infarction. |
| Numerator | For the numerator, the period of care is a readmission to any hospital following a period of care for acute myocardial infarction and the principal diagnosis of the readmission having a principal diagnosis code listed in the numerator computation.  Number of unplanned readmissions to the any hospital following management of acute myocardial infarction.   * Principal diagnosis code in (‘I21’, ‘122’, 'I50’, 'I95’, 'I63’, 'I31’, 'I26’, 'I61’, 'I46’, 'I64’, 'I74’) * And Care Type = '4-Acute' * And Admission type is Emergency (Admission Type in ('O', 'C')) |
| Denominator | The denominator includes acute periods of care for acute myocardial infarction, defined as having a principal diagnosis code listed in the denominator computation but excluding periods of care in which the separation mode was death or left against medical advice. The length of stay of the period of care must be at least 1 day, and the patient must be 15 years of age or older.  Number of periods of care for acute myocardial infarction.   * Principal diagnosis code in ('I21', 'I22') * And Care Type = '4-Acute' * And Length of stay >= 1 day * And Age is >= 15 years * And Admission type is Emergency (Admission Type in ('O', 'C')) * And Separation Mode NOT IN ('D-Death', 'Z-Left against medical advice') |
| Statewide target | ≤ 4% |
| Achievement | Less than or equal to 4% - Achieved  Greater than 4% - Not achieved |
| Improvement | For the purpose of the performance risk assessment, improvement is compared to previous quarter performance and based on the annual rate. |

| Indicator | Rate of unplanned readmissions to any hospital following a knee replacement procedure, per 100 periods of care |
| --- | --- |
| Description | Unplanned readmissions to any hospital within 60 days of patients’ separation from acute care for knee replacement surgery. |
| Calculating performance | Hospital-based outcome indicators for unplanned / unexpected readmissions are focused on improving safety and quality of patient care. High rates should be seen as a prompt to further investigation. Learnings may be applied from low rates.  Unplanned and unexpected readmissions to any hospital where the principal diagnosis and readmission interval indicate that the readmission may be related to the care provided by the hospital during the patient’s period of care for the knee replacement procedure. |
| Numerator | For the numerator, the period of care is a readmission to any hospital following a period of care for knee replacement procedure and the principal diagnosis of the readmission having a principal diagnosis code listed in the numerator computation.  Number of unplanned readmissions to the any hospital following a knee replacement procedure.  Principal diagnosis code in ('T84', 'M17', 'I26', 'R33', 'S89', 'I21', 'I50', 'N13', 'M23', 'I74’, 'M06', 'Z48', 'S76', 'E87', 'S72', 'S81', 'F05', 'A41', 'S80', 'S83', 'J18', 'S82', 'Z47', 'A49', 'J15', 'R26', 'R29', 'M05', 'S86', 'S70', 'S52', 'S33', 'S73', 'S43’, ‘I60’, ‘I61’, ‘I62’, 'I63', 'I64', ‘T810’, ‘T814’, ‘T813’, ‘T815’, ‘T818’, ‘N179’)  And  Care Type = '4-Acute' |
| Denominator | The denominator includes acute periods of care for knee replacement procedure, defined as having a procedure code listed in the denominator computation but excluding periods of care in which the separation mode was death or left against medical advice. The patient must be 18 years of age or older.  Number of periods of care for knee replacement procedure.  Procedure code in (49518-00, 49519-00, 49521-02, 49521-00, 49521-01, 49521-03, 49524-00, 49524-01)  And Care Type = '4-Acute'  And Age is >= 18 years  And Separation Mode NOT IN ('D-Death', 'Z-Left against medical advice') |
| Statewide target | ≤ 5.5% |
| Achievement | Less than or equal to 5.5% - Achieved  Greater than 5.5% - Not achieved |
| Improvement | For the purpose of the performance risk assessment, improvement is compared to previous quarter performance and based on the annual rate. |

| Indicator | Rate of unplanned readmissions to any hospital campus following management of heart failure, per 100 periods of care |
| --- | --- |
| Description | Unplanned readmissions to any hospital within 30 days of patients’ separation, for management of heart failure. |
| Calculating performance | Hospital-based outcome indicators for unplanned / unexpected readmissions are focused on improving safety and quality of patient care. High rates should be seen as a prompt to further investigation. Learnings may be applied from low rates.  Unplanned and unexpected readmissions to any hospital where the principal diagnosis and readmission interval indicate that the readmission may be related to the care provided by the hospital during the patient’s period of care for the management of heart failure. |
| Numerator | For the numerator, the period of care is a readmission to any hospital following a period of care for heart failure and the principal diagnosis of the readmission having a principal diagnosis code listed in the numerator computation.  Number of unplanned readmissions to the any hospital following management of heart failure.  Principal diagnosis code in (‘I50’, 'J18’, 'I21’, 'I95’, 'I42’, 'R55’, 'J90’, 'J22’, 'J96’, 'E86’, 'J15’, 'R42’, 'I26')  And Care Type = '4-Acute'  And Admission type is Emergency (Admission Type in ('O', 'C')) |
| Denominator | The denominator includes acute periods of care for heart failure, defined as having a principal diagnosis code listed in the denominator computation but excluding periods of care in which the separation mode was death or left against medical advice. The length of stay of the period of care must be at least 1 day, and the patient must be 15 years of age or older.  Number of periods of care for heart failure.  Principal diagnosis code in (‘I50’, ‘I11’, ‘I13’)  And Care Type = '4-Acute'  And Length of stay >= 1 day  And Age is >= 15 years  And Admission type is Emergency (Admission Type in ('O', 'C'))  And Separation Mode NOT IN ('D-Death', 'Z-Left against medical advice') |
| Statewide target | ≤ 11.3% |
| Achievement | Less than or equal to 11.3% - Achieved  Greater than 11.3% - Not achieved |
| Improvement | For the purpose of the performance risk assessment, improvement is compared to previous quarter performance and based on the annual rate (outlier status). |

| Indicator | Rate of unplanned readmissions to any hospital following a paediatric tonsillectomy and adenoidectomy surgery procedure, per 100 periods of care |
| --- | --- |
| Description | Unplanned readmissions to any hospital within 15 days of patients’ separation, following a paediatric tonsillectomy and adenoidectomy surgery procedure. |
| Calculating performance | Hospital-based outcome indicators for unplanned / unexpected readmissions are focused on improving safety and quality of patient care. High rates should be seen as a prompt to further investigation. Learnings may be applied from low rates.  Unplanned and unexpected readmissions to any hospital where the principal diagnosis and readmission interval indicate that the readmission may be related to the care provided by the hospital during the patient’s period of care for the paediatric tonsillectomy and adenoidectomy procedure. |
| Numerator | For the numerator, the period of care is a readmission to any hospital following a period of care for paediatric tonsillectomy and adenoidectomy procedure and the principal diagnosis of the readmission having a principal diagnosis code listed in the numerator computation.  Number of unplanned readmissions to the any hospital following a paediatric tonsillectomy and adenoidectomy procedure.  Principal diagnosis code in (‘E16.2','E86','E89.8','E89.9','G47.0','G47.32','H65.3','H65.9','H66.0',  'H66.9','I88.9','J01.9','J02.9','J03.x','J06.x','J18.x','J20.9','J21.9','J22',  'J32.9','J35.x','J36','J39.1','J39.2','J69.0','J95.89','J95.9','K91.0',  'K91.89','K91.9','K92.0','R04.0','R04.1','R04.2','R06.0','R06.1','R06.5',  'R06.8','R07.0','R11','R13','R50.x','R52.9','R53','R56.x','R58','R63.0',  'R63.3','R63.8','T39.1','T40.2','T81','T88.8','T88.9','Z03.8','Z03.9','Z48.x')  And  Care Type = '4-Acute' |
| Denominator | The denominator includes acute periods of care for paediatric tonsillectomy and adenoidectomy procedure, defined as having a procedure code listed in the denominator computation but excluding periods of care in which the separation mode was death or left against medical advice. The length of stay of the period of care must be less than or equal to 30 days, and the patient must be between 0 and 14 years of age (inclusive).  Number of periods of care for paediatric tonsillectomy and adenoidectomy procedure.  Procedure code in (41789-00, 41801-00, 41789-01) (Any position)  And Care Type = '4-Acute'  And Length of stay <= 30 days  And Age is <= 14 years  And Separation Mode NOT IN ('D-Death', 'Z-Left against medical advice') |
| Statewide target | ≤ 3.7% |
| Achievement | Less than or equal to 3.7% - Achieved  Greater than 3.7% - Not achieved |
| Improvement | For the purpose of the performance risk assessment, improvement is compared to previous quarter performance and based on the annual rate (outlier status). |

| Indicator | Unplanned and potentially preventable readmission of mother within 28 days of discharge from a birthing admission |
| --- | --- |
| 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 mean 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% CI) assessed against state-wide rates. |
| 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) |
| 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 statewide rate (outlier status). |

| Indicator | Potentially preventable readmission of a neonate within 28 days of discharge from a birthing admission |
| --- | --- |
| 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 mean 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. |
| 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. Stillbirths and neonatal deaths prior to discharge are excluded.  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).  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. |
| 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 statewide rate (outlier status). |

**Mental health**

| Indicator | Percentage of closed community cases re-referred within six months (adult) | |
| --- | --- | --- |
| Description | High levels of case re-referral within a short timeframe are widely regarded as reflecting deficiencies in client care and potentially points to inadequacies in the functioning of the overall system.  The community case re-referral rate is the community counterpart of 28-day inpatient readmission measure. Re-referral to mental health services following separation of case closure may indicate that treatment was either incomplete or ineffective. | |
| Calculating performance | Data are lagged by six months to allow all case re-referrals occurring in the six months prior to the end of the reporting period to be captured. For example, if the reporting period is from 1 July 2017 to 30 September 2017, then community cases closed in the six months prior to any date in this period are included.  This indicator is expressed as a percentage and rounded to the nearest whole number. | |
| Numerator | Total number of adult mental health community case re-referrals within 6 months of case closure. Lagged by six months. Excludes cases that were opened on the same day or the day after the previous case closure, assuming they are data errors. | |
| Denominator | Total number of adult mental health community cases that were closed in the reporting period. A community case is defined as a case with at least one community episode. Lagged by 6 months. | |
| Statewide target | < 25% | |
| Achievement | Less than 25% | Achieved |
| Greater than or equal to 25% | 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.  Cumulative values reported during each reporting period.  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 closed community cases re-referred within six months (older persons) | |
| Description | High levels of case re-referral within a short timeframe are widely regarded as reflecting deficiencies in client care and potentially points to inadequacies in the functioning of the overall system.  The community case re-referral rate is the community counterpart of 28-day inpatient readmission measure. Re-referral to mental health services following separation of case closure may indicate that treatment was either incomplete or ineffective. | |
| Calculating performance | Data are lagged by six months to allow all case re-referrals occurring in the six months prior to the end of the reporting period to be captured. For example, if the reporting period is from 1 July 2017 to 30 September 2017, then community cases closed in the six months prior to any date in this period are included.  This indicator is expressed as a percentage and rounded to the nearest whole number. | |
| Numerator | Total number of aged mental health community case re-referrals within 6 months of case closure. Lagged by six months. Excludes cases that were opened on the same day or the day after the previous case closure, assuming they are data errors. | |
| Denominator | Total number of aged mental health community cases that were closed in the reporting period. A community case is defined as a case with at least one community episode. Lagged by 6 months. | |
| Statewide target | < 25% | |
| Achievement | Less than 25% | Achieved |
| Greater than or equal to 25% | 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.  Cumulative values reported during each reporting period.  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 closed community cases re-referred within six months (CAMHS/CYMHS) | |
| --- | --- | --- |
| Description | High levels of case re-referral within a short timeframe are widely regarded as reflecting deficiencies in client care and potentially points to inadequacies in the functioning of the overall system.  The community case re-referral rate is the community counterpart of 28-day inpatient readmission measure. Re-referral to mental health services following separation of case closure may indicate that treatment was either incomplete or ineffective. | |
| Calculating performance | Data are lagged by six months to allow all case re-referrals occurring in the six months prior to the end of the reporting period to be captured. For example, if the reporting period is from 1 July 2017 to 30 September 2017, then community cases closed in the six months prior to any date in this period are included.  This indicator is expressed as a percentage and rounded to the nearest whole number. | |
| Numerator | Total number of CAMHS/CYMHS community case re-referrals within 6 months of case closure. Lagged by six months. Excludes cases that were opened on the same day or the day after the previous case closure, assuming they are data errors. | |
| Denominator | Total number of CAMHS/CYMHS community cases that were closed in the reporting period. A community case is defined as a case with at least one community episode. Lagged by 6 months. | |
| Statewide target | < 25% | |
| Achievement | Less than 25% | Achieved |
| Greater than or equal to 25% | 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.  Cumulative values reported during each reporting period.  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 | Rate of seclusion episodes per 1,000 occupied bed days - Inpatient (CAMHS) | |
| --- | --- | --- |
| Description | High levels of seclusion are widely regarded as inappropriate treatment and may point to inadequacies in the functioning of the overall systems and risks to the safety of consumers receiving mental health care.  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 inpatient units in Victoria. | |
| Calculating performance | This indicator comprises CAMHS acute inpatient services provided by public mental health services and includes all CAMHS acute admissions.  Occupied bed days are calculated where the admission event type is one of the following:  SA (statistical admission)  R (return from leave)  A (admission – formal)  T (ward transfer).  Leave events within an admission are excluded.  Admission events that do not have any temporal overlap with the reporting period are excluded. Only the minutes of the admission events that overlap with the reporting period are counted. The minutes for each CAMHS acute admission event are then summed and divided by 1,440 to give the total occupied bed days for the campus for the reporting period.  Any period of seclusion relating to a CAMHS acute admission ending in the reporting period is counted. The number of seclusions is divided by the number of occupied bed days. The quotient is then multiplied by 1,000.  CAMHS clients are identified by program type. | |
| Numerator | The number of seclusion episodes ended in child and adolescent mental health inpatient units.  A seclusion episode not recorded against an admission where required (i.e., Service Location Code is '3', '12' or '13'), is recorded against the mental health inpatient unit where the consumer had an open admitted episode at the start of the seclusion episode | |
| Denominator | The number of occupied bed days in child and adolescent mental health inpatient units. Excludes leave days, virtual wards, and units without a seclusion room (e.g., Forensicare Bass, Daintree & Jardine Units, Mother baby Units, Eating Disorder Units etc.).  The total length of stay for all admission events that were open during the period and have an Admission Event Type in 'SA','R','A','T' is summed and converted into days. | |
| Statewide target | ≤ 5 seclusions per 1,000 bed days (< 5/1,000) | |
| Achievement | Less than or equal to < 5/1,000 | Achieved |
| Greater than > 5/1,000 | 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 episodes per 1,000 occupied bed days - Inpatient (adult) | |
| --- | --- | --- |
| Description | High levels of seclusion are widely regarded as inappropriate treatment and may point to inadequacies in the functioning of the overall systems and risks to the safety of consumers receiving mental health care.  Reducing restraint and seclusion is a national safety priority, and incorporating this indicator ensures appropriate monitoring of seclusion use in adult mental health inpatient units in Victoria. | |
| Calculating performance | This indicator comprises adult acute inpatient services provided by public mental health services and includes adult acute admissions as well as patients at ORYGEN Youth Health Melbourne Clinic campus. Occupied bed days are calculated where the admission event type is one of the following:  SA (statistical admission)  R (return from leave)  A (admission – formal)  T (ward transfer).  Leave events within an admission are excluded.  Admission events that do not have any temporal overlap with the reporting period are excluded. Only the minutes of the admission events that overlap with the reporting period are counted. The minutes for each adult acute admission event are then summed and divided by 1,440 to give the total occupied bed days for the campus for the reporting period.  Any period of seclusion relating to an adult acute admission ending in the reporting period is counted. The number of seclusions is divided by the number of occupied bed days. The quotient is then multiplied by 1,000.  Improvement is compared to previous quarter performance. | |
| Numerator | The number of seclusion episodes ended in adult mental health inpatient units.  A seclusion episode not recorded against an admission where required (i.e., Service Location Code is '3', '12' or '13'), is recorded against the mental health inpatient unit where the consumer had an open admitted episode at the start of the seclusion episode. | |
| Denominator | The number of occupied bed days in adult mental health inpatient units. Excludes leave days, virtual wards, and units without a seclusion room (e.g., Forensicare Bass, Daintree & Jardine Units, Mother baby Units, Eating Disorder Units etc.).  The total length of stay for all admission events that were open during the period and have an Admission Event Type in 'SA','R','A','T' is summed and converted into days. | |
| Statewide target | ≤ 8 seclusions per 1,000 bed days (< 8/1,000) | |
| Achievement | Less than or equal to 8/1,000 | Achieved |
| Greater than > 8/1,000 | 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 episodes per 1,000 occupied bed days - Inpatient (older persons) | |
| --- | --- | --- |
| Description | High levels of seclusion are widely regarded as inappropriate treatment and may point to inadequacies in the functioning of the overall systems and risks to the safety of consumers receiving mental health care.  Reducing restraint and seclusion is a national safety priority, and incorporating this indicator ensures appropriate monitoring of seclusion use in aged mental health inpatient units in Victoria. | |
| Calculating performance | This indicator comprises aged acute inpatient services provided by public mental health services and includes all aged acute admissions.  Occupied bed days are calculated where the admission event type is one of the following:  SA (statistical admission)  R (return from leave)  A (admission – formal)  T (ward transfer).  Leave events within an admission are excluded.  Admission events that do not have any temporal overlap with the reporting period are excluded. Only the minutes of the admission events that overlap with the reporting period are counted. The minutes for each aged acute admission event are then summed and divided by 1,440 to give the total occupied bed days for the campus for the reporting period.  Any period of seclusion relating to an aged acute admission ending in the reporting period is counted. The number of seclusions is divided by the number of occupied bed days. The quotient is then multiplied by 1,000.  Aged clients are identified by the type of admission. | |
| Numerator | The number of seclusion episodes ended in aged mental health inpatient units.  A seclusion episode not recorded against an admission where required (i.e., Service Location Code is '3', '12' or '13'), is recorded against the mental health inpatient unit where the consumer had an open admitted episode at the start of the seclusion episode. | |
| Denominator | The number of occupied bed days in aged mental health inpatient units. Excludes leave days, virtual wards, and units without a seclusion room (e.g., Forensicare Bass, Daintree & Jardine Units, Mother baby Units, Eating Disorder Units etc.).  The total length of stay for all admission events that were open during the period and have an Admission Event Type in 'SA','R','A','T' is summed and converted into days. | |
| Statewide target | ≤ 5 seclusions per 1,000 bed days (< 5/1,000) | |
| Achievement | Less than or equal to < 5/1,000 | Achieved |
| Greater than > 5/1,000 | 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 consumers followed up within 7 days of separation – Inpatient (CAMHS) | |
| --- | --- | --- |
| Description | A responsive, post-discharge community support system is essential for consumers who have experienced a mental health admission to maintain clinical and functional stability, and to minimise the need for readmission.  Consumers discharged after a mental health admission with linkages to community services and supports are less likely to be at risk of readmission.  Research indicates that mental health consumers have increased vulnerability immediately following discharge, including higher risk for suicide. | |
| Calculating performance | Contacts can be of any duration, in any location for any type of recipient, carried out by the local mental health service or another mental health service.  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.  Contacts on the day of separation and interstate consumers are excluded.  Both the numerator and the denominator include consumers separated from a mental health service to a private residence or accommodation and exclude same day separations.  Separations are lagged by seven days to allow all post-discharge follow ups in the reporting period to be captured. For example, if the reporting period is from 1 July 2017 to 30 September 2017, then separations from 24 June 2017 to 24 September 2017 are included.  This indicator is expressed as a percentage and rounded to the nearest whole number. | |
| Numerator | Total number of separations from a child and adolescent inpatient unit to private residence / accommodation where the consumer was contacted within 7 days of separation. Ended episodes are counted against the Mental Health Area (catchment campus) of the consumer. Excludes same day stays. Excludes interstate clients. | |
| Denominator | Total number of separations from a child and adolescent inpatient unit to private residence / accommodation. Ended episodes are counted against the Mental Health Area (catchment campus) of the consumer. Excludes same day stays. Excludes interstate clients. | |
| Statewide target | ≥ 88% | |
| Achievement | Greater than or equal to 88% | Achieved |
| Less than 88% | 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 consumers followed up within 7 days of separation – Inpatient (adult) | |
| --- | --- | --- |
| Description | A responsive, post-discharge community support system is essential for consumers who have experienced a mental health admission to maintain clinical and functional stability, and to minimise the need for readmission.  Consumers discharged after a mental health admission with linkages to community services and supports are less likely to be at risk of readmission.  Research indicates that mental health consumers have increased vulnerability immediately following discharge, including higher risk for suicide. | |
| Calculating performance | Contacts can be of any duration, in any location for any type of recipient, carried out by the local mental health service or another mental health service.  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.  Contacts on the day of separation are excluded.  Both the numerator and the denominator include consumers separated from a mental health service to a private residence or accommodation and exclude same day separations.  Separations are lagged by seven days to allow all post-discharge follow ups in the reporting period to be captured. For example, if the reporting period is from 1 July 2017 to 30 September 2017, then separations from 24 June 2017 to 24 September 2017 are included.  This indicator is rounded to the nearest whole number. | |
| Numerator | Total number of separations from an adult inpatient unit to private residence / accommodation where the consumer was contacted within 7 days post separation. Excludes same day stays. Lagged by 7 days. | |
| Denominator | Total number of separations from an adult inpatient unit to private residence / accommodation. Excludes same day stays. Lagged by 7 days. | |
| Statewide target | ≥ 88% | |
| Achievement | Greater than or equal to 88% | Achieved |
| Less than 88% | 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 consumers followed up within 7 days of separation - Inpatient (older persons) | |
| --- | --- | --- |
| Description | A responsive, post-discharge community support system is essential for consumers who have experienced a mental health admission to maintain clinical and functional stability, and to minimise the need for readmission.  Consumers discharged after a mental health admission with linkages to community services and supports are less likely to be at risk of readmission.  Research indicates that mental health consumers have increased vulnerability immediately following discharge, including higher risk for suicide. | |
| Calculating performance | Contacts can be of any duration, in any location for any type of recipient, carried out by the local mental health service or another mental health service.  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.  Contacts on the day of separation are excluded.  Both the numerator and the denominator include consumers separated from a mental health service to a private residence or accommodation and exclude same day separations.  Separations are lagged by seven days to allow all post-discharge follow ups in the reporting period to be captured. For example, if the reporting period is from 1 July 2017 to 30 September 2017, then separations from 24 June 2017 to 24 September 2017 are included.  This indicator is expressed as a percentage and rounded to the nearest whole number. | |
| Numerator | Total number of separations from an aged inpatient unit to private residence / accommodation where the consumer was contacted within 7 days post separation. Excludes same day stays. Lagged by 7 days. | |
| Denominator | Total number of separations from an aged inpatient unit to private residence / accommodation. Excludes same day stays. Lagged by 7 days. | |
| Statewide target | ≥ 88% | |
| Achievement | Greater than or equal to 88% | Achieved |
| Less than 88% | 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 consumers re-admitted within 28 days of separation - Inpatient (CAMHS) | |
| --- | --- | --- |
| Description | Child and adolescent 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 child and adolescent 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 child and adolescent 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 | Total number of readmissions (planned or unplanned) to any unit within 28 days of separation from a child and adolescent inpatient unit. Excludes a) same day admissions b) consumers that were originally separated because they were transferred to another inpatient unit or absconded c) overnight ECT admissions (where ECT occurred on the day of separation) d) re-admissions to the following specialty inpatient units: Mother/Baby, Eating Disorder, PICU and Neuropsychiatry. Lagged by one month. | |
| Denominator | Total number of separations from a child and adolescent inpatient unit, where the consumer was discharged home or to a residential service. Excludes a) same day admissions b) consumers that were discharged because they were transferred to another inpatient unit or absconded c) overnight ECT admissions (where ECT occurred on the day of separation). Lagged by one month. | |
| Statewide target | < 14% | |
| Achievement | Less than 14% | Achieved |
| Greater than or equal to 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 | Percentage of consumers re-admitted within 28 days of separation - Inpatient (adult) | |
| --- | --- | --- |
| 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 | Total number of readmissions (planned or unplanned) to any unit within 28 days of separation from an adult inpatient unit. Excludes a) same day admissions b) consumers that were originally separated because they were transferred to another inpatient unit or absconded c) overnight ECT admissions (where ECT occurred on the day of separation) d) re-admissions to the following specialty inpatient units: Mother/Baby, Eating Disorder, PICU and Neuropsychiatry. Lagged by one month. | |
| Denominator | Total number of separations from an adult inpatient unit, where the consumer was discharged home or to a residential service. Excludes a) same day admissions b) consumers that were discharged because they were transferred to another inpatient unit or absconded c) overnight ECT admissions (where ECT occurred on the day of separation). Lagged by one month. | |
| 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 | Percentage of consumers re-admitted within 28 days of separation - Inpatient (older persons) | |
| --- | --- | --- |
| Description | Aged 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 aged 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 aged 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 | Total number of readmissions (planned or unplanned) to any unit within 28 days of separation from an aged inpatient unit. Excludes a) same day admissions b) consumers that were originally separated because they were transferred to another inpatient unit or absconded c) overnight ECT admissions (where ECT occurred on the day of separation) d) re-admissions to the following specialty inpatient units: Mother/Baby, Eating Disorder, PICU and Neuropsychiatry. Lagged by one month. | |
| Denominator | Total number of separations from an aged inpatient unit, where the consumer was discharged home or to a residential service. Excludes a) same day admissions b) consumers that were discharged because they were transferred to another inpatient unit or absconded c) overnight ECT admissions (where ECT occurred on the day of separation). Lagged by one month | |
| Statewide target | < 7% | |
| Achievement | Less than 7% | Achieved |
| Greater than or equal to 7% | 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. | |

**Maternity and newborn**

| Indicator | Percentage of full-term singleton babies (without congenital anomalies) who are considered in poor condition shortly after birth (Apgar) | |
| --- | --- | --- |
| 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 adaptation 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 and correlates highly with Victorian Managed Insurance Authority claims within the first year of life.  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, babies born with congenital anomalies, multiple births, stillbirths, babies born before arrival at hospital, and babies with an unknown Apgar score at 5 minutes | |
| Numerator | Number of singleton infants, with no congenital anomalies, who are born alive with an Apgar score of < 7 at 5 minutes after birth. | |
| Denominator | Number of singleton infants born alive after 37 weeks gestation, with no congenital anomalies. | |
| Statewide target | ≤ 1.4% | |
| Achievement: | Less than or equal to 1.4% | Achieved |
| Greater than 1.4% | Not achieved |
| Improvement | Improvement is assessed against the previous quarter’s performance. | |
| 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 | Percentage of singleton babies with severe fetal growth restriction (FGR) delivered at 40 or more weeks gestation | |
| --- | --- | --- |
| Description | The purpose of this indicator is to identify 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 and Victorian Managed Insurance Authority claims within one year of birth.  The percentage 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, infants with birthweight of less than 150 grams, multiple births and births at earlier gestations (less than 32 weeks). | |
| Numerator | The number of babies with severe FGR, who are born at 40 or more weeks gestation | |
| Denominator | The number of babies with severe FGR, who are born at 32 or more weeks gestation | |
| Statewide target | ≤ 28.6% | |
| Achievement: | Equal to or less than 28.6% | Achieved |
| Greater than 28.6% | Not achieved |
| Improvement | Improvement is assessed against the previous quarter’s performance. | |
| 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 | Average change in the functional independence measure (FIM) score per day of care for rehabilitation separations |
| --- | --- |
| Description | Also referred to as: “Functional independence gain from an episode of rehabilitation admission to discharge relative to length of stay.”  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 can 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 (Victorian Admitted Episodes Dataset) and reported quarterly with a one quarter lag. Results are reported at health service level. |

| Indicator | Rehabilitation | |
| --- | --- | --- |
| Numerator | Sum of (Separation FIM Total Score minus Admission FIM Total Score) for all rehabilitation patients | |
| Denominator | Sum of length of stay for all rehabilitation patients, excluding leave days | |
| Statewide target | ≥ 0.645 | |
| Achievement | Equal to or above 0.645 | Achieved |
| Below 0.645 | Not achieved |

**Aboriginal Health – Cultural Safety**

| Indicator | Percentage of Aboriginal emergency department presentations who did not wait to be seen | |
| --- | --- | --- |
| Description | This measure reports the percentage of emergency department presentations with an Aboriginal and/or Torres Strait Islanders status and a departure status of ‘did not wait’. | |
| Calculating performance | This indicator is measured at the campus level and excludes patients with a departure status of ‘Dead on Arrival’  This indicator is expressed as a percentage and rounded to one decimal point. | |
| Improvement | Improvement is compared to previous quarter performance. | |
| Numerator | Number of Aboriginal and/or Torres Strait Islanders emergency department presentations with a departure mode of ‘did not wait’ (Departure Status Code = 11). | |
| Denominator | Number of Aboriginal and/or Torres Strait Islanders emergency department presentations excluding Dead on Arrival (Departure Status Code = 8) | |
| Frequency of reporting and data collection | Reported quarterly.  Data is submitted by health services via VEMD (Victorian Emergency Minimum Dataset). Refer to *Department of Health policy and funding guidelines* for further information on data submission timelines. | |
| Statewide target | Annual reduction of 25 per cent in gap between Aboriginal and non-Aboriginal people rates of DNW based on 2021/22 annual rates. | |
| Achievement | Equal to or above 25% reduction | Achieved |
| Below 25% | Not achieved |

| Indicator | Percentage of Aboriginal admitted patients who left against medical advice | | |
| --- | --- | --- | --- |
| Description | This measure reports the percentage of admitted patients with an Aboriginal and/or Torres Strait Islanders status and a separation mode of ‘left against medical advice’. | | |
| Calculating performance | This indicator is measured at the health service level and excludes patients with a separation mode of ‘Statistical’.  This indicator includes only Care Type = 4  This indicator is expressed as a percentage and rounded to one decimal point. | | |
| Numerator | Number of Aboriginal and/or Torres Strait Islanders admitted patients with a separation mode of ‘left against medical advice’ (Separation Mode Code = Z). | | |
| Denominator | Number of Aboriginal and/or Torres Strait Islanders admitted patients excluding Statistical separation (Separation Mode Code = S) | | |
| Frequency of reporting and data collection | Reported quarterly (lagged by a quarter).  Data is submitted by health services via VAED (Victorian Admitted Episodes Dataset). Refer to *Department of Health policy and funding guidelines* for further information on data submission timelines. | | |
| Statewide target | Annual reduction of 25 per cent in gap between Aboriginal and non-Aboriginal people rates of DNW based on 2021/22 annual rates. | |
| Achievement | Equal to or above 25% reduction | Achieved |
| Below 25% | Not achieved |

**Ambulance services**

|  |  |
| --- | --- |
| Element | Details |
| Description | The VHES Ambulance Emergency questionnaire seeks to discover the experience of people who were treated and 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 (000), as well as those who receive a non-emergency transport service. |
| Calculating performance | 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.  There is no minimum sample size for any VHES categories. The sample size will be stratified by region so the survey sample is representative of patient population, if necessary, smaller regions will be oversampled to ensure each region receives the minimum number of survey completed to receive a report in the VHES results portal (n=10).  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 to the contractor the details of eligible patients who interacted with Ambulance Victoria, during the two data collection periods, as follows:   * For eligible patients who interacted with Ambulance Victoria in February and March, data to be submitted by 16th of April and 16th May, respectively. * For eligible patients who interacted with Ambulance Victoria in July and August, data to be submitted by 16th of September and 16th October, respectively.   Results from individual collections are reported in Q2 and Q4 respectively, and a combined result is reported Annually. |
| Improvement | For the purpose of the performance risk assessment improvement is assessed against the previous performance |

|  |  |  |
| --- | --- | --- |
| Indicator | Percentage of respondents who rated care and treatment received from paramedics as good or very good | |
| Description | This indicator measures the results of the ‘very good’ and ‘good’ response to the ambulance 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 and treatment you received from paramedics?’. | |
| Denominator | Weighted sum of valid responses to the question: ‘Overall, how would you rate the care and treatment you received from 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 respondents who rated care, treatment, advice and/or transport received from the ambulance service as good or very good | |
| Description | This indicator measures the results of the ‘very good’ and ‘good’ response to the ambulance 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, treatment, advice and/or transport you received from the ambulance service?’. | |
| Denominator | Weighted sum of valid responses to the question: ‘Overall how would you rate the care, treatment, advice and/or transport 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 | Percentage of patients experiencing severe cardiac or traumatic pain whose level of pain was reduced significantly | |
| --- | --- | --- |
| 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 | |
| --- | --- | --- |
| 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) <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 | |
| --- | --- | --- |
| 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 | |
| --- | --- | --- |
| 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 discharge | |
| --- | --- | --- |
| 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**

|  |  |
| --- | --- |
| 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. |
| 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 | |
| --- | --- | --- |
| 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’, ‘don’t know’, ‘neither agree nor disagree’ responses to each of the eight safety culture questions in the health service’s People Matter survey | |
| Statewide target | 62% | |
| Achievement | Equal to or greater than 62% | Achieved |
| Less than 62% | Not achieved |

| Indicator | I am encouraged by my colleagues to report any patient safety concerns I may have | |
| --- | --- | --- |
| 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’, ‘don’t know’, ‘neither agree nor disagree’ responses to the assessed question. | |
| Statewide target | 62% | |
| Achievement | Equal to or greater than 62% | Achieved |
| Less than 62% | Not achieved |

| Indicator | Patient care errors are handled appropriately in my work area | |
| --- | --- | --- |
| 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’, ‘don’t know’, ‘neither agree nor disagree’ responses to the assessed question. | |
| Statewide target | 62% | |
| Achievement | Equal to or greater than 62% | Achieved |
| Less than 62% | Not achieved |

| Indicator | My suggestions about patient safety would be acted upon if I expressed them to my manager | |
| --- | --- | --- |
| 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’, ‘don’t know’, ‘neither agree nor disagree’ responses to the assessed question. | |
| Statewide target | 62% | |
| Achievement | Equal to or greater than 62% | Achieved |
| Less than 62% | Not achieved |

| Indicator | Management is driving us to be a safety-centred organisation | |
| --- | --- | --- |
| Numerator | Percentage of staff with a positive response to the safety culture question: Management is driving us to be a safety-centred organisation | |
| Denominator | The total number of ‘agree’, ‘strongly agree’, ‘disagree’ or ‘strongly disagree’, ‘don’t know’, ‘neither agree nor disagree’ responses to the assessed question. | |
| Statewide target | 62% | |
| Achievement | Equal to or greater than 62% | Achieved |
| Less than 62% | Not achieved |

| Indicator | The culture in my work area makes it easy to learn from the errors of others | |
| --- | --- | --- |
| 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’, ‘don’t know’, ‘neither agree nor disagree’ responses to the assessed question. | |
| Statewide target | 62% | |
| Achievement | Equal to or greater than 62% | Achieved |
| Less than 62% | Not achieved |

| Indicator | This health service does a good job of training new and existing staff | |
| --- | --- | --- |
| 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’, ‘don’t know’, ‘neither agree nor disagree’ responses to the assessed question. | |
| Statewide target | 62% | |
| Achievement | Equal to or greater than 62% | Achieved |
| Less than 62% | Not achieved |

| Indicator | Trainees in my discipline are adequately supervised | |
| --- | --- | --- |
| 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’, ‘don’t know’, ‘neither agree nor disagree’ responses to the assessed question. | |
| Statewide target | 62% | |
| Achievement | Equal to or greater than 62% | Achieved |
| Less than 62% | Not achieved |

| Indicator | I would recommend a friend or relative to be treated as a patient here | |
| --- | --- | --- |
| 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’, ‘don’t know’, ‘neither agree nor disagree’ responses to the assessed question. | |
| Statewide target | 62% | |
| Achievement | Equal to or greater than 80% | Achieved |
| Less than 62% | Not achieved |

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

| Indicator | Percentage of staff who personally experienced bullying at work in last 12mths / People Matter survey responses | |
| --- | --- | --- |
| Description | Relates to the People Matter survey question: Have you personally experienced bullying at work in the last 12months’?  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 |
| --- | --- |
| 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 Master’s courses. |
| Improvement | For the purpose of the performance risk assessment, improvement is calculated annually compared to previous year’s survey results. |
| 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 | |
| --- | --- | --- |
| 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 | |
| --- | --- | --- |
| 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 | |
| --- | --- | --- |
| 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 | |
| --- | --- | --- |
| Description | Timely reception of ambulance patients in EDs (emergency departments) 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. The following Arrival Transport Mode (VEMD) codes are applied:   * ‘01’ Air Ambulance – excludes helicopter * ‘02’ Helicopter * ‘03’ Road Ambulance Service   The Separation/Departure Date (not Arrival Date) is used for calculating the emergency department indicators.  Exclusion:  - Type of Visit code 19 (COVID-19 assessment clinic)[[12]](#footnote-13) does not form part of the non-admitted patient emergency department care national minimum dataset and is to be excluded.  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 *Department of Health and Human Services policy and funding guidelines* for further information on VEMD data submission timelines. | |

|  |  |  |
| --- | --- | --- |
| Indicator | Percentage of triage category 1 emergency patients seen immediately | |
| 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 presentations with a departure status code of: * T1 = Left at own risk without consultation * 10 = left after advice regarding treatment options * 11 = left at own risk without treatment * 30 = referred to collocated clinic.   The Separation/Departure Date (not Arrival Date) is used for calculating the emergency department indicators.  Exclusion:  - Type of Visit code 19 (COVID-19 assessment clinic)[[13]](#footnote-14) does not form part of the non-admitted patient emergency department care national minimum dataset and is to be excluded.  This indicator is expressed as a percentage and rounded to the nearest whole number (0.5 is rounded up).  **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 *Department of Health and Human Services 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 | |
| --- | --- | --- |
| 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: * T1 = Left at own risk without consultation * 10 = left after advice regarding treatment options * 11 = left at own risk without treatment * 30 = referred to collocated clinic.   The Separation/Departure Date (not Arrival Date) is used for calculating the emergency department indicators.  Exclusion:  - Type of Visit code 19 (COVID-19 assessment clinic)[[14]](#footnote-15) does not form part of the non-admitted patient emergency department care national minimum dataset and is to be excluded.  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 *Department of Health 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 | |
| --- | --- | --- |
| 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 those presentations with a departure status code of:  30 – patients referred to a collocated clinic.  The Separation/Departure Date (not Arrival Date) is used for calculating the emergency department indicators.  Exclusion:  - Type of Visit code 19 (COVID-19 assessment clinic)[[15]](#footnote-16) does not form part of the non-admitted patient emergency department care national minimum dataset and is to be excluded.  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 *Department of Health and Human Services 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 | |
| --- | --- | --- |
| 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 (i.e., Triage Category 6).  For clarity, only Triage Categories 1-5 are counted.  The Separation/Departure Date (not Arrival Date) is used for calculating the emergency department indicators.  Exclusion:  - Type of Visit code 19 (COVID-19 assessment clinic)[[16]](#footnote-17) does not form part of the non-admitted patient emergency department care national minimum dataset and is to be excluded.  **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 emergency department length of stay of greater than 24 hours (1,440 minutes), regardless of departure status code | |
| Statewide target | 0 | |
| Achievement | Equal to 0 | Achieved |
| Greater than 0 | 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 *Department of Health and Human Services policy and funding guidelines for* further information on VEMD data submission timelines. | |

| Indicator | Percentage of ‘urgent’ (category ‘C’) mental health triage episodes with a face-to-face contact received within 8 hours | |
| --- | --- | --- |
| Description | Mental health services provide a clear and consistent point of entry 24 hours a day, seven days a week, linking consumers and carers to appropriately qualified and experienced mental health professionals, or the right care and supports where an MHS response is not required.  Monitoring access and response times is an important measure for how clinical models are being developed and implemented in the mental health triage system, to improve triage outcomes and identify areas for service and/or system improvement. | |
| Calculating performance | Percentage of 'urgent' (category 'C') triage episodes where a direct response was provided by the area mental health service within eight hours.  Data are lagged by two months to allow for data collection and submission into the Triage Minimum Dataset. If the reporting period is from 1 July 2017 to 30 September 2017, then triage episodes dated two months prior to any date within this reporting period will be counted. | |
| Numerator | Total triage events requiring an urgent response (Triage Scale C), where the response was direct and within requirements (within 8 hours). Lagged by two months. | |
| Denominator | Total triage events requiring an urgent response (Triage Scale C), where the timeframe is known. Lagged by two months. | |
| 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 quarterly and annually.  Quarterly and annual results are also generated.  Data is submitted by health services via the Mental Health Triage Minimum Dataset. Refer to the *Department of Health policy and funding guidelines for* further information on Mental Health Triage data submission timelines. | |

| Indicator | Percentage of mental health-related emergency department presentations with a length of stay of less than four hours | |
| --- | --- | --- |
| Description | This indicator measures the effectiveness of emergency department processes and patient flow. The measure aims to encourage more timely management of people presenting to emergency department for mental health-related reasons who are admitted to the hospital, referred to another hospital or departed within 4 hours. | |
| Calculating performance | Percentage of mental health–related presentations to Victorian emergency departments with a length of stay of less than four hours. Reported by departure date. Excludes COVID-19 assessment clinics and triage category ‘6’ (dead on arrival).  Mental health-related emergency department presentations include service events flagged with any one of the following:   * A ‘referred by’ code of:   + 16: Mental health telephone assessment/advisory line   + 18: Other mental health staff   + 21: Apprehended under the *Mental Health Act 2014* – Police/Protective Service Officer * A ‘human intent’ code of:   + 2: Intentional self-harm   + 18: Intentional self-harm – non-suicidal self-injury   + 19: Intentional self-harm – suicide attempt   + 20: Intentional self-harm – suicidal intent cannot be determined * A primary or other diagnosis of:   + F01-F99: Mental and behavioural disorders   + Z004: General psychiatric examination, not elsewhere classified   + Z046: General psychiatric examination, requested by authority   + Z915: Personal history of self-harm   + R4581: Suicidal ideation * The ‘seen by mental health practitioner’ date/time field is not null * A ‘departure status’ code of:   + 17: Mental health bed at another hospital campus   + 23: Mental health residential facility   + 25: Mental health observation / assessment unit   + 26: Other mental health bed – this campus   31: Mental health and AoD hub short stay unit | |
| Numerator | Number of mental health-related emergency department presentations where arrival to departure was less than four hours. | |
| Denominator | Number of mental health-related emergency department presentations. | |
| Statewide target | 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 Mental Health Triage Minimum Dataset. Refer to the *Department of Health Services 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) <http://www.health.vic.gov.au/surgery/policies>.

| Indicator | Percentage of elective surgery patients admitted within clinically recommended time | |
| --- | --- | --- |
| Description | All elective surgery patients are allocated an urgency category that indicates the desirable timeframe for admissions due to their clinical condition.  The three urgency categories are:   * 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[[17]](#footnote-18) and with a “Readiness Status” code of either:   * readiness status of ‘R’ (ready for surgery) * readiness status of ‘V’ (ready for surgery, but delayed due to COVID-19 response)   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 * P – special purpose, COVID-19  admitted to another campus arranged by this campus/health service and has received the awaited procedure under contract or similar arrangement due to the COVID-19 response   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. | |
| Frequency of reporting and data collection | Performance is monitored and assessed monthly.  Data is submitted by health services via ESIS. Refer to *Department of Health and Human Services 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 | |
| --- | --- | --- |
| 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[[18]](#footnote-19) and with a “Readiness Status” code of either:   * readiness status of ‘R’ (ready for surgery) * readiness status of ‘V’ (ready for surgery, but delayed due to COVID-19 response)   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 * P – special purpose, COVID-19  admitted to another campus arranged by this campus/health service and has received the awaited procedure under contract or similar arrangement due to the COVID-19 response   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. | |
| Frequency of reporting and data collection | Performance is monitored and assessed monthly.  Data is submitted by health services via ESIS. Refer to the *Department of Health and Human Services policy and funding guidelines* for further information on ESIS data submission timelines. | |

| Indicator | Reduce long waiting elective surgery patients | |
| --- | --- | --- |
| 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[[19]](#footnote-20) 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 or V.  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% OR if statewide target not met, at least 15% proportional improvement from prior year as calculated at 30 June | Achieved |
| Greater than 5% AND less than 15% proportional improvement from prior year as calculated at 30 June | Not achieved |
| 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 on the elective surgery waiting list | |
| 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[[20]](#footnote-21) and with a readiness status of R (ready for care) or V (ready for surgery but delayed due to COVID-19 response) 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 | | |
| Target | Specific health service target as agreed in the Statement of Priorities | | |
| 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 *Department of Health and Human Services policy and funding guidelines* for further information on ESIS data submission timelines. | | |

| Indicator | Number of patients admitted from the elective surgery waiting list |
| --- | --- |
| 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 base 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 monthly, 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[[21]](#footnote-22) are used to assess this indicator. The Intended Procedure code must be <500.  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. * P – special purpose, COVID-19  admitted to another campus arranged by this campus/health service and has received the awaited procedure under contract or similar arrangement due to the COVID-19 response   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 | Total number of admitted patients |
| Target | Specific health service (base) target as agreed in the Statement of Priorities |
| 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 and performance results are generated based on year to date activity. The target will be reported as a year-to-date figure that will be cumulative across the financial year.  Data is submitted by health services via ESIS. Refer to the *Department of Health and Human Services policy and funding guidelines for* further information on ESIS data submission timelines. |

|  |  |
| --- | --- |
| Indicator | Number of patients (in addition to base) admitted from the elective surgery waiting list |
| Description | This indicator measures the stocks and flows of additional elective surgery procedures conducted with funding from Surgical Recovery and Reform initiatives. This (in addition to base) activity is included in the total activity reported in indicator ‘number of patients admitted from the elective surgery waiting list.’ but has its own additional targets specific to funding provided.  Individual targets include ‘Public in Public’ and ‘Public in Private’ procedures and are negotiated with each health service in addition to existing elective surgery admissions target (base).  Targets for the number of patients admitted from the waiting list (base and in addition to base) 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 monthly, 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 in excess of the existing elective surgery admissions indicator.  Performance is calculated using the same criteria as existing indicator ‘Number of patients admitted from the elective surgery waitlist.’ Refer to calculating performance section of this indicator for further detail.  All admissions in excess of the existing elective surgery admissions (base) target will be counted under this admissions (in addition to base) metric as well as being reflected as part of the total admissions in the base indicator.  This indicator is expressed as a whole number. |
| Numerator | Number of admitted patients in excess of base number of admitted patients, if target for base was met. |
| Target | Specific health service (in addition to base) target as agreed in the Statement of Priorities |
| Achievement | Achieved  Not achieved |
| Improvement | n/a |
| Frequency of reporting and data collection | Performance is monitored and assessed monthly and performance results are generated based on year to date activity. The target will be reported as a year to date figure that will be cumulative across the financial year.  Data is submitted by health services via ESIS. Refer to the *Department of Health and Human Services policy and funding guidelines for* further information on ESIS data submission timelines. |

| Indicator | Number of hospital-initiated postponements made within 28 days of a scheduled elective surgery admissions per 100 | |
| --- | --- | --- |
| 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[[22]](#footnote-23) 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.  A postponement is hospital-initiated if the **“Reason for Scheduled Admission Date Change”** code 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.  Counting rule:  HiPs must align to the same reporting period that the initial procedure was scheduled.  This means that a HiP is counted in the same reporting period as its initial procedure (and not when the HiP is registered in the system).  E.g., A HiP is logged in Q1 for a procedure scheduled to occur in Q2. This will NOT be counted in the HiPs total for Q1, but instead counted in the HiPs total for Q2.  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 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 *Department of Health and Human Services policy and funding guidelines* for further information on ESIS data submission timelines. | |

**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 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)[[23]](#footnote-24).

| Indicator | Proportion of urgent patients referred by a GP or external specialist who attended a first appointment within 30 days | |
| --- | --- | --- |
| 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*. | |

| Indicator | Proportion of routine patients referred by a GP or external specialist who attended a first appointment within 365 days | |
| --- | --- | --- |
| 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 | |
| --- | --- | --- |
| 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://www.health.vic.gov.au/policy-and-funding-guidelines-for-health-services) <https://www.health.vic.gov.au/policy-and-funding-guidelines-for-health-services>.  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://www.health.vic.gov.au/data-reporting/victorian-integrated-non-admitted-health-vinah-dataset) <https://www.health.vic.gov.au/data-reporting/victorian-integrated-non-admitted-health-vinah-dataset> | |
| 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*. | |

**Timely response (Ambulance Victoria only)**

| Indicator | Percentage of emergency (Code 1) incidents responded to within 15 minutes | |
| --- | --- | --- |
| 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 | |
| --- | --- | --- |
| 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 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 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 | |
| --- | --- | --- |
| 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.  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 cases where the caller receives advice or service from another health provider as an alternative to an emergency ambulance response – statewide | |
| --- | --- | --- |
| Description | Low-acuity triple zero (000) cases diverted to the Referral Service may be offered a more appropriate alternative to an emergency ambulance dispatch.  A successful referral is when a triple zero call does not result in an emergency ambulance dispatch and is diverted to a non-emergency response or referred to an alternative service provider such as a medical practitioner, nursing service, other health professional service, home self-care or advice.  Ambulance Victoria manages call diversion via a Referral Service that performs a secondary triage with the patient, following the primary triage from the Emergency Services Telecommunications Authority (ESTA) call-taker.  This 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 | |
| --- | --- | --- |
| 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. | |
| 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 Thomas Embling Hospital (TEH) Male Acute Units – Security | |
| --- | --- | --- |
| Description | Number of security patients admitted to male acute units at TEH | |
| Calculating performance | Performance is assessed quarterly. | |
| Numerator | The number of admissions to Forensic inpatient units where the client is male and on a security order at the time of admission.  Numerator calculation: Select admissions to Forensicare 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 Thomas Embling Hospital within 7 days of certification | |
| --- | --- | --- |
| Description | Percentage of male security patients admitted to Thomas Embling Hospital within 7 days of being certified as requiring compulsory treatment. | |
| Calculating performance | Performance is assessed quarterly. | |
| Numerator | Total number of male security patients who were certified as requiring compulsory treatment, and who were transferred to Thomas Embling within 14 days.  Numerator calculation:  Total number of male clients admitted to Thomas Embling Hospital who were placed on a court secure treatment order or a secure treatment order (order codes 105 and 202) within the applicable time period and count the number of days between certification and transfer to Thomas Embling Hospital. | |
| 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 | 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 | Data collection TBC.  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 from Thomas Embling Hospital to a correctional centre within 21 days | |
| --- | --- | --- |
| Description | Percentage of male security patients discharged from Thomas Embling Hospital to a correctional centre within 21 days | |
| Calculating performance | Performance is assessed quarterly. | |
| Numerator | Total number of discharges within 21 days from Forensicare inpatient units (Thomas Embling Hospital) 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 Forensicare 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.    1. 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.    2. 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).    3. Exclude those instances where the length of stay is greater than 21.    4. Exclude same day stays 2. Count the number of discharges per team. | |
| Denominator | Total number of occupants in the Forensicare inpatient units (Thomas Embling Hospital) 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 Forensicare acute units in the applicable time period. Exclude same day stays.    1. 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.    2. 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 | 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 | 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 Thomas Embling Hospital discharged within 7 days of becoming a civil patient | |
| --- | --- | --- |
| Description | Percentage of male security patients at Thomas Embling Hospital whose security order expired, who were discharged to community or Designated Mental Health Service within 7 days. | |
| Calculating performance | Performance is assessed quarterly. | |
| Numerator | Total number of male security patients at Thomas Embling Hospital 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 Thomas Embling Hospital 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 7 days after the security order expired.    1. Obtain all Forensicare acute unit clients who had a security order expire (order codes 105 & 202) during the reporting period    2. Exclude those who have had an extension with a subsequent security order or who have returned to MAP Exclude those who are still in Thomas Embling Hospital 21 days after their security order expired 2. Count the number. | |
| Denominator | Total number of male Forensicare inpatient (Thomas Embling Hospital) clients whose security order expired during the reference period.  Denominator calculation:   1. Obtain male clients admitted to Thomas Embling Hospital acute units who had a security order (code 105 & 202) expire during the reporting period.    1. Obtain all Forensicare acute unit clients who had a security order expire (order codes 105 & 202) during the reporting period    2. 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 | 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 | 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 | |
| --- | --- | --- |
| 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 Health Agencies Reporting Tool (HeART) and the target which is the YTD budget loaded in the HeART (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 the Foundation).  Phased monthly targets are based on the September HeART 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 HeART.  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 HeART by the health service.  Note that the department does not support retrospective changes to phased targets. | |
| Numerator | YTD operating result before capital and depreciation | |
| Denominator | YTD total revenue | |
| Target | As agreed in the SoP for each health service | |
| Achievement | Actual YTD operating as % of revenue is greater than Budgeted YTD operating as % of revenue | Achieved |
| Actual YTD operating as % of revenue is less than Budgeted 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 Health Agencies Reporting Tool (HeART).  Data is expected to be submitted by health services monthly via HeART. Refer to the Guidelines for completing the Health Agencies Reporting Tool (HeART) (finance return) for further information. | |

| Indicator | Average number of days to pay trade creditors | |
| --- | --- | --- |
| 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 Health Agencies Reporting Tool (HeART).  Data is expected to be submitted by health services monthly via HeART. Refer to the *Guidelines for completing the Health Agencies Reporting Tool (HeART) (finance return)* for further information. | |

| Indicator | Average number of days to receive patient fee debtors | |
| --- | --- | --- |
| 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 Health Agencies Reporting Tool (HeART).  Data is expected to be submitted by health services monthly via HeART. Refer to the Guidelines for completing the Health Agencies Reporting Tool (HeART) (finance return) for further information. | |

| Indicator | Adjusted current asset ratio (ACAR) |
| --- | --- |
| 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 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 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 long service leave (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. |
| 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 Health Agencies Reporting Tool (HeART).  Data is expected to be submitted by health services monthly via HeART. Refer to the Guidelines for completing the Health Agencies Reporting Tool (HeART) (finance return) for further information. |

| Indicator | Actual number of days available cash, measured on the last day of each month | |
| --- | --- | --- |
| 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 HeART *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 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 HeART 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.  The annual result is generated on receipt of audited financial data submitted in the Health Agencies Reporting Tool (HeART).  Data is expected to be submitted by health services monthly via HeART. Refer to the Guidelines for completing the Health Agencies Reporting Tool (HeART) (finance return) for further information. | |

|  |  |  |
| --- | --- | --- |
| Indicator | Forecast number of days available cash, measured on the last day of each month | |
| 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 and reported only for Q1, Q2 and Q3 as not relevant for Annual.  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 June 30 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 Health Agencies Reporting Tool (HeART) *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 Health Agencies Reporting Tool (HeART) 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 Health Agencies Reporting Tool (HeART).  Data is expected to be submitted by health services monthly via HeART. Refer to the Guidelines for completing the Health Agencies Reporting Tool (HeART) (finance return) for further information. | |

| Indicator | Variance between forecast and actual Net result from transactions (NRFT) for the current financial year ending 30 June | |
| --- | --- | --- |
| 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 by 7 June\* of the current financial year, in the *Revised Estimates* HeART 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 HeART 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 Revised Estimates HeART submission to the department by 7 June\* 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 multiple times each financial year. As year-end approaches, the forecasts should be most accurate when the Revised Estimates for the final feed to the Department of Treasury and Finance are provided in early June.  These estimates assist the Treasurer in determining the State’s final financial result.  Performance is monitored and assessed annually.  Data is expected to be submitted by health services monthly via HeART. Refer to the Guidelines for completing the Health Agencies Reporting Tool (HeART) (finance return) for further information. | |

\* The date is subject to change and will be dependent on timelines published by DTF for the 2021-22 financial year. The date will be early June and anticipated to be on 7 June 2022.

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

Ararat – East Grampians Health

Bacchus Marsh

Ballarat Health

Bendigo Hospital

Box Hill Hospital – Eastern Health

Broadmeadows Hospital – Northern 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

Kyabram and District Health

Latrobe Regional Hospital

Maroonda Hospital – Eastern Health

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

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

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

Werribee Hospital – Mercy Health

1. Further work will be undertaken on leave event measures terminology that better captures patient experience and Aboriginal community’s holistic understanding of health and wellbeing. [↑](#footnote-ref-2)
2. Also captured in Forensicare SOP/Monitor [↑](#footnote-ref-3)
3. Also captured in Ambulance Victoria’s SOP/Monitor [↑](#footnote-ref-4)
4. Further work will be undertaken on leave event measures terminology that better captures patient experience and Aboriginal community’s holistic understanding of health and wellbeing. [↑](#footnote-ref-5)
5. Also captured in Forensicare SOP/Monitor [↑](#footnote-ref-6)
6. Also captured in Ambulance Victoria’s SOP/Monitor [↑](#footnote-ref-7)
7. Also captured in Ambulance Victoria’s SOP/Monitor [↑](#footnote-ref-8)
8. Also captured in Forensicare SOP/Monitor [↑](#footnote-ref-9)
9. Also captured in Ambulance Victoria’s SOP/Monitor [↑](#footnote-ref-10)
10. Also captured in Forensicare SOP/Monitor [↑](#footnote-ref-11)
11. Also captured in Ambulance Victoria’s SOP/Monitor [↑](#footnote-ref-12)
12. Type of Visit code 19 was introduced in March 2020. [↑](#footnote-ref-13)
13. Type of Visit code 19 was introduced in March 2020. [↑](#footnote-ref-14)
14. Type of Visit code 19 was introduced in March 2020. [↑](#footnote-ref-15)
15. Type of Visit code 19 was introduced in March 2020. [↑](#footnote-ref-16)
16. Type of Visit code 19 was introduced in March 2020. [↑](#footnote-ref-17)
17. Principal Prescribed Procedure (PPP) codes of less than 500 are accepted for episodes that were registered before 1 July 2019. [↑](#footnote-ref-18)
18. Principal Prescribed Procedure (PPP) codes of less than 500 are accepted for episodes that were registered before 1 July 2019. [↑](#footnote-ref-19)
19. Principal Prescribed Procedure (PPP) codes of less than 500 are accepted for episodes that were registered before 1 July 2019. [↑](#footnote-ref-20)
20. Principal Prescribed Procedure (PPP) codes of less than 500 are accepted for episodes that were registered before 1 July 2019. [↑](#footnote-ref-21)
21. Principal Prescribed Procedure (PPP) codes of less than 500 are accepted for episodes that were registered before 1 July 2019. [↑](#footnote-ref-22)
22. Principal Prescribed Procedure (PPP) codes of less than 500 are accepted for episodes that were registered before 1 July 2019. [↑](#footnote-ref-23)
23. This policy is currently being refreshed [↑](#footnote-ref-24)