Attachment 1

Response prepared by DHHS to Questions on Notice received during evidence of Kym Peake on 25 July 2019 before the Royal Commission into Victoria's Mental Health System

Question on notice: how the mental health key performance indicators (**KPIs**) in the Statement of Priorities (**SoP**) have evolved since 2014/2015

Response prepared by DHHS:

1. The KPIs in the SoP changed only slightly in the period 2014-15 to 2019-20, as shown in **Attachment A**.

2. Between 2014-15 and 2019-20, mental health indicators in the SoPs have included 28-day readmission for adults, and both seclusion and post-discharge follow up across the three age group target populations (children and adolescents, adults and older people).

3. A composite seclusion rate across all age groups was present for the four year period 2014-15 to 2017-18. Seclusion rates differ between age groups, and it is rare, for example, for an elderly person to be secluded within a mental health service. It is more common with adults and most common with forensic clients. Compiling rolling results together in a composite score is unhelpful as it renders these differences opaque. As the composite rate is considered to hamper analysis, it was not continued after 2017-18.

4. The targets for seclusion and 28-day readmission did not change in the five year period 2014-15 to 2018-19.

5. The target for post-discharge follow up was unchanged at 75% between 2014-15 and 2017-18 (four years). It was increased to 80% in 2017-18 and remains at that level.

6. As referred to in Ms Peake's evidence, a new mental health Performance and Accountability Framework (**PAF**) has been in development[1] since late 2018. The PAF was published in September 2020, and includes a number of new proposed measures for the 2020-21 SoP in the appendix (see **Attachment B**). These proposed SoP indicators are also referred to in the table at **Attachment A**, as the PAF has been endorsed and published. Processes for the 2020-21 year have been delayed by the COVID-19 pandemic, and hence the 2020-21 SoP has not yet been finalised.

7. The PAF has progressed the evolution of mental health KPIs in the SoP. The PAF proposes that:

    7.1 the existing indicators in the SoP be retained but some targets change. For example, lower seclusion targets tailored to target populations are proposed. This will assist in moving services towards less frequent use of

[1] Transcript of evidence from day 18 on 25 July 2019, page 1793, lines 32-47.

seclusion, and acknowledges the differences in age groups in relation to seclusion performance;

7.2 28-day readmission remains for adults and is expanded with indicators for older people, children and adolescents. The target for CAMHS services (22%) reflects practices in the sector, which tends towards a shorter length of stay to maintain the child or young person's connections with family, friends, school and community but to provide for readmission if needed; and

7.3 post-discharge follow up remains important, as this is often a vulnerable time for consumers. This indicator is unchanged (target 80%).

8. There are several new SoP indicators in the PAF. These include measures of positive patient experience. These indicators draw on data from the Your Experience of Service (YES) survey about how consumers experience the service system.

9. The National Mental Health and Suicide Prevention Information Priorities[2] have personalised care and support as one of three information priorities. This 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.

10. The consumer experience related measures include:

10.1 rate of YES survey completion (target 20%);

10.2 percentage of mental health consumers reporting a positive experience of care (target 80%); and

10.3 perception of safety: percentage of consumers reporting they 'usually' or 'always' felt safe using this service (target 90%).

11. Access to care when it is required is an important issue for consumers, carers and services. The PAF proposes two new measures in this regard:

11.1 percentage of 'urgent' (category C) triage episodes with a face-to-face contact received within 8 hours (target 80% of presentations); and

11.2 percentage of mental health related Emergency Department (**ED**) presentations with a length of stay of less than 4 hours (target 81%, which is the same target as for all ED presentations).

12. Most consumers receive services in the community, but the SoP indicators historically have been focussed on inpatient care. A further new measure aims to look at people whose care in the community may be ceased too soon: percentage

[2] National Mental Health and Suicide Prevention Information Priorities, 3rd edition, October 2019, unpublished

of closed community cases re-referred within six months (CAMHS, adults and older people), (target 25%). This indicator is the community counterpart of 28-day readmission to inpatient care measure. Re-referral may indicate that treatment was either incomplete or ineffective.

13. The PAF sets out in considerable detail how the indicators will be monitored and measured. SoP KPI results are reported to CEOs and Boards, and health services must publish their results in their annual report. Work is currently underway to revise reporting to services to better align with the PAF.

14. Post-discharge follow up for adults is an example of a KPI that has been in the SoP since 2010-11. In 2008-09, the state-wide result for this indicator was 73.6%. It has improved over time, and was at a level of 90.6% in 2019-20.

15. A responsive community support system for people who have experienced an acute psychiatric episode requiring hospitalisation is essential to maintain clinical and functional stability and to minimise the need for hospital readmission. Consumers have increased vulnerability immediately following discharge, including higher risk of suicide. Monitoring the proportion of discharges that are followed up within 7 days is a good measure of the timeliness of this care. This indicator reflects the effectiveness of the interface between admitted care and non-admitted care.

16. Evolution of the mental health KPIs within SoPs has accelerated recently. The proposed new indicators reflect the importance of mental health as part of health, and increase the prominence of mental health within health service governance.

Attachment A to Response prepared by DHHS to questions received on notice during evidence of Kym Peake during 2019 Public Hearings

Statement of Priorities (SoP) Evolution of mental health indicators

	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21 proposed
Seclusion	*Composite seclusion rate per 1000 beddays - target 15	*Composite seclusion rate per 1000 beddays - target 15	*Composite Seclusion rate per 1,000 beddays - 15	*Seclusion events - all acute admissions - 15			
	*CAMHS seclusion rate per 1000 beddays - 15	*CAMHS seclusion rate per 1000 beddays - 15	*CAMHS seclusion rate per 1,000 beddays - 15	*Seclusion events - child and adolescent acute admissions - 15	*Seclusion events - child and adolescent acute admissions - 15	*Seclusion events - child and adolescent acute admissions - 15	*Seclusion events - child and adolescent acute admissions – Target 10
	*Adult seclusion rate per 1000 beddays - 15	*Adult seclusion rate per 1000 beddays - 15	*Adult seclusion rate per 1,000 beddays - 15	*Seclusion events - adult acute admissions - 15	*Seclusion events - adult acute admissions - 15	*Seclusion events - adult acute admissions - 15	*Seclusion events - adult acute admissions – Target 10
	*Aged seclusion rate per 1000 beddays - 15	*Aged seclusion rate per 1000 beddays - 15	*Aged seclusion rate per 1,000 beddays - 15	*Seclusion events - aged acute admissions - 15	*Seclusion events - aged acute admissions - 15	*Seclusion events - aged acute admissions - 15	*Seclusion events - aged acute admissions – Target 5
28 day readmissions	*adult 28 days readmission rate - 14%	*adult 28 days readmission rate - 14%	*Adult 28 day readmission rate (%) - target 14%	*Adult mental health 28-day readmissions - target 14%	*Adult mental health 28-day readmissions - target 14%	*Adult mental health 28-day readmissions - target 14%	*Adult mental health 28-day readmissions - target 14%
							*Aged mental health 28-day readmissions - target 14%
							*CAMHS mental health 28-day readmissions - target 22%
Post-discharge follow up	*CAMHS post discharge follow up - 75%	*CAMHS post discharge follow up - 75%	*CAMHS post discharge follow up (%) - 75%	*Post discharge follow up - child and adolescent acute admissions - 75%	*Post discharge follow up - child and adolescent acute admissions - 80%	*Post discharge follow up - child and adolescent acute admissions - 80%	*Post discharge follow up - child and adolescent acute admissions - 80%
	*Adult post discharge follow up - 75%	*Adult post discharge follow up - 75%	*Adult post discharge follow up (%) - 75%	*Post discharge follow up - adult acute admissions - 75%	*Post discharge follow up - adult acute admissions - 80%	*Post discharge follow up - adult acute admissions - 80%	*Post discharge follow up - adult acute admissions - 80%
	*Aged post discharge follow up - 75%	*Aged post discharge follow up - 75%	*Aged post discharge follow up (%)	*Post discharge follow up - aged acute admissions - 75%	*Post discharge follow up - aged acute admissions - 80%	*Post discharge follow up - aged acute admissions -	*Post discharge follow up - aged acute admissions -

	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21 proposed
						80%	80%
Positive patient experience							Percentage of mental health consumers reporting a positive experience of care 80%
							Rate of Your Experience of Service (YES) survey completion Target 20%
Zero harm							Perception of safety: percentage of consumers reporting they 'usually' or 'always' felt safe using this service Target 90%
Best practice							Percentage of closed community cases re-referred within six months CAMHS 25% Adults- 25% Aged- 25%
Reduced waiting							Percentage of 'urgent' (category C) triage episodes with a face-to-face contact received within 8 hours (80% of presentations)
Equitable access							Percentage of mental health related emergency department presentations with a length of stay of less than 4 hours (81% of presentations).

Mental health performance and accountability framework

VICTORIA State Government | Health and Human Services

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

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Introduction

Mental health is an integral component of health. The *Mental health performance and accountability framework* is a companion document to the *Victorian health services Performance Monitoring Framework.* Both frameworks are used to monitor and support better health outcomes for Victorians, however, their foci and scope are different but intertwined.

The *Victorian health services Performance Monitoring Framework* (VHSPMF) focus is to be transparent regarding how the department, as the system steward of Victoria's public health system, takes a risk-based approach to overseeing health service performance in relation to the delivery of safe, high quality, accessible and sustainable health care for Victorians. It applies across a range of health services, including metropolitan health services, small rural health services, and Ambulance Victoria. Within health services, the VHSPMF applies to a range of programs, for example, surgical, maternity and mental health care.

The *Mental health performance and accountability framework* focus is on the clinical mental health system and using best practice principles in monitoring and driving clinical mental health improvements. It is solely dedicated to mental health performance and accountability, allowing for more granular and measured appraisal of mental health performance and outcomes for consumers. This in turn supports and informs the *Victorian health services Performance Monitoring Framework*.

Mental health is an integral and essential component of health. The *Mental health performance and accountability framework* enables a stronger focus on accountability, service and system performance in Victorian state-funded clinical mental health services.

Purpose of the framework

The purpose of the *Mental health performance and accountability framework* (the framework) is to provide a structure for tracking mental health system performance in Victoria. Specifically, it includes monitoring:

- the implementation of mental health policy
- the performance of clinical mental health services
- the outcomes of people receiving mental health treatment and care.

The focus of the framework is to:

- inform monitoring of change over time
- support safe and effective service delivery
- help identify levers for closing any gaps between actual performance and targeted outcomes.

Objectives of the framework

The objectives of the framework are to:

- provide a clear structure for mental health system reporting and monitoring, and instigate positive change
- promote accountability to government and the community
- align with or complement other monitoring and reporting in mental health such as national indicators
- enable a more systematic and innovative approach to collecting, analysing, reporting and leveraging information

- be policy relevant and respond to changing priorities but also maintain consistency over time of core elements of the framework to enable longitudinal analysis
- have strong stakeholder buy-in and be accessible to audiences through different methods of reporting.

Scope

The mental health service system is complex and involves different levels of government and service types. The scope of this framework comprises Victorian state-funded clinical mental health treatment and support services. All target populations (adult, aged, children and adolescents, forensic and specialist) are included. Private and primary health services are generally not in scope. However, instances where public mental health services receive Department of Health and Human Services (the department) funds to deliver public acute inpatient mental health services from private hospital beds are within scope.

Process

Staff from the department's Mental Health and Drugs Branch have worked with internal and external colleagues to develop this framework. The Progress Measures Working Group has provided invaluable advice to the project. The group includes representatives from:

- consumer and carer organisations
- clinical mental health services
- the Mental Health Tribunal
- Mental Health Complaints Commissioner
- universities
- Victorian Agency for Health Information
- Mental Health Drugs and Data Team
- Safer Care Victoria
- the Office of the Chief Psychiatrist.

We acknowledge the expert assistance of the Australian Mental Health Outcomes and Classification Network in facilitating two workshops during development of the framework.

Policy and legislative environment

Victoria's 10-year mental health plan sets the government's long-term vision to improve the mental health and wellbeing of all Victorians. Released in November 2015, it provides the foundation for mental health reforms. The plan focuses on:

- providing people with better access to services, care and support
- intervening earlier
- creating and supporting local solutions
- developing mental health workforce.

Monitoring progress and reporting on outcomes under the plan helps assess the impact of programs and services on people's lives over time. A range of indicators have been developed to track whether initiatives and programs are contributing to better outcomes for people with mental illness through an outcomes framework. Results are reported annually in Victoria's mental health services annual report.

Victoria's *Mental Health Act 2014* sets out a framework to:

- promote recovery-oriented practice
- minimise compulsory treatment
- protect and support the rights of people living with mental illness.

The Act provides for the mental health assessment, detention and compulsory treatment of people with severe mental illness. Compulsory treatment must only be used where necessary to prevent serious harm to the person or to others. The principles of the act include:

- Assessment and treatment must be provided in the least restrictive way possible.
- Services should aim to bring about the best possible therapeutic outcomes and promote recovery and full participation in community life.
- People should be involved in all decisions about their assessment, treatment and recovery and be supported to make or take part in those decisions.
- People should be allowed to make decisions about their treatment and recovery that involve a degree of risk.
- People should have their rights, dignity and autonomy respected and promoted.

On 24 February 2019 the Victorian Government announced the terms of reference and Commissioners for the landmark Royal Commission into Victoria's Mental Health System. The royal commission is examining the current system's strengths, limitations and challenges. It will provide recommendations on how best to support Victorians with mental illness.

The royal commission will make short-, medium- and long-term recommendations. It released an interim report in November 2019 and will release its final report by February 2021. The Victorian Government has committed to implementing all recommendations.

Concurrently, the Productivity Commission is conducting a national inquiry into mental health. This inquiry is considering the role of mental health in supporting economic participation, enhancing productivity and economic growth. The Productivity Commission will make recommendations about how governments, employers and others can improve population mental health to realise economic, social participation and productivity benefits over the long term. The Productivity Commission's final report is due in June 2020.

In 2018–19 the Victorian Auditor-General's Office released two reports related to mental health. The first of these, *Access to mental health services*, sought to determine if people with mental illness have timely access to appropriate treatment and support services. The second, *Child and youth mental health,* sought to determine whether child and youth mental health services are effectively preventing, supporting and treating child and youth mental illness. The department is now implementing the recommendations of the reports. This process will also be informed by the outcomes of the Royal Commission into Victoria's Mental Health System. Both of the Auditor-General's reports made recommendations about performance monitoring.

Data collection and use

To effectively undertake monitoring and evaluation, we need to collect the right data. There also needs to be investment in data quality. Despite the high cost and burden associated with data collection, data currently collected in Victoria's public mental health system could be better analysed and reviewed to inform decision making. This will improve outcomes for consumers, families and carers. Rationalising the multitude of mental-health related reporting activities will reduce administrative burden and create a simpler, more authoritative system.

However, despite the high volume of data collected, gaps remain. In Victoria, a lack of access measures has been the subject of criticism from the Victorian Auditor-General. This in turn relates to data quality and availability. Data is often lacking on population sub-groups such as:

- Aboriginal people
- lesbian, gay, bisexual, transgender/transsexual, intersex and queer/questioning (LGBTIQ) people
- culturally diverse people.

The Productivity Commission has recommended that Australian governments develop and fund strategies to address known data gaps and limitations where it is cost effective and statistically valid to do so.[1] Clinical mental health data can be considered as in Figure 1, drawn from the forthcoming National Mental Health and Suicide Prevention Information Priorities.

Data has value when it can be transformed into information that assists decision making. It is also helpful if clinicians, managers and other stakeholders can see the value in collecting data items, and in supporting good data quality. Under the Australian Health Care Agreements, health ministers agreed to introducing routine consumer outcomes measurement in mental health services nationally. Outcome measures attempt to assess whether a change has occurred for a consumer as a result of mental health care. Services are required to support the National Outcomes and Casemix Collection (NOCC).[2]

However, often clinicians do not have easy access to consumer-related outcome measures tools. Also, unlike physical health care in Victoria, the data that mental health clinicians collect is not used to calculate funding. Recent work in Victoria and nationally via the Australian Mental Health Care Classification has begun to focus on using data (and particularly outcome measures) to develop future funding models. In physical health care, the link between data and funding (casemix) has driven improvements to data collection and coding that have been absent from mental health.

Victoria takes part in national data collections for mental health, from which the Key Performance Indicators for Australian Public Mental Health Services are drawn.[3] National collections include data relating to community, admitted and residential mental health care. The Australian Institute of Health and Welfare (AIHW) reports on the 16 national indicators. The AIHW also facilitates cross-jurisdictional and, to some extent, international comparisons of performance. The International Initiative for Mental Health Leadership leads benchmarking across several countries.[4] It uses indicators such as readmissions, length of stay and community contacts.

Varying definitions and standards for data collections are problematic – for example, between state and national collections, or between departmental and central agency collections. Consistently applied data standards are critical to upholding the data collection principle of ‘single provision, multiple use’. It aims for consistent indicator definitions across reporting. This also reduces the reporting burden on services and the department.

Benchmarking aims to drive a quality improvement cycle by enabling entities to access regular reports on performance relative to similar entities. The intention is to support a collaborative environment that supports information sharing and learning between peers. Nationally, previous work has occurred on benchmarking against the Key Performance Indicators for Australian Public Mental Health Services.[5] There is likely to be increasing movement towards national service level benchmarking in mental health. The AIHW publishing hospital-level restrictive intervention data in 2019 and 2020 is an example of this.[6]

Providing transparent data at the area mental health service level and below is an essential ingredient in creating a more consumer-oriented mental health system. It also improves service outcomes for people

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[1] Productivity Commission 2019, *Mental health draft report*, Australian Government, Canberra, p. 1,009.

[2] The NOCC <https://meteor.aihw.gov.au/content/index.phtml/itemId/636931> is a national collection of clinician and consumer-rated measures of consumer symptoms and functioning at key points of care within public specialised clinical mental health services. The NOCC promotes routine use of outcome measures in public mental health services and an informed mental health sector.

[3] National Mental Health Performance Subcommittee 2013, *Key performance indicators for Australian public mental health services, third edition*, Commonwealth of Australia, Canberra. Note that as at February 2020, data were available for 13 of the 16 indicators (see the AIHW website <www.aihw.gov.au/mhsa>).

[4] Project management and data analysis support is delivered by the UK NHS Benchmarking Network <https://www.uppdragpsykiskhalsa.se/wp-content/uploads/2019/11/International-MH-report-31-October-2019.pdf>.

[5] AHMAC MHSC Mental Health Information Strategy Subcommittee 2009, *National Mental Health Benchmarking Project Evaluation Report, MHISS discussion paper no. 7*, Commonwealth of Australia, Canberra.

[6] See the AIHW website <https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/restrictive-practices/seclusion>. Refer to Table RP.10.

using services. Reporting at the state level is valuable for assessing Victoria's position relative to other jurisdictions. However, it lowers transparency and accountability, which are enhanced by regional and service level reporting. The statewide result for seclusion or emergency department access, for example, does not assist in identifying areas where there are issues with seclusion and access. The framework focuses on service-level monitoring and reporting, breaking down data by target population and setting.

This promotes accountability and drives improvements in service quality through:

- publishing data that informs consumer choice and drives self-improvement among providers
- benchmarking analyses, where services can regularly compare their performance against similar services.

Figure 1: Victorian clinical mental health services data[7]

Used with permission from the Australian Institute of Health and Welfare.

[7] AIHW 2019, *National mental health and suicide prevention information priorities*, 3rd edition, unpublished.

Service system

The Victorian Government funds clinical mental health services delivering assessment, treatment and clinical case management in hospitals and community settings. Residential services, such as prevention and recovery care services and public sector residential aged care services for older people with mental illness, are also provided in the community.

The Victorian Government invested $1.63 billion in clinical mental health services in 2019–20. Clinical mental health services are delivered within geographically defined catchment areas. Services in each catchment provide mental health care to people who live in that area so they have access to local treatment and support (see Table 1). Victoria also has several specialist mental health services provided on a statewide basis (Table 2). These services include:

- specialist perinatal units
- eating disorder services
- dual diagnosis services
- transcultural mental health services
- treatment for people with a personality disorder.

The Victorian Institute of Forensic Mental Health (Forensicare) provides clinical forensic mental health services that span all components of the mental health and criminal justice sectors. Forensicare was created under the *Mental Health Act 1986* and continues under the 2014 Mental Health Act. As such, governance arrangements for Forensicare differ from those of other mental health services, which fall under the *Health Services Act 1988*. This means, for example, that the Minister for Mental Health rather than the Minister for Health executes the Forensicare's Statement of Priorities. Under the Mental Health Act the Chief Psychiatrist:

- provides clinical leadership and advice to mental health service providers, including Forensicare
- promotes continuous improvement in the quality and safety of mental health services
- promotes the rights of people receiving these services.

Table 1: Victoria's mental health service system – area-based clinical services[8]

Target population	Services
Child and adolescent services / Child and youth services[9]	• Acute inpatient services • Autism assessment • Consultation and liaison psychiatry • Continuing care • Day programs • Intensive mobile youth outreach services • School-based early intervention programs
Adult services[9]	• Acute community intervention services • Acute inpatient services • Community care units • Consultation and liaison psychiatry • Continuing care • Early psychosis (16–25 years) • Prevention and recovery care (PARC) • Psychiatric assessment and planning units • Secure extended care and inpatient services • Youth PARC (16–25 years)
Aged persons services (65+ years)	• Acute inpatient services • Aged persons mental health community teams • Aged persons mental health residential services

Table 2: Victoria's mental health service system – statewide specialist services

Service type	Services
Statewide specialist services	• Aboriginal services • Autism services • Brain disorder services • Dual diagnosis services • Dual disability services • Eating disorder services • Neuropsychiatry • Perinatal services • Personality disorder services • Torture and trauma counselling • Victorian Institute of Forensic Mental Health (Forensicare) • Victorian Transcultural Mental Health • Transition support hubs

[8] Delivery of activities varies between areas. Some services have separate teams for the various activities; others operate 'integrated teams' performing a number of different functions.

[9] Service models for children and young people vary across the state. Some areas have Child and Adolescent Mental Health Services (0–18 years); some have Child and Youth Mental Health Services (0–25 years); and others have specific services for adolescents (12–18 years) or youth (16–24 years).

Service system aims

The department's vision is to achieve the best health, wellbeing and safety of all Victorians so they can live a life they value.[10]

Mental health services aim to:

- promote mental health and wellbeing and, where possible, prevent the development of mental health problems, mental illness and suicide
- when mental health problems and illness do occur, reduce the impact (including the effects of stigma and discrimination)
- promote recovery and physical health and encourage meaningful participation in society by providing services that:
  - are high quality, safe and responsive to consumer and carer goals
  - facilitate early detection of mental health issues and mental illness, followed by appropriate intervention
  - are coordinated and provide continuity of care
  - are timely, affordable and readily available to those who need them
  - are sustainable.

Governments aim for mental health services to meet these objectives in an equitable and efficient way.[11]

[10] Department of Health and Human Services 2019, *Strategic plan*, State Government of Victoria, Melbourne.

[11] The vision and objectives draw on governments' broad objectives as expressed in the Australian Government's *National mental health policy 2008* and the Council of Australian Governments' 2017 *Fifth national mental health and suicide prevention plan*. See the 2018 *Report on government services* <https://www.pc.gov.au/research/ongoing/report-on-government-services/2018>.

Broader performance context

Victoria's clinical mental health services are one element of Victoria's state-funded health system. They are subject to state and national safety, quality, reform and performance systems. These each have their own focus, governance and reporting requirements.

This framework is based on the domains and sub-domains of the *National mental health performance framework* (NMHPF). The Mental Health Principal Committee endorsed the NMHPF in March 2019. It is based on the COAG Health Council's *Australian health performance framework*, to which other sector-specific health performance frameworks must be linked (see Figure 2).

Health frameworks do not always adequately 'fit' mental health. The Mental Health Principal Committee found that the *Australian health performance framework* provided a good structure for performance reporting but that the language used within it did not align with the principles of best practice mental health care. A specific mental health framework therefore remained necessary. The NMHPF includes reference to carers and to concepts such as rights-based care, recovery, trauma-informed care and mortality gap. The objective of the framework is to improve health outcomes for all Australians living with mental illness and ensure sustainability of the Australian health system.

Similarly, the *Victorian health services performance monitoring framework* (VHSPMF)[12] articulates the Government's wider performance monitoring of Victorian public health services and hospitals. The VHSPMF is a whole-of-organisation performance monitoring and assessment vehicle, encompassing key performance measures as well as underlying risk factors that highlight the health service's environmental context, which may contribute to, or be a factor in, poor performance. Figure 2 provides a clear visual representation of the companion or complementary relationship between the framework and the VHSPMF.

The VHSPMF covers four domains:

- high-quality and safe care
- strong governance, leadership and culture
- effective financial management
- timely access to care.

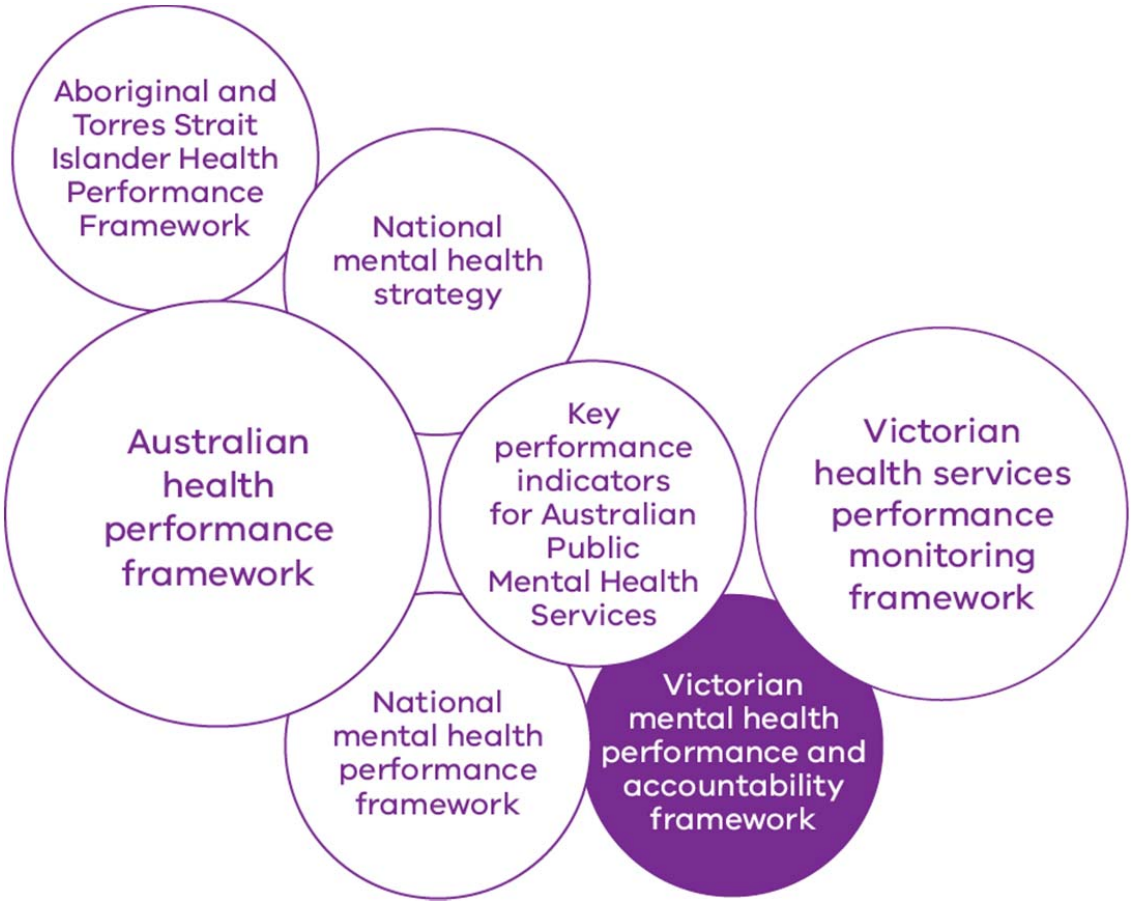
The VHSPMF promotes transparency and shared accountability for performance improvement across the system and helps inform future policy and planning strategies.

As the VHSPMF is a whole-of-organisation vehicle, some mental health measures and content are captured in its assessment for completeness. Further, the VHSPMF incorporates findings identified by the framework, considering the framework's mental health specialisation and depth. This level of detail cannot be applied within a broad evaluation, and the framework provides a dedicated lens to mental health performance assessment, allowing for more granular and measured appraisal of mental health performance. One benefit of a distinct performance and accountability framework for mental health is that aspects of service delivery that are sector-specific can be clearly captured.

An important principle is that the same expectations should be set for consumers of mental health services as for other health system users wherever possible. Targets such as time to a mental health bed from the emergency department should align across the health service.

[12] The *Victorian health services performance monitoring framework* is available from health.vic – Performance monitoring framework <https://www2.health.vic.gov.au/hospitals-and-health-services/funding-performance-accountability/performance-monitoring>

Figure 2: Performance drivers for Victoria's clinical mental health services



Performance domains and measures supporting the framework

Performance domains

The performance domains and sub-domains that support and provide the basis for the framework's approach are drawn from the NMHPF. Table 3 outlines the six NMHPF domains with 'Equity' intended to be an overarching consideration, applicable to all domains.

Table 3: National mental health performance framework domains

Value	Domain	Sub-domains
Equity	Safety	• Consumer safety • Carer safety • Provider safety • Community safety
	Appropriateness	• Consumer and carer participation • Consumer and career experience of care • Relevance to consumer and carer needs
	Effectiveness	• Consumer outcomes • Community tenure • Carer outcomes • Compliance with standards
	Continuity of care	• Continuity between providers • Continuity over time • Cross setting continuity
	Accessibility	• Access for those in need • Local access • Emergency response
	Efficiency and sustainability	• Outcomes orientation • Provider knowledge and skill • Inpatient care • Community care • Workforce planning • Training investment • Research investment

Defining the domains

Safety

This refers to avoiding (or reducing to acceptable limits) actual or potential harm (physical or psychological) from health care. This harm might come about from healthcare management or the healthcare environment. This domain includes the safety of care delivered to consumers (including patient-reported incidents and restrictive practices) as well as the safety of staff and carers.

Appropriateness

This means that service is person-centred, culturally appropriate, rights-based, trauma-informed and recovery-oriented. Mental health consumers and carers are treated with dignity and confidentiality and encouraged to take part in choices about their care. Consumers and carers report positive experiences (patient reported experience measures (PREMs) and patient-reported outcome measures (PROMs)).

Effectiveness

Under this domain, care, intervention or action achieves the desired outcome. This is from both the clinical and mental health consumer and carer perspective, as reflected in PROMs. Care is based on evidence-based standards.

Continuity of care

This is the ability to provide uninterrupted and integrated care or service across programs, practitioners and levels over time. Good mental health care requires good communication – between hospital departments (such as mental health and cardiac care) and from health provider to health provider (for example, psychiatrist to GP). Coordination mechanisms work for mental health consumers, carers and health care providers. Care and support is holistic and includes psychosocial and physical components.

Accessibility

This means that people can obtain health care at the right place and right time. It takes into account different population needs and the affordability of care

Efficiency and sustainability

Under this domain, the right care is delivered at minimum cost. The mental health workforce, physical capital such as facilities and beds, and technology are supported, maintained and renewed. Innovation occurs to improve efficiency and respond to emerging needs. Members of the workforce receive the support they need and report positive experiences.

Equity

Equity is an overarching concept in the NMHPF. Equity influences all elements of the framework:

- the determinants of health
- health status
- the health system and its context.

The *Australian health performance framework* explicitly recognises the need for monitoring equity across these elements for different population groups and sub-groups. We will do this by breaking down performance measure data into groups such as:

- Aboriginal and Torres Strait Islander people
- people living in different geographic areas

- different socioeconomic groupings.

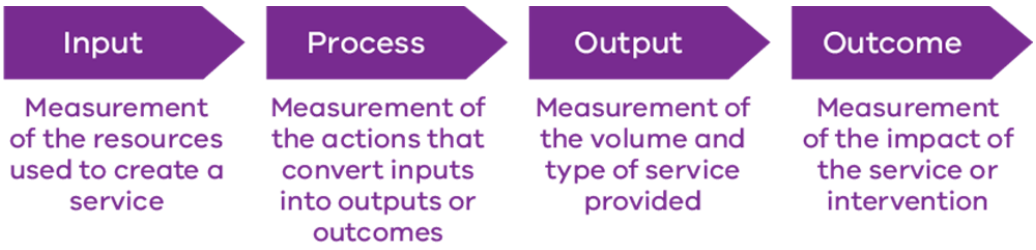
Within the *Australian health performance framework*, equity means minimising avoidable differences between groups or individuals.

The concept of equity may apply differently to specific indicators. For some indicators, it would be useful to see equity across population groups (equal treatment for individuals/groups in same circumstances). For others, it would be helpful to see individuals/groups being treated differently according to their level of need.

Performance measurement – the basis and approach to indicator inclusion

Performance measurement usually uses four main types of indicators (see Figure 3). Choice of the type of indicator is based on the purpose of the indicator and the availability of the right data. In the past, measurement has focused on input, process and output measures. This is partly because of the availability of data (or lack of it) and the developing nature of measurement systems. The Victorian Government is now placing more focus on outcome measurement. Other types of performance measures may also be used, providing a range of information on public mental health services.

Figure 3: Types of indicators



Input measures help us understand the capabilities and structural characteristics of the organisation (for example, staff numbers, quality of facilities). Process measures help determine whether people receive care that is evidence-based or conforms with expectations about quality (for example, treatment with dignity, appropriate care). Measures of output assist in understanding the quantities of services and in developing efficiency indicators (for example, cost per contact). Outcome measures are the basis for understanding whether consumers are improving in their clinical status and wellbeing.

The indicators included in this framework have been identified through a number of approaches including:

- a review of existing state, national and international performance frameworks
- an assessment of available data sources
- consultation with stakeholders.

In selecting indicators, consumers' experience of mental health services is another important source of measures. It is a key part of determining how well a service is performing to meet the consumer's goals. The Organisation for Economic Coordination and Development (OECD) supports the need to collect patient-reported indicators at multiple levels:

- disease level
- sector level
- health service level
- whole-system level (both PREMS and PROMs).

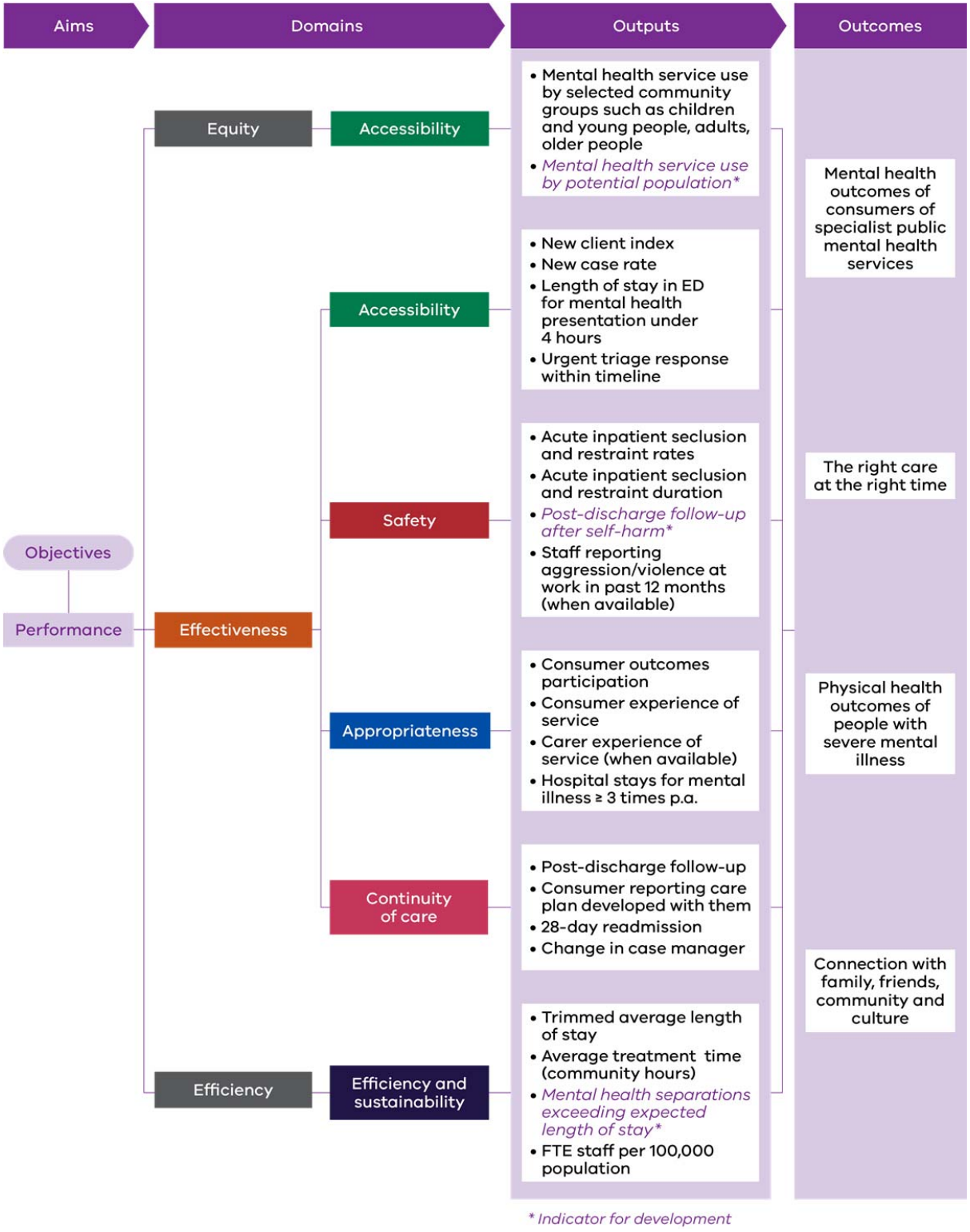
This helps to build a more person-centred view of health system performance. The measures used to hold services accountable must also balance clinically relevant indicators and consumer-focused outcomes.

Several factors allow mental health services to promote high-quality care and improve outcomes for consumers:

- benchmarking performance
- determining optimal performance levels
- establishing best practice approaches.

The framework also uses a service provision program logic (see Figure 4) to follow the sequence of steps in the government service provision process (the conversion of inputs to outputs and outcomes).

Figure 4: Mental health service provision program logic



Summary tables of performance indicators

The indicators below are organised by domain and by whether they are a core, context or future indicator. A forward-looking approach has meant that some indicators are in development and not yet available. There are areas where indicators are still needed, such as access or continuity of care measures, but information system changes, indicator technical specifications or information sources are in development.

The future measures have been discussed and are regarded as technically feasible.

- **Core indicators** are generally those for which performance targets have been developed, and which are included in the *Statement of Priorities*, *Policy and funding guidelines*, the *Program report on integrated service monitoring* or *Victorian State Budget Paper No. 3*.
- **Context indicators** support a broader assessment of performance. The mental health system is complex, and context indicators support understanding and analysis of core indicators.
- **Future indicators** are those where the need for an indicator has been identified, but the measure cannot currently be reported. Work will be undertaken to establish the indicator, noting that those that require changes to CMI/ODS may have a lengthy lead time.

Core, context and future indicators are listed in Tables 4–9.

The indicator set will be reviewed and updated every one to two years. Some indicators will be added as data becomes available. Indicators may shift between categories; for example, there are currently three core indicators relating to compliance with outcome measures requirements. At present, performance is variable and frequently better in inpatient care than in the community. However, as outcome measures become part of funding calculations, compliance should improve. Over time, it should be possible to move away from compliance measures as core indicators and instead look at self-rated and clinician-rated outcomes for consumers.

At this stage, results from the Carer Experience Survey and the People Matter Survey are anticipated to be available for the first time in 2020–21. Pending this, they are listed as context indicators. Again, these indicators may shift between categories over time, moving towards core indicator status. The Australian Mental Health Outcomes and Classification Network is developing new consumer-rated measures that may provide new data about important areas such as employment and income. When completed, and if adopted by Victoria, these measures could provide extra information about consumer outcomes.

Indicators will usually be applied across target populations such as age groups. For some indicators, such as length of stay, the expected duration is longer for a particular group (older people). For other indicators, data may only be available for one or some target populations. The YES survey, for example, has until now been offered to people aged 16 or older. The survey is likely to be extended to a broader age range.

Specific data about vulnerable groups will be included in reporting over time. This will start with a focus on Aboriginal people and children and young people on a child protection order. Because these are small populations, there will need to be enough numbers for reliable analysis. This may not be possible at the service level.

Legend for tables:

[a] New indicator for specification and development by the Victorian Agency for Health Information

[b] New data source, for example, Carer Experience Survey, People Matter survey

[c] New indicator for specification and development by the Victorian Agency for Health Information. Requires changes to CMI/ODS because longer lead time expected.

Table 4: Safety domain indicators

Sub-domain	Core	Context	Future
Consumer safety	1. Seclusion per 1,000 occupied bed days		1. Percentage of emergency department presentations for intentional self-harm with community mental health follow-up within specified timeframe[a]
	2. Seclusion duration		
	3. Bodily restraint per 1,000 occupied bed days	1. Restraint duration	
	4. Perception of safety: percentage of consumers who report they usually or always felt safe using the service		
Carer safety		2. Perception of safety: percentage of carers who report they usually or always felt the service was safe[b]	
Provider safety		3. Mental health staff: overall positive response to People Matter Survey safety and culture questions[b]	
		4. Percentage of mental health staff who report that during the last 12 months in their current organisation they have been subject to aggression or violent behaviour at work[b]	
Community safety	N/A		

Table 5: Appropriateness domain indicators

Sub-domain	Core	Context	Future
Consumer and carer participation	1. Percentage of valid Health of the Nation Outcome Scales (HoNOS) compliant cases	1. Percentage of mental health consumers who have an advance statement recorded	1. Percentage of valid HoNOS compliant measured cases using matched pairs[a]
	2. Percentage of self-rating measures completed (BASIS for adults and aged, SDQ for children and young people 4–17 years)	2. Percentage of mental health consumers who have a nominated person recorded	2. Percentage self-rating measures completed – BASIS for adults and aged, SDQ for children and young people 4–17 years measured using matched pairs[a]
	3. Rate of Your Experience of Service (YES) completion		
Consumer and carer experience of care	4. Percentage of consumers who rated their overall experience of care with a service as positive	1. Percentage of consumers reporting the effect the service had on their ability to manage their day-to-day life was very good or excellent	
		2. Percentage of consumers who reported they usually or always had opportunities for family and carers to be involved in their treatment or care if they wanted	3. Rate of mental health consumer and carer workers per 1,000 mental health care staff[a]
		3. Percentage of consumers reporting their individuality and values were usually or always respected	
		4. Mental health carer experience of service: overall experience score[b]	
Relevance to consumer and carer needs			4. Percentage of mental health consumers with a physical health check conducted in the preceding 12 months[c]
			5. Proportion of care as an inpatient versus community

Table 6: Effectiveness domain indicators

Sub-domain	Core	Context	Future
Consumer outcomes	1. Significant improvement in mental health consumers' clinical outcomes (HoNOS – by 4 sub-scales: behaviour, impairment, symptoms and social sub-scales)		1. Self-reported change in mental health consumers' clinical outcomes using BASIS-32, SDQ (youth)[a]
	2. Proportion of measures completed Life Skills Profile-16		2. Proportion of measures completed LSP-16 using matched pairs[a]
Community tenure	3. Percentage of separations readmitted within 7 and 28 days	1. Percentage of PARC separations followed by an acute admission (within 7 days of separation)	3. High exception indicator: mental health separations exceeding expected length of stay[a]
	4. Percentage of closed community cases re-referred within six months	2. Percentage of admissions where the consumer had 3 or more admitted episodes over the preceding 12 months	4. Proportion of measures completed (Phase of care)[b]
Carer outcomes		3. Proportion of carers reporting that they were usually or always involved in planning for the ongoing care, treatment and recovery of their family member, partner or friend[b]	
Compliance with standards			

Table 7: Continuity of care domain indicators

Sub-domain	Core	Context	Future
Continuity between providers		1. Percentage of closed community cases with a change in case manager	
			2. Documented discharge plan on hospital separation (% of patients discharged from acute inpatient facilities (excluding those discharged against medical advice) who have a documented discharge plan within 24 hours of discharge[c]
Continuity over time		2. Percentage of consumers reporting that a care plan was usually or always developed with them that considered all their needs	3. Percentage of registered consumers lost to follow-up by community mental health services at 6 months and 1 year[a]
Cross-setting	1. Percentage of separations from an acute inpatient unit where the consumer received post-discharge follow-up within 7 days	3. Percentage of separations from an acute inpatient unit with a face-to-face post-discharge follow-up within 7 days	4. Percentage of admissions where the consumer had more than 5 admitted episodes over the preceding 12 months involving more than one campus

Table 8: Accessibility indicators

Sub-domain	Core	Context	Future
Access for those in need	1. Mental health new client index	1. Percentage of open community cases commenced during the preceding 3 months	1. Time from referral to first service event (e.g. community mental health appointment)[c]
Local access	2. Rate of bed occupancy (excluding leave) – inpatient	2. Rate of operational inpatient beds per 10,000 population	2. Rate of operational inpatient beds per 10,000 population (adjusted by SEIFA)[a]
			3. Mental health service use by potential population including consideration of SEIFA[a]
			4. Travel distance to service[c]
Emergency response	3. Percentage of mental health-related emergency department presentations with a length of stay of less than 4 hours		
	4. Percentage of 'urgent' (category 'C') triage episodes with face-to-face contact received within 8 hours	3. Percentage of 'crisis' (category 'B') triage episodes with face-to-face contact received within 2 hours	

Table 9: Efficiency and sustainability indicators

Sub-domain	Core	Context	Future
Inpatient care	1. Trimmed average length of acute mental health inpatient stay ≤ 35 days (adults and young people)	1. Percentage of separations from an inpatient unit with a length of stay greater than 3 months, including leave, excluding same day stays	
	2. Trimmed average length of acute mental health inpatient stay ≤ 50 days (older persons)	2. Average cost per acute mental health admitted patient day	
Community care	3. Average treatment days per 3-month community mental health care period	3. Average treatment time (minutes/hours) per 3-month community mental health care period[a]	
Workforce planning		4. FTE staff employed by area mental health service per 100,000 population	
Training and investment	N/A	5. Percentage of staff with a positive response to People Matter question: 'This health service does a good job of training new and existing staff'[b]	
Research investment	N/A		

Reporting, monitoring and governance

Reporting

Regular reporting and monitoring is critical to evaluating performance, identifying emerging issues and ensuring accountability for mental health services. The Mental Health and Drugs Branch is responsible for the framework and will work with the Victorian Agency for Health Information and the Mental Health and Drugs Data Team to monitor implementation of the framework. The Victorian Agency for Health Information will develop and deliver the reports. Mental Health and Drugs Branch will conduct an annual or biennial review of the indicator set, informed by advice from the Progress Measures Working Group and other stakeholders, to maintain currency and relevance.

Reporting against the indicator set will occur at multiple levels and at different intervals depending on the purpose of the specific indicator. Availability of data will also influence the level and frequency of reporting. Service performance measures will usually be reported to services quarterly on a categorised basis that can be rolled up to service-level as needed. Some data, particularly consumer and carer experience data, is only available annually.

Monitoring

Within the Mental Health and Drugs Branch, the Programs and Performance Unit leads system-wide performance monitoring of clinical mental health services across all age groups and specialist and forensic mental health services. The Programs and Performance Unit works in partnership with colleagues across the department to ensure robust oversight of the system and to plan for service improvements. Programs and Performance play a key role in ensuring that mental health services are effectively monitored under the department's VHSPMF. The unit provides a link between the Mental Health and Drugs Branch and the two other branches responsible for monitoring overall health service performance – the 'Performance and Improvement – Metro Health and Ambulance Services Branch' that monitors metropolitan public health services, and the 'Performance & Improvement Rural Health Branch' that monitors regional and rural public health services and hospitals.

Governance

Mental health is one element of performance conversations that occur formally on at least a quarterly basis. This takes the form of performance meetings between executive management of health services and the department. It is anticipated that elements of the framework (for example, new indicators within the Statement of Priorities) will increase the focus on mental health in performance meetings and performance monitoring more broadly. This is consistent with the department's role as system steward under the Mental Health Act.

Program meetings between the Mental Health and Drugs Branch and health services mental health staff are the key engagement mechanism for mental health program oversight with individual health services. The twice-yearly meetings offer a dedicated and structured opportunity for the department and health services to provide strategic oversight and monitoring of mental health programs. The framework will also inform these meetings.

Consistent with the VHSPMF, if performance concerns are raised that require attention, the department, specifically through their performance teams, and mental health services will work together to evaluate the risk, and develop and implement a performance improvement plan.

The level of intervention by the department intensifies in line with the health service's identified underperformance and safety concerns. Increasing levels of consultation, support and intervention strategies are tailored, depending on the level of monitoring required. Performance concerns raised by the PAF will be captured within the VHSPMF intelligence section and risk profiles adjusted accordingly.

Such decisions depend on:

- the extent of underperformance
- the capacity or demonstrated level of remediation
- any significant issues relating to governance and culture, given their risk to achieving and supporting sustained improvement.

The department will consider evidence supporting the steps taken and progress made by the health service and determine the level of intervention needed accordingly.

This varies from case-to-case and can result in either increased intervention (for example, through an independent report indicating systemic clinical risk) or decreased intervention (for example, through verifying an effective remediation action). This is discussed in more detail in the VHSPMF.[13]

Mental Health and Drugs Branch will work collaboratively with the other two branches in monitoring overall health performance across rural and metropolitan areas to address any identified performance issues.

[13] The *Victorian health services performance monitoring framework* is available from health.vic – Performance monitoring framework <https://www2.health.vic.gov.au/hospitals-and-health-services/funding-performance-accountability/performance-monitoring>

Appendix: Measures relating to the Victorian Health Services Performance Monitoring Framework

The indicators below are contained and monitored within the VHSPMF. To reflect their importance, a subset of indicators are also iterated and highlighted in the Statement of Priorities, which has the same four performance domains as the VHSPMF:

- high-quality and safe care
- strong governance, leadership and culture
- timely access to care
- effective financial management

Statement of Priorities

Statement of Priorities are annual accountability agreements between Victorian public healthcare services and the Minister for Health. They outline the key performance expectations, targets and funding for the year as well as government service priorities. The Victorian Government commits to publish Statements of Priorities in November each year and to present data on the performance of the health system in the public domain.

Proposed new Ministerial priorities are shown in purple and with 'new'. Targets may be subject to refinement, including disaggregation by age group in some cases.

High-quality and safe care

Mental health

Performance objective	Proposed measures	Rationale	Target
Positive patient experience	**(new)** Percentage of mental health consumers reporting a positive experience of care	Consumers' experience of mental health services is a key part of determining how well a service is performing to meet the consumer's goals. The OECD supports the need for patient-reported indicators to be collected at the disease, sector, health service and whole system levels (both PREMS and PROMS). This helps to build a more person-centred view of health service performance.	80%
	(new) Rate of Your Experience of Service (YES) survey completion	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. Results from the 2017, 2018 and 2019 YES Surveys suggest a wide variation between services in completion rates.	20%

Performance objective	Proposed measures	Rationale	Target
Zero harm	**(new)** Perception of safety: Percentage of consumers reporting they 'usually' or 'always' felt safe using this service	Patient safety is the prevention of harm to patients from the care that is intended to help them. Safety is an essential part of quality care and a fundamental principle of person-centred care. Patients may be the most reliable reporters of some aspects of the healthcare process. Their perspectives should be considered when pursuing changes to improve patient safety.	90%
Best practice	**(new)** Percentage of closed community cases re-referred within six months: children and adolescents (CAMHS) adults aged persons	High levels of case re-referral within a short timeframe reflect flaws in client care and potentially point to problems in the system overall. The community case re-referral rate is the community version of the 28-day readmission to inpatient care measure. Re-referral may indicate that inpatient treatment was either incomplete or ineffective.	< 25%
Zero harm	Rate of ended seclusion episodes per 1,000 occupied bed days within: an acute inpatient unit (adult, aged, CAMHS and forensic settings) a subacute inpatient unit (forensic settings)	Restrictive interventions such as seclusion should be reduced and where possible eliminated in mental health services. Seclusion should only be used after all possible preventative practices have been tried or considered and have been found to be unsuitable. High levels of seclusion are inappropriate. They may point to flaws in the system overall and risks to the safety of consumers receiving mental health care. The use of seclusion in public sector mental health organisations is regulated in Victoria. This indicator is also monitored at the national level.	≤ 10/1,000 occupied bed days (adult and CAMHS) ≤ 5/1,000 occupied bed days (aged)
Best practice	Percentage of separations from an acute inpatient unit (adult, aged, CAMHS) with a subsequent readmission within 28 days	Specialist mental health services are aimed primarily at people with a serious mental illness or mental disorder who have high levels of disturbance and psychosocial disability due to their illness or disorder. Frequent readmissions within a short timeframe reflect flaws in inpatient treatment and/or follow-up care and potentially in the system overall. Unplanned readmission to a psychiatric facility following a recent discharge may indicate that inpatient treatment was either incomplete or ineffective. Readmission rates for mental health patients can reflect the quality of care, effectiveness of discharge planning and level of	14% adult and aged 22% CAMHS

Performance objective	Proposed measures	Rationale	Target
		support provided to patients after discharge, as well as other factors. This indicator is also monitored at the national level.	
	Percentage of separations from an acute mental health inpatient unit with a post-discharge follow-up within 7 days: CAMHS[14] adult aged	Timely post-discharge follow-up is an important part of client care. It helps maintain clinical and functional stability and minimise the need for readmission. Consumers have increased vulnerability right after discharge, including higher risk of suicide. Monitoring the proportion of discharges that are followed up within 7 days is a good measure of the timeliness of this care. This indicator reflects the effectiveness of the interface between admitted care and non-admitted care. It is also monitored at the national level.	80%

Timely access to care

Emergency care

Performance objective	Proposed measures	Rationale	Target
Reduced waiting	**(new)** Percentage of 'urgent' (category 'C') triage episodes with a face-to-face contact received within 8 hours	Timely access to services by people requiring care is a key issue. The aim of this indicator is to ensure treatment occurs within appropriate clinical benchmark times.	tbc
Equitable access	**(new)** Percentage of mental health-related emergency department presentations with a length of stay of less than 4 hours	This indicator measures the effectiveness of hospital processes and patient flow. The measure aims to encourage more timely management of emergency department mental health patients who are admitted to the hospital, referred to another hospital or discharged within 4 hours.	81%

[14] CAMHS result reported by the responsible area mental health service. Adult and aged results are reported by the discharging hospital.

Program report for integrated service management (PRISM)

The indicators below are not contained in the Statement of Priorities, they are instead contained in the *PRISM* report. PRISM is designed to provide a broad view of performance across a range of services provided to the Victorian community by health services.

High-quality and safe care

Proposed measures	Rationale
(new) Significant improvement in mental health consumer's clinical outcomes (HoNOS) – acute inpatient units and community: CAMHS adult aged	A capable service is results-oriented and has systems in place to regularly monitor consumer outcomes. Outcome measures form a critical part of any treatment plan. They provide an important platform for dialogue and collaboration between the consumer, their carer and the clinical team. They also form a vital component of planning for discharge from a mental health service.
(new) Percentage of separations from an acute mental health inpatient unit with a subsequent readmission within 7 days CAMHS adult aged	High levels of readmission within a short timeframe reflect flaws in inpatient treatment and/or follow-up care. They potentially point to problems in the system overall. Unplanned readmission to a psychiatric facility after a recent discharge may indicate that inpatient treatment was either incomplete or ineffective
(new) Percentage of admissions to an acute inpatient unit where the consumer had 3 or more admitted episodes over the preceding 12 months: CAMHS adult aged	Frequent hospitalisations may reflect challenges in getting the right care, medication and support in the community.
(new) Percentage of separations from an acute inpatient unit with a face-to-face post-discharge follow-up: CAMHS[14] adult aged	Face-to-face contact is preferred and should be encouraged.
(new) Average treatment time (hours) per 3-month community mental health care period	Treatment time is the community version of length of stay. It provides an indication of the relative volume of care provided to people seen in ambulatory care. Frequency of servicing is the main driver of differences in community care costs and may reflect differences between health service organisation practices. This indicator promotes a fuller understanding of an organisation's community care costs. It may also show degrees of accessibility to public sector community mental health services.
Percentage of 'crisis' (category 'B') triage episodes with a face-to-face contact within 2 hours	Timely access to services by people needing care is a key issue. The aim of this indicator is to ensure treatment occurs within appropriate clinical benchmark times.

Future development

The following indicators are in the pipeline of development to be incorporated in a future monitoring and reporting modality.

Strong governance, leadership and culture

Organisational culture

Performance objective	Proposed measures	Rationale	Target
Workforce safety and engagement	People Matter Survey: percentage of mental health staff with overall positive response to safety and culture questions	Safety culture means the way that patient safety is thought about, structured and implemented in an organisation. Organisational culture can greatly influence patient safety through its impact on effective communication, collaboration and engagement across a health service. Poor safety culture is often identified internationally as a feature of serious failings of care. Research shows links between staff experiences of organisational safety culture and other quality and safety outcomes, including adverse event rates and patient experience.	80%
	(new) Percentage of mental health staff who report that during the last 12 months in their current organisation they were subject to aggression or violent behaviour at work	Safety is an essential part of quality care and includes the safety of mental health staff. A safe work environment that supports workforce health and wellbeing is essential to delivering safe, high-quality care. Having a workplace that is not physically and psychologically safe can lead to poor performance and affects the ability of staff to deliver safe care. Encouraging incident reporting and conducting regular reviews of workplace violence, lost time injury rates and planned and unplanned 'Code Grey' incidents is critical to preventing and managing workplace violence. This is integral to achieving culture change.	–
	(new) People Matter Survey – percentage of staff with a positive response to the question: 'This health service does a good job of training new and existing staff'	Workforce training is essential to system sustainability and providing contemporary care.	80%

Policy and funding guidelines

The indicators below are contained within the *Policy Guide* of the *Policy and Funding Guidelines*.[15] These guidelines represent the system-wide terms and conditions (for funding, administrative and clinical policy) of funding for Victorian government-funded healthcare organisations.

Domain	Measure or indicator	Unit of measure	Adult report	CAMHS report	Older person report	Government target	Frequency	Status
Safety	Seclusion rate – all ages	Rate per 1,000 occupied bed days	Yes	Yes	Yes	–	Quarterly	Mandatory
	Seclusion duration – all ages	Hours	Yes	Yes	Yes	–	Quarterly	Quarterly
	Bodily restraint rate – all ages	Rate per 1,000 occupied bed days	Yes	Yes	Yes	–	Quarterly	Mandatory
Appropriateness	Proportion of consumers who rated their experience of care with a service in the last 3 months as very good or excellent (YES survey)	Percentage	Yes	Yes	Yes	–	Annual	Mandatory
	HoNOS compliance – all inpatient all ages	Percentage	Yes	Yes	Yes	> 85%	Quarterly	Mandatory
	HoNOS compliance – ambulatory, all ages	Percentage	Yes	Yes	Yes	> 85%	Quarterly	Mandatory
	BASIS/SDQ self-rating measures compliance	Per centage	Yes	Yes	Yes	> 85%	Quarterly	Mandatory
	Response rate to YES Survey	Percentage	Yes	Yes	Yes	–	Annual	Mandatory

[15] The publications that constitute the *Policy and Funding Guidelines* are available from health.vic – Policy and funding guidelines <https://www2.health.vic.gov.au/about/policy-and-funding-guidelines>

Domain	Measure or indicator	Unit of measure	Adult report	CAMHS report	Older person report	Government target	Frequency	Status
Effectiveness	28-day readmission rate	Percentage	Yes	Yes		–	Quarterly	Mandatory
	Case re-referral rate (lagged)	Percentage	Yes	Yes	Yes	–	Quarterly	Mandatory
	LSP-16 compliance	Percentage	Yes	No	Yes	> 85%	Quarterly	Mandatory
Continuity of care	Post-discharge community mental health care follow-up	Percentage	Yes	Yes	Yes	–	Quarterly	Mandatory
Accessibility	Percentage of mental health patients with a length of stay in the emergency department of less than 4 hours	Percentage	Yes	Yes	Yes	–	Quarterly	Mandatory
	Pre-admission contact	Percentage	Yes	Yes	Yes	61	Quarterly	Mandatory
Efficiency and sustainability	Trimmed average length of acute mental health inpatient stay ≤ 35 days	Days	Yes	Yes	No	< 16 days	Quarterly	Mandatory
	Trimmed average length of acute mental health inpatient stay ≤ 50 days	Days	No	No	Yes	< 30 days	Quarterly	Mandatory

Glossary

Goals (or aims): These specify the results expected from the service or organisation whose performance will be measured.[16]

Indicator: A quantitative measure that is used to assess the extent to which a given objective has been achieved.[17]

Input: A resource used to create a service (for example, funding, staff, beds, capital assets, human values).[13]

Outcome: The impact of the service or intervention, or results achieved. Outcomes concern the extent to which a service or system achieves its objectives. Outcomes may be measured for the individual consumer (for example, improvements in health status) or for a whole population (for example, reduction in suicide rates). Outcomes may be short, intermediate or long term and measured from various perspectives (for example, clinician, consumer, carer views).[17]

Output: The volume and type of service provided, usually measured in quantitative terms such as number of consumers treated, contacts, bed days or episodes of care.[17]

Patient reported experience measures (PREMs): Measures used to obtain patients' views and observations on aspects of health care services they have received. This includes their views on the accessibility and physical environment of services (for example, waiting times and the cleanliness of consultation rooms and waiting spaces) and aspects of the patient–clinician interaction (such as whether the clinician explained procedures clearly or responded to questions in a way that they could understand).[18]

Patient reported outcome measures (PROMs): Questionnaires that help patients to report on outcomes relating to their health. These questionnaires focus on various aspects of health such as symptoms, daily functioning and quality of life.[19]

Performance indicators: The means by which an objective can be judged to have been achieved or not achieved. Indicators are therefore tied to goals and objectives and serve as yardsticks by which to measure the degree of success in goal achievement. Performance indicators are quantitative tools and are usually expressed as a rate, ratio or percentage.[13]

Processes: Key activities of a service or system in providing care to consumers. Because processes are concerned with the activities that go on within and between practitioners and consumers, their measurement provides a basis to monitor whether the way in which services are provided conforms with expectations. Defined technically, processes are the activities by which inputs are converted to outputs.[13]

Target (or benchmark): The desired standard of performance to be achieved on the indicator.[13]

Target population: The population group primarily targeted by a clinical mental health service.[20]

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[16] AMHOCN 2006, *National mental health benchmarking project manual, part 2* <https://www.amhocn.org/publications/national-mental-health-benchmarking-project-manual-part-2-basic-concepts-guide>

[17] AIHW 2019, *National Mental Health and Suicide Prevention Information Priorities, 3rd edition*, unpublished

[18] AIHW 2018, *Australia's health 2018*, Australian Government, Canberra

[19] ACSQHC 2019, About PROMs <https://www.safetyandquality.gov.au/our-work/indicators-measurement-and-reporting/patient-reported-outcomes/about-proms>

[20] National Mental Health Performance Subcommittee 2013, *Key performance indicators for Australian public mental health services, third edition*, Commonwealth of Australia, Canberra