

# Agency performance

# Financial

The total cost of providing health services to WA in 2015–16 was \$8.4 billion. Results for 2015–16 against agreed financial targets (based on Budget statements) are presented in Table 4.

Full details of the Department of Health's financial performance during 2015–16 are provided in the Financial statements.

**Table 4: Actual results versus budget targets for WA Health**

| Financial  | 2015–16 Target \$'000 | 2015–16 Actual \$'000 | Variation \$ +/- |
|--|-----------------------|-----------------------|------------------|
| Total cost of service  | 8,149,524             | 8,420,946             | 271,422          |
| Net cost of service  | 4,799,867             | 4,933,295             | 133,428          |
| Total equity   | 10,119,720            | 9,576,838             | -542,882         |
| Net increase/decrease in cash held                                     | (107,948)             | (325,300)             | (217,352)        |
| Approved full time equivalent staff level (salary associated with FTE) | 4,686,045             | 4,703,263             | 17,218           |

**Note:** 2015–16 targets are specified in the 2015–16 Budget statements.

**Data sources:** Budget Strategy Branch, Health Corporate Network.

# Summary of key performance indicators

Key performance indicators assist the Metropolitan Health Service to assess and monitor the extent to which Government outcomes are being achieved. Effectiveness indicators provide information that aid with assessment of the extent to which outcomes have been achieved through the resourcing and delivery of services to the community. Efficiency indicators monitor the relationship between the service delivered and the resources used to produce the service. Key performance indicators also provide a means to communicate to the community how the Metropolitan Health Service is performing.

A summary of the Metropolitan Health Service key performance indicators and variation from the 2015–16 targets is given in Table 5.

**Note:** Table 5 should be read in conjunction with detailed information on each key performance indicator found in the Disclosure and Compliance section of this report.

**Table 5: Actual Results versus KPI Targets**

| Key performance indicators   | 2015–16 Target | 2015–16 Actual | Variation |
|--|----------------|----------------|-----------|
| <b>Outcome 1: Restoration of patients' health, provision of maternity care to women and newborns, and support for patients and families during terminal illness.</b> |                |                |           |
| <b>Key effectiveness indicators:</b>   |                |                |           |
| Percentage of patients discharged to home after admitted hospital treatment  | ≥98.1%         | 98.1%          | 0.0%      |
| Survival rates for Stroke, by age group:   |                |                |           |
| 0–49 years   | ≥95.3%         | 94.8%          | -0.5%     |
| 50–59 years  | ≥94.1%         | 92.8%          | -1.3%     |
| 60–69 years  | ≥93.3%         | 92.9%          | -0.4%     |
| 70–79 years  | ≥90.8%         | 89.8%          | -1.0%     |
| 80+ years  | ≥83.3%         | 83.3%          | 0.0%      |

| Key performance indicators  | 2015–16 Target | 2015–16 Actual | Variation |
|---|----------------|----------------|-----------|
| Survival rates for Acute Myocardial Infarction (AMI), by age group:   |                |                |           |
| 0–49 years  | ≥99.5%         | 99.2%          | -0.3%     |
| 50–59 years   | ≥99.2%         | 98.7%          | -0.5%     |
| 60–69 years   | ≥98.4%         | 97.9%          | -0.5%     |
| 70–79 years   | ≥96.7%         | 96.3%          | -0.4%     |
| 80+ years   | ≥92.7%         | 92.3%          | -0.4%     |
| Survival rates for Fractured Neck of Femur (FNOF), by age group:  |                |                |           |
| 70–79 years   | ≥98.8%         | 99.0%          | 0.2%      |
| 80+ years   | ≥96.4%         | 96.1%          | -0.3%     |
| Percentage of unplanned readmissions within 28 days for selected surgical procedures:                       |                |                |           |
| Knee replacement  | N/A            | 2.2%           | N/A       |
| Hip replacement   | N/A            | 2.1%           |           |
| Tonsillectomy and Adenoidectomy   | N/A            | 7.1%           |           |
| Hysterectomy  | N/A            | 4.7%           |           |
| Prostatectomy   | N/A            | 3.4%           |           |
| Cataract surgery  | N/A            | 0.1%           |           |
| Appendicectomy  | N/A            | 3.9%           |           |
| Rate of unplanned hospital readmissions within 28 days to the same hospital for a mental health condition   | ≤5.6%          | 7.9%           | 2.3%      |
| Percentage of live births with an Apgar score of three or less five minutes post delivery, by birth weight: |                |                |           |
| 0–1499 grams  | ≤3.7%          | 3.8%           | 0.1%      |
| 1500–1999 grams   | ≤0.3%          | 0.3%           | 0.0%      |
| 2000–2499 grams   | ≤0.2%          | 0.4%           | 0.2%      |
| 2500+ grams   | ≤0.1%          | 0.2%           | 0.1%      |

| Key performance indicators  | 2015–16 Target | 2015–16 Actual | Variation |
|---|----------------|----------------|-----------|
| <b>Key efficiency indicators:</b>   |                |                |           |
| Average cost per casemix adjusted separation for tertiary hospitals   | \$7,380        | \$8,082        | \$702     |
| Average cost per casemix adjusted separation for non-tertiary hospitals   | \$5,487        | \$7,448        | \$1,961   |
| Average cost of public admitted patient treatment episodes in private hospitals   | \$3,494        | \$3,933        | \$439     |
| Average cost per day-bed for admitted patients (small hospitals)  | \$699          | \$1,055        | \$356     |
| Average cost per home based hospital patient day  | \$328          | \$378          | \$50      |
| Average cost per client receiving contracted palliative care services   | \$3,767        | \$2,084        | -\$1,683  |
| Average cost per emergency department attendance  | \$679          | \$765          | \$86      |
| Average cost per public patient non-admitted activity   | N/A*           | \$357          | N/A       |
| Average cost per trip of Patient Assisted Travel Scheme   | \$44           | \$31           | -\$13     |
| <b>Outcome 2: Enhanced health and wellbeing of Western Australians through health promotion, illness and injury prevention and appropriate continuing care.</b> |                |                |           |
| <b>Key effectiveness indicators:</b>  |                |                |           |
| Loss of life from premature death due to identifiable causes of preventable disease (person years of life lost):  |                |                |           |
| Breast cancer   | ≤2.2           | 1.7            | -0.5      |
| Cervical cancer   | ≤0.3           | 0.3            | 0.0       |
| Rate of hospitalisations for gastroenteritis in children (0–4 years) (per 1,000)  | ≤3.7           | 4.3            | 0.6       |

| Key performance indicators   | 2015–16 Target           | 2015–16 Actual | Variation |
|--|--------------------------|----------------|-----------|
| Rate of hospitalisation for selected respiratory conditions Asthma, by age group (per 1,000):    |                          |                |           |
| 0–4 years  | ≤1.2                     | 2.7            | 1.5       |
| 5–12 years   | ≤1.8                     | 2.2            | 0.4       |
| 13–18 years  | ≤0.2                     | 0.6            | 0.4       |
| 19–34 years  | ≤0.4                     | 0.4            | 0.0       |
| 35+ years  | ≤0.6                     | 0.7            | 0.1       |
| Acute Bronchitis (0–4 years of age) (per 1,000)  | ≤0.1                     | 0.1            | 0.0       |
| Bronchiolitis (0–4 years of age) (per 1,000)   | ≤7.7                     | 9.5            | 1.8       |
| Croup (0–4 years of age) (per 1,000)   | ≤2.1                     | 2.2            | 0.1       |
| Rate of hospitalisation for falls in older persons (per 1,000)                                   | 0.5% reduction per annum | 29.4           | -0.2      |
| Rate of childhood dental screening   |                          |                |           |
| (a) Percentage of eligible school children who are enrolled in the School Dental Service program |                          |                |           |
| • Pre-primary program  | ≥69%                     | 69.0%          | 0.0%      |
| • Primary program  | ≥69%                     | 84.0%          | 15.0%     |
| • Secondary program  | ≥69%                     | 76.0%          | 7.0%      |
| (b) Percentage of school children who are free of dental caries                                  | ≥65%                     | 69.0%          | 4.0%      |
| Dental health status of target clientele   |                          |                |           |
| (a) Average number of DMFT for school children (age 12 years)                                    | 0.60–1.7                 | 0.60           | N/A       |
| (b) Average number of DMFT for adults  | N/A                      | 8.4            | N/A       |

| Key performance indicators  | 2015–16 Target | 2015–16 Actual | Variation |
|---|----------------|----------------|-----------|
| Access to dental treatment services for eligible people   |                |                |           |
| (a) People who accessed Dental Health Services  | ≥15%           | 15%            | 0%        |
| (b) People who completed dental treatment   |                |                |           |
| • Emergency   | ≤50%           | 41%            | 9%        |
| • Non-Emergency   | ≥50%           | 59%            | 9%        |
| Average waiting times for dental services   | ≤24 months     | 4 months       | 20 months |
| Percent of contacts with community-based public mental health non-admitted services within seven days prior to admission to a public mental health inpatient unit | 70%            | 56.4%          | -13.6%    |
| Percent of contacts with community-based public mental health non-admitted services within seven days post discharge from public mental health inpatient units    | 75%            | 58.9%          | -16.1%    |
| <b>Key efficiency indicators:</b>   |                |                |           |
| Average cost per capita of Population Health Units  | \$96           | \$89           | -\$7      |
| Average cost per breast screening   | \$165          | \$187          | \$22      |
| Average cost of service for school dental service   | \$133          | \$118          | -\$15     |
| Average cost of completed courses of adult dental care  | \$349          | \$395          | \$46      |
| Average cost per day-bed in specialised mental health inpatient units   | \$1,217        | \$1,716        | \$499     |
| Average cost per three-month period of care for community mental health   | \$1,704        | \$2,148        | \$444     |

# Performance towards the National Partnership Agreement targets

WA signed the National Partnership Agreement on Improving Public Hospital Services in 2011. The objective of the agreement was to drive major improvements in public hospital service delivery and better health outcomes for Australians. It included the National Elective Surgery Target (NEST) and the National Emergency Access Target (NEAT).

Following the expiry of the National Partnership Agreement during 2015, WA Health introduced a new WA Elective Services Target (WEST) and WA Emergency Access Target (WEAT). As these were not implemented until 2016, for the purposes of this report, NEST and NEAT are reported up to the end of the 2015 calendar year.

## National Elective Surgery Target (NEST)

Elective surgery is a term used to describe surgery that is medically necessary, but can be delayed for at least 24 hours. The NEST commenced on 1 January 2012 and focused on two areas. Under NEST Part 1 of the national agreement, WA had a target to increase the percentage of elective surgery cases admitted within the clinically recommended time for all urgency categories. Under NEST Part 2 of the national agreement, WA had a target to reduce the average overdue days waited beyond the clinically desirable times for each urgency category.

The urgency categories and clinically desirable times were:

- category 1 – admitted within 30 days
- category 2 – admitted within 90 days
- category 3 – admitted within 365 days.

## Part 1: Treating patients within the clinically recommended time

WA Health was required to progressively increase the number of elective surgeries performed within the clinically recommended time by 2016.

From 2010 to 2015, the number of patients treated within clinically recommended times improved from the baseline by approximately 6.2 per cent for category 1, by approximately 11.5 per cent for category 2 and approximately 0.8 per cent for category 3 (see Table 6).

From 1 January to 31 December 2015, 92.8 per cent of urgency category 1 patients were admitted within 30 days, lower than the set target of 100 per cent. For urgency category 2 patients, 88.3 per cent were admitted within the recommended 90 days, which is below the set target of 100 per cent and 98.0 per cent of urgency category 3 patients were admitted within the recommended 365 days, which is marginally below the set target of 100 per cent.

**Table 6: Percentage of WA patients admitted within the clinically recommended time, by category, 2010–2015**

|            |             | 2010<br>Baseline<br>(%) | 2011<br>(%) | 2012<br>(%) | 2013<br>(%) | 2014<br>(%) | 2015<br>(%)  |
|------------|-------------|-------------------------|-------------|-------------|-------------|-------------|--------------|
| Category 1 | Performance | 87.4                    | 86.6        | 86.3        | 95.9        | 98.1        | <b>92.8</b>  |
|            | Target      | -                       | 87.4        | 94.0        | 100.0       | 100.0       | <b>100.0</b> |
| Category 2 | Performance | 79.2                    | 83.5        | 82.0        | 89.4        | 91.6        | <b>88.3</b>  |
|            | Target      | -                       | 79.2        | 84.0        | 88.0        | 95.0        | <b>100.0</b> |
| Category 3 | Performance | 97.2                    | 96.3        | 96.4        | 97.7        | 98.5        | <b>98.0</b>  |
|            | Target      | -                       | 97.2        | 98.0        | 98.0        | 98.5        | <b>100.0</b> |

**Data sources:** Wait List Data Collection, Inpatient Data Collections.

## Part 2: Reducing the average waiting time for overdue patients

Performance against the elective surgery targets from 1 January to 31 December 2015 shows that WA did not meet the 2015 targets for each urgency category (see Table 7); however, the average overdue waiting time for Category 1 and 2 patients had improved significantly compared to the 2010 baseline.

**Table 7: Average overdue wait time (in days) for WA patients who have waited beyond clinically recommended times, by category, 2010–2015**

|            |             | 31 Dec 2010 (baseline) | 31 Dec 2011 | 31 Dec 2012 | 31 Dec 2013 | 31 Dec 2014 | 31 Dec 2015 |
|------------|-------------|------------------------|-------------|-------------|-------------|-------------|-------------|
| Category 1 | Performance | 27.0                   | 27.3        | 12.1        | 12.9        | 36.3        | <b>14.7</b> |
|            | Target      | -                      | 27          | 0           | 0           | 0           | <b>0</b>    |
| Category 2 | Performance | 90.0                   | 77.4        | 54.2        | 55.0        | 48.7        | <b>71.3</b> |
|            | Target      | -                      | 90          | 68          | 45          | 23          | <b>0</b>    |
| Category 3 | Performance | 87.0                   | 69.3        | 66.9        | 75.8        | 62.9        | <b>89.4</b> |
|            | Target      | -                      | 87          | 65          | 44          | 22          | <b>0</b>    |

**Notes:** As part of the National agreement, this measure is assessed at 31 December as a point in time measure.

**Data sources:** Wait List Data Collection, Inpatient Data Collections

## National Emergency Access Target (NEAT)

The National Emergency Access Target (NEAT) aim was to drive improvements in access to emergency care for patients.

Between 2012 and 2015 all States and Territories have been striving to meet progressive annual interim targets with the aim of ensuring that where clinically appropriate patients presenting to a public hospital emergency department would be admitted, transferred or discharged within four hours. By 2015, WA Health's aim was to ensure that 90 per cent of patients presenting to a public hospital emergency department would be admitted, transferred or discharged within four hours, where clinically appropriate.

NEAT performance is calculated as an average of all participating hospitals over the calendar year. In the Metropolitan Health Service, the participating hospitals included all tertiary hospitals (Fiona Stanley Hospital, Fremantle Hospital, King Edward Memorial Hospital, Princess Margaret Hospital, Royal Perth Hospital and Sir Charles Gairdner Hospital) as well as general hospitals (Armadale Health Service, Rockingham General Hospital, St John of God Midland Hospital, Swan District Hospital (closed November 2015), Joondalup Health Campus and Peel Health Campus).

Results for Metropolitan Health Service compared to the State result and National targets are presented in Table 8. In 2015, 76.0 per cent of patients presenting to a Metropolitan Health Service emergency department were admitted, transferred or discharged within four hours. This is below the 2015 State average of 80.3 per cent and the National target of 90.0 per cent.

**Table 8: Percentage of emergency department presentations at Metropolitan Health Service hospitals with a length of stay of 4 hours or less, 2014–2015**

| Year        | MHS (%)     | State (%)   | Target (%)      |
|-------------|-------------|-------------|-----------------|
| 2011        | 76.9        | 79.3        | 71.3 (baseline) |
| 2012        | 75.7        | 78.3        | 76.0            |
| 2013        | 75.1        | 77.6        | 81.0            |
| 2014        | 77.8        | 79.7        | 85.0            |
| <b>2015</b> | <b>76.0</b> | <b>80.3</b> | <b>90.0</b>     |

**Data source:** Emergency Department Data Collection.

# Improvements towards emergency department access

Emergency departments are specialist multidisciplinary units with expertise in managing acutely unwell patients for their first few hours in hospital. With the increasing demand on emergency departments and health services, it is imperative that health service provision is continually monitored to ensure the effective and efficient delivery of safe high-quality care.

## Percentage of emergency department patients seen within recommended times

When patients first enter an emergency department they are assessed by specially trained nursing staff on how urgently treatment should be provided. The aim of this process, known as triage, is to ensure treatment is given in the appropriate time and should prevent adverse conditions arising from deterioration in the patient's condition.

The triage process and scores are recognised by the Australasian College for Emergency Medicine and is recommended for prioritising those who present to an emergency department. A patient is allocated a triage category between 1 (immediate) and 5 (least urgent) that indicates their treatment acuity. Treatment should commence within the recommended time of the triage category allocated (see Table 9).

**Table 9: Triage category, treatment acuity and WA performance targets**

| Triage Category | Description  | Treatment Acuity       | Target |
|-----------------|--|------------------------|--------|
| 1               | Immediate life-threatening   | Immediate (≤2 minutes) | 100%   |
| 2               | Imminently life-threatening  | ≤10 minutes            | ≥80%   |
| 3               | Potentially life-threatening or important time-critical treatment or severe pain | ≤30 minutes            | ≥75%   |
| 4               | Potentially life-serious or situational urgency or significant complexity        | ≤60 minutes            | ≥70%   |
| 5               | Less urgent  | ≤120 minutes           | ≥70%   |

By measuring this indicator, changes over time can be monitored that assist in managing the demand on emergency department services and the effectiveness of service provision. This, in turn, can enable the development of improved management strategies that ensure optimal restoration to health for patients.

In 2015–16, 91.8 per cent of all triage 5 patients were seen within the clinically recommended time, above the target of 70 per cent. (see Table 10).

In 2015–16 the Australasian College for Emergency Medicine targets for patients categorised as triage 1, 2, 3 and 4 were not met (see Table 10). While the targets have not been met, the 2015–16 results remain consistent with previous years.

**Table 10: Percentage of metropolitan emergency department patients seen within recommended times, by triage category, 2011–12 to 2015–16**

| Triage Category | 2011–12 (%) | 2012–13 (%) | 2013–14 (%) | 2014–15 (%) | 2015–16 (%) | Target |
|-----------------|-------------|-------------|-------------|-------------|-------------|--------|
| 1               | 97.3        | 99.5        | 99.6        | 99.7        | 98.8        | 100%   |
| 2               | 73.6        | 78.1        | 85.0        | 82.4        | 78.7        | ≥80%   |
| 3               | 44.1        | 42.4        | 52.4        | 49.9        | 46.9        | ≥75%   |
| 4               | 61.5        | 58.8        | 66.9        | 63.8        | 62.5        | ≥70%   |
| 5               | 92.1        | 89.7        | 93.0        | 92.2        | 91.8        | ≥70%   |

**Note:** Peel Health Campus data is not included due to data quality issues.

**Data source:** Emergency Department Data Collection.

## Percentage of admitted patients transferred to an inpatient ward within 8 hours of emergency department arrival

Timely movement of patients from the emergency department is important because it potentially reduces adverse incidents that may result from overcrowding or access block (patients waiting for eight hours or more for admission). Most patients who require a hospital bed will benefit from early transfer to the inpatient unit that can best treat their condition.

The monitoring of emergency department patients transferred to an inpatient ward within eight hours can aid in supporting further improvements in the clinical service redesign, bed management and health reform. This, in turn, can help drive improvements in the timeliness of care for patients presenting to the emergency department without any detriment to clinical care.

Over a number of years, the health services have implemented operational improvements that have resulted in an increase in the percentage of patients who were transferred to an inpatient ward within eight hours. Thus the target has been revised over a number of years to reflect these improvements.

In 2015–16, 86.8 per cent of metropolitan patients were transferred to an inpatient ward within 8 hours of arrival to an emergency department, above the target of 85 per cent (see Table 11).

**Table 11: Percentage of metropolitan admitted patients transferred to an inpatient ward within 8 hours of emergency department arrival, 2011–12 to 2015–16**

|  | 2011–12 (%) | 2012–13 (%) | 2013–14 (%) | 2014–15 (%) | 2015–16 (%) |
|--|-------------|-------------|-------------|-------------|-------------|
| <b>Percentage of patients transferred within 8 hours</b> | 86.9        | 84.5        | 86.4        | 88.0        | <b>86.8</b> |
| <b>Target</b>  | 75.0        | 80.0        | 85.0        | 85.0        | <b>85.0</b> |

**Data source:** Emergency Department Data Collection.

## Rate of emergency attendances for falls in older persons

Falls are common in older people and increase in prevalence with advancing old age. A significant proportion of falls can lead to severe injuries that impact quality of life and frequently result in attendance to an emergency department. With the growth of the ageing population, fall-related injuries threaten to significantly increase demand on the public hospital system.

Interventions and prevention programs, such as the *Falls Prevention Model of Care 2014*, can reduce the number and severity of falls in older persons, thus enhancing their overall health and wellbeing and enabling them to remain independent and productive members of their community. By measuring the rate of emergency department attendances for falls in older persons, processes that aid timely treatment within the emergency department, and effective intervention and prevention programs, can be delivered.

In 2015, the rate of persons aged 80 years and older who attended a metropolitan emergency department for falls was 98.3 per 1,000 persons (see Table 12). The rate of emergency department attendances for falls for persons aged 55 to 79 years was slightly higher than prior years.

**Table 12: Rate of metropolitan emergency attendances for falls per 1,000 by age group, 2011-2015**

| Age Group (Years) | 2011 | 2012 | 2013 | 2014 | 2015        |
|-------------------|------|------|------|------|-------------|
| <b>55–64</b>      | 14.3 | 13.8 | 14.0 | 13.9 | <b>15.3</b> |
| <b>65–79</b>      | 26.7 | 26.1 | 26.0 | 25.1 | <b>26.9</b> |
| <b>80+</b>        | 99.3 | 96.5 | 92.4 | 94.7 | <b>98.3</b> |

**Notes:** While the results for this performance indicator are based on patient's residential code, it does not mean that the patient presented to an emergency department close to where they reside.

Refer to the Key Performance Indicator section of this report is information on the 'Rate of hospitalisations for falls per 1,000 by age group, 2011 to 2015'.

**Data source:** Emergency Department Data Collection.