

Department of Health



Revised Tasmanian Health Service 2019-20 Service Plan (August 2019)

Amendments

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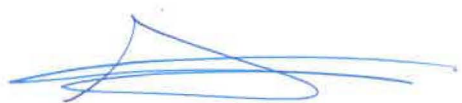
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Approval of revision to the Service Plan

Pursuant to section 9(2) of the Tasmanian Health Service Act 2018, on 30 June 2019 the Minister for Health and the Secretary, Department of Health reached agreement on the terms and conditions of the Tasmanian Health Service 2019-20 Service Plan (the Service Plan).

Pursuant to section 11(1), of the Tasmanian Health Service Act 2018, the Minister for Health and the Secretary, Department of Health (the parties) agree to amend the Service Plan on the terms set out in this document.

Signed by:



The Honourable Sarah Courtney MP
Tasmanian Minister for Health

Date signed: 10/9/19



Michael Pervan
Secretary
Department of Health

Date signed: 21 August 2019

Tasmanian Health Service 2019-20 Service Plan

The Service Plan applies from 1 July 2019 to 30 June 2020. It does not override existing laws, agreements, public sector codes, statutes, government policies or contracts.

The evaluation of THS performance against the requirements of the Service Plan will be undertaken as outlined in the Performance Framework (refer Part E of the Service Plan).

The THS Executive will ensure that structures and processes are in place to:

- comply with the requirements of the Service Plan
- fulfil its statutory obligations
- ensure good corporate governance (as outlined in the Act) and
- follow operational directives, policy and procedural manuals and technical bulletins as issued by the Department of Health (the Department) in its role as system manager.

The Service Plan consists of the following sections:

- **Part A:** Tasmanian Public Health System – Responsibilities
- **Part B:** Health Planning
- **Part C:** 2019-20 Budget Initiatives
- **Part D:** Funding Allocation and Activity Schedule
- **Part E:** Performance
- **Part F:** Key Performance Indicators

This Service Plan operates within the Performance Framework and in the context of the Department's Purchasing and Funding Guidelines and financial requirements. This Service Plan does not specify every responsibility of the THS, however, this does not diminish other applicable duties, obligations or accountabilities, or the effects of the Department's policies, plans and Ministerial Directions.

Amendments to the Service Plan

As outlined in Section 11 of the Act, the Secretary may provide to the Minister a proposed amendment to the Service Plan.

If the Minister approves a proposed amendment of the Service Plan under subsection 11(2)(a), the Service Plan is amended in accordance with the amendment, on and from the date on which notice of the amendment is given to the Secretary and the THS Executive under subsection 11(6).

The Service Plan may be amended at any time before or during the financial year.

Agreements, Standards and Requirements

Financial Management Standards

In accordance with Section 17(e) of the Act, the THS must manage its budget, as determined by the Service Plan, to ensure the efficient and economic operation and delivery of health services and use of its resources. Accordingly, it is critical that the THS has strong financial management and accountability.

The THS and relevant staff must comply with the following financial instruments:

- *Financial Management Act 2016*
- Treasurer's Instructions
- Australian Accounting Standards

To ensure compliance, the THS should:

- ensure its actions are consistent with the Minister's expectations
- establish appropriate oversight committees including a Finance and Performance Committee
- ensure all financial aspects of the THS are monitored and appropriate actions are taken when issues are identified and
- ensure there is an effective system of internal controls for all financial management system's and processes.

Provision of Health Services and Health Support Services under Contractual Arrangements

The THS may provide health services and health support services under contracts for service with third parties provided that:

- any necessary approvals required under the Act have been obtained
- the health services and health support services are provided on at least a full cost recovery basis and
- the contractual arrangement has been approved by the Secretary before the contract has been entered.

National Partnership Agreement: Mersey Community Hospital

This National Partnership Agreement (the Agreement) facilitated the transfer of the Mersey Community Hospital (MCH) to the Tasmanian Government. As of 1 July 2017, the State Government resumed ownership of the MCH and became responsible for delivering on outcomes and outputs assigned for implementation, and for reporting on the delivery of services to the Australian Government.

The Australian Government is responsible for providing a financial contribution to Tasmania of \$736.6 million to support the implementation of the Agreement, and monitoring and assessing the performance in the delivery of services to ensure that outputs are delivered and outcomes are achieved within the agreed timeframes.

MCH activity is now included in the Tasmanian total National Weighted Activity Unit (NWAU) values for the National Health Reform Agreement (NHRA) payments. However, to ensure that Tasmania does not receive double funding for the MCH (for the period 2017-18 to 2026-27 inclusive), Tasmania will not be

entitled to receive an Activity Based Funding (ABF) payment under the NHRA, or any subsequent agreement, for the agreed funding profile described in the Agreement.

National Health Reform Agreement

The Service Plan complies with the requirements of the NHRA.

http://www.federalfinancialrelations.gov.au/content/npa/health/_archive/national-agreement.pdf.

The NHRA requires the Tasmanian Government to establish service agreements (or a Service Plan in the Tasmanian context) with each local hospital network and to implement a performance and accountability framework including processes for remediation of poor performance.

Under clause 4 of the NHRA, the THS is required to provide health and emergency services through the public hospital system, based on the following Medicare principles:

- eligible persons are to be given the choice to receive, free of charge as public patients, health and emergency services of a kind or kinds that are currently, or were historically, provided by hospitals
- access to such services by public patients free of charge is to be on the basis of clinical need and within a clinically appropriate period and
- arrangements are to be in place to ensure equitable access to such services for all eligible persons, regardless of their geographic location.

The universality principle (4b) ensures that the following must not be a determinant of an eligible person's priority or eligibility for receiving hospital services:

- whether or not an eligible person has health insurance
- an eligible person's financial status or place of residence and
- whether or not an eligible person intends to elect, or elects, to be treated as a public or private patient.

ABF is a key component of the NHRA signed in 2011. ABF applies a funding methodology based on the level of hospital activity and the complexity of cases (case-mix) using the National Efficient Price (NEP) to calculate the cost of these. Since 2014 most public hospitals have been funded using ABF although some smaller or regional hospitals have continued to receive block funding.

In the 2014–15 Federal Budget it was announced that the ABF methodology would be abolished from 2017 onwards and replaced with a formula using population growth and movements in the Consumer Price Index (CPI). The Agreement has effectively reversed this earlier budget decision. The Australian Government agreed to meet 45 per cent of the efficient growth in block funding for smaller or regional hospitals. This became the basis for an addendum to the NHRA negotiated with the states and territories before commencement on 1 July 2017. The Addendum to the NHRA committed all parties to begin to implement a range of reforms designed to improve health outcomes for patients and decrease potentially avoidable demand for public hospital services.

To deliver better health outcomes, improve patient safety and support greater efficiency in the health system the Addendum also incorporated Safety and Quality into hospital pricing and funding models.

Safety and Quality

The Australian Commission on Safety and Quality in Health Care

The National Safety and Quality Health Service (NSQHS) standards, and associated accreditation scheme, were developed by The Australian Commission on Safety and Quality in Health Care (ACSQHC) to drive the continuous improvement of the quality and safety of health care in Australia. The NSQHS standards became mandatory for all hospitals, day procedure centres and public dentists from 1 January 2013.

The THS is required to be accredited to the relevant NSQHS Standards by an approved accrediting agency. This includes:

- acute, sub-acute services, mental health services, and statewide services such as forensic health, alcohol and drug related services and oral health services
- community sector organisations funded by the THS to provide sub-acute public hospital beds such as palliative care beds; in-patient care type facilities; or any day procedure type services
- services operated by the THS are required under the Safety, Quality and Strategic Performance expectations of the Ministerial Charter to achieve accreditation to safeguard high standards of care and continuous quality improvement.

Aged Care Accreditation

The Australian Government's quality standards and accreditation framework provides assurance to recipients of aged care services. Relevant law requires Australian Government-funded aged care providers to meet quality standards. From 1 June 2019 the new Aged Care Quality Standards come into effect in response to the Aged Care Legislation Amendment Principle (Single Quality Framework).

The Accreditation Standards apply to residential aged care providers and short-term restorative care provided in a residential setting.

The Home Care Standards apply to care provided in a person's own home or the community, including short-term restorative care delivered in a home setting, and care delivered under the Commonwealth Home Support Programme (CHSP).

Professional Training Accreditation

Accreditation requires an onsite review by the appropriate professional bodies College and other accrediting agencies to assess a hospital's ability to provide training and supervision of the required standard, and its degree of compliance with the Colleges professional documents.

The THS is expected to notify the Secretary of upcoming accreditation assessments (of all types) and inform the Secretary if there is a risk that the services they provide may be assessed as not meeting the accreditation standards to which they ascribe.

Sentinel Events and Hospital Acquired Complications

The addendum to the NHRA includes a commitment for the Australian Government and state and territory governments to implement a number of reforms designed to improve patient safety and support greater efficiency in the health system, by reducing sentinel events, hospital acquired complications (HAC), and avoidable hospital readmissions. This will deliver better health outcomes, improve patient safety and support greater efficiency in the health system.

The 2019-20 Tasmanian ABF Model applies the national safety and quality pricing adjustments for HAC and zero funding of sentinel events.

More details regarding HAC and sentinel events are provided in *Appendix I*.

Data Compliance and Provision

Since implementation of the NHRA and ABF, the importance of complete, accurate, timely and transparent health and hospital casemix data has become more important than ever in terms of the level of hospital funding, decision making for planning and resource allocation.

For 2019-20 there are six ABF patient service categories which are being used nationally and have their own classification system. These are:

- Admitted acute care
- Sub-acute and non-acute care
- Non-admitted care
- Mental health care
- Emergency care and
- Teaching, training and research.

The Department submits a range of data to national and state agencies or bodies, including the Independent Hospital Pricing Authority (IHPA), National Health Funding Body (NHFB), the Australian Institute of Health and Welfare (AIHW), the Department of Veterans Affairs (DVA), National Joint Replacement Register, and the Australian Bureau of Statistics.

Data reporting to national bodies and performance reporting against the Key Performance Indicators (KPIs) in the Service Plan will require the Department to regularly import data from hospital systems. The THS is to ensure that such data is recorded in accordance with the requirements of each data collection, ensuring data quality and timeliness. The references/standards for each element are as follows:

- Coding and Classification Standards:
 - ICD-10-AM (International Statistical Classification of Diseases and Related Health Problems, Eleventh Edition, Australian Modification)
 - ACHI Australian Classification of Health Interventions
 - Australian Coding Standards
 - AN-SNAP, URG and Tier 2 classification business rules
 - Tasmanian directions:
 - Tasmanian Casemix Technical Bulletins
 - Tasmanian ABF Policy Instruction
- Costing: Australian Hospital Patient Costing Standards
- Counting: data definitions outlined in Tasmanian:
 - Admission and Transfer Discharge Policy Manual
 - Hospital Admitted Care Types Guidelines
 - Health Data Dictionary

More detail can be found at:

http://www.dhhs.tas.gov.au/intranet/system/activity_based_funding_abf/activity_based_funding_abf_resources2

Audit of THS Emergency Departments

In April 2019, the Department received the Report of the Auditor-General No 11 of 2018-19 – Performance of Tasmania's four major hospitals in the delivery of Emergency Department services.

The Report is comprehensive and recommends that the THS and the Department:

- Take urgent action to strengthen whole of system leadership and coordination of initiatives designed to improve patient flow
- Urgently review the root causes of the growth in ED adverse events and implement targeted initiatives to mitigate the impacts and reduce the future incidence
- Urgently implement a culture improvement program and initiatives with clearly defined goals, accountabilities and timeframes
- Develop an effective sector-wide consultation and engagement strategy to support sustained improvements in patient flow
- Expedite the development and implementation of proactive strategies that effectively leverage the insights of the 2017 Clinical Utilisation Study to both reduce and minimise the incidence of avoidable admissions and non-qualified continuing days of stay for admitted patients
- Strengthen support to, and the accountability of, health system leadership teams for improving their performance in sustainably reducing the rate of avoidable admissions and non-qualified continuing days of stay for admitted patients
- Review and strengthen the change management and project management capability and skills of THS and hospitals to ensure future reform initiatives are adequately supported to deliver sustained behaviour change and impact; and to ensure that future reform initiatives are underpinned by effective implementation and delivery planning processes that are regularly monitored
- Review and, where relevant, action outstanding recommendations from the Patients First, Staib Sullivan and Monaghan reviews;
 - Expedite development of the revised THS Performance Framework
 - Strengthen performance monitoring and reporting processes.

An implementation plan outlining specific actions relevant to each of the above recommendations will be finalised no later than 19 July 2019, enabling the implementation plan to be informed by the outcomes of the Access Solutions meeting (conducted on 19 June 2019). The implementation plan will be monitored through the Service Plan process and the revised THS Performance Framework.

Part A: Tasmanian Public Health System Responsibilities

Tasmania's health system is comprised of a wide network of public, private and not-for-profit services that collectively seek to deliver positive health outcomes for all Tasmanians. The health system covers the full range of services, from population and allied health services, general practitioners, allied health and community services, and tertiary and community hospitals.

A significant part of Tasmania's health system (including services provided under the Service Plan) is delivered under the Act. For the purposes of the Service Plan, the high level responsibilities of the Minister, the Department, the THS Executive and the THS are summarised below.

Minister for Health

The Minister for Health is responsible for the administration of the Act. Ministerial guidance and direction is provided through:

- the Ministerial Charter - which sets out the broad policy expectations for the THS and is issued by the Minister. The THS and Secretary must comply with the Ministerial Charter
- the Service Plan - the Minister approves the Service Plan that is to apply to the THS each financial year.

The Secretary, Department of Health

The Secretary is responsible to the Minister for the performance of the THS and THS Executive, including ensuring that the THS Executive is performing and exercising the functions and powers of the THS.

In line with this responsibility, the Secretary is assigned a number of functions and powers to guide, monitor and manage the THS in undertaking its functions and powers, including:

- the ability to give direction to the THS in relation to the performance of its functions, and the exercise of its powers. This includes issuing policy or directing the THS to undertake actions to improve performance, including actions under the Performance Framework and
- responsibility for developing the Service Plan, including KPI, service volumes and performance standards. The Service Plan is the key accountability document and is intrinsically linked to the performance of the THS in undertaking its functions and powers.

Tasmanian Health Service Executive

The role of the THS Executive is to administer and manage the THS. This includes:

- performing and exercising the functions and powers of the THS and
- ensuring that the THS delivers the services set out in the Service Plan including the agreed volume and performance standards in accordance with the budget set out in the Service Plan.

The Tasmanian Health Service

The THS, through its Executive, is accountable to the Minister via the Secretary for performing its functions and exercising its powers in a satisfactory manner. Through its Executive, the output of the THS must be in accordance with the requirements of the Service Plan.

The functions of the THS are to:

- ensure that the broad policy expectations of the Minister, as specified in the Ministerial Charter, are achieved
- provide the health services and health support services required under the Service Plan, and to provide those services to the specified quality standards and within the specified funding allocation
- conduct and manage public hospitals, health institutions, health services, and health support services, that are under the THS's control
- ensure quality and effective provision of health services and health support services that are purchased by the THS
- manage the funding allocation, as determined by the Service Plan, and its other funds, so as to ensure:
 - the efficient and economic operation of public hospitals, health facilities, health services, and health support services, that are under the THS's control
 - the efficient and economic delivery of health services, and health support services, that are purchased by the THS and
 - the efficient and economic use of its resources
- consult and collaborate, as appropriate, with other providers in the planning and delivery of health services and health support services
- provide training and education relevant to the provision of health services and health support services
- undertake research and development relevant to the provision of health services and health support services
- assist patients, and their carers, to travel to and from, and be accommodated close to where the patient is to receive health services
- collect and provide health data, for the purposes of research, quality improvement, accreditation, reporting and for any other purposes including for quality governance and
- collect and provide health data to enable the statewide planning and coordination of the provision of relevant services.

Part B: Health Planning

The Statement of Purchaser Intent (SoPI) 2019-20 has a number of functions:

- It is a synthesis of government priorities and a response to health trends across the State
- It signals the Department's intentions over the coming four years to assist with forward planning
- It informs the Service Plan articulating purchasing intentions resulting from government priorities and Budget commitments
- It articulates purchasing intent in specific and measurable terms enabling the Department as purchaser to clearly ascertain and account for what is being purchased

Purchasing intentions, outlined in the SoPI, take into account the following factors:

- priority conditions as determined by the chronic conditions that contribute to 80 per cent of the disease burden in Tasmania
- complexity through the development of the healthcare complexity model which considers multimorbidity, vulnerability to poor outcomes, treatment burden and ability to engage with care
- roles and responsibilities as provided for in the Tasmanian Role Delineation Framework and the Capability Framework which is currently under development and will consider roles and responsibilities of sectors within the broader health system
- funding available for the purchase of service activity consistent with government priorities and Budget commitments

The SoPI is available at:

https://www.dhhs.tas.gov.au/about_the_department/health_planning/statement_of_purchaser_intent

Part C: 2019-20 Budget Initiatives

New Initiatives

Health Demand

Additional funding of \$180 million has been allocated in the 2019-20 Budget and over the Forward Estimates period to meet operational costs associated with health demand pressures across the THS. \$45 million will be provided in the 2019-20 Budget including \$5 million for the Royal Hobart Hospital (RHH) ED.

Women's Health Package

The August 2019 revision updates the THS 2019-20 Service Plan to adjust the Women's Health Initiative target to provide 458 additional procedures that will specifically target women who have waited the longest on the elective surgery waiting list for their procedures. The State Government has provided \$2 million for the Women's Health Initiative.

27 Mental Health Beds in Southern Tasmania

The 2018-19 Budget provided funding to provide 25 new mental health beds in the South, for safe, supportive 'step down' care post hospitalisation; 'step up' care to avoid hospitalisation for those whose condition has escalated; and community mental health services. These beds will help take pressure off the RHH.

Funding of \$11.8 million was allocated in 2018-19 for mental health infrastructure (\$9.2 million for the Peacock Centre and \$2.6 million for Mistral Place), and \$29.9 million was provided over six years for the operation of the new beds (\$15.7 million for the Peacock Centre and \$14.2 million for Mistral Place).

In October 2018, the government announced an additional \$8.9 million in new funding to build a brand-new mental health facility on a greenfield site at St John's Park, delivering more capacity for the mental health system and extra mental health beds. The existing capital funding of \$2.6 million for Mistral Place was redirected to this project, bringing the total build budget to \$11.5 million.

This increased the commitment to deliver 25 extra mental health beds to 27 extra beds.

While the St John's Park facility is under construction, an equivalent Mental Health - Hospital in the Home Service will be established (with the \$14.2 million for Mistral Place redirected to this project), which allows patients to receive hospital level care whilst being accommodated in their own home, thereby reducing pressure on the ED. The government provided an additional \$1.7 million over two years in the 2019-20 Budget towards this service.

Mental Health Service Hospital Avoidance Program

In response to the Mental Health Integration Taskforce Report and the Emergency Department Access Solutions Meeting, a Mental Health Service Hospital Avoidance Program (MHS-HAP) will be established in 2019-20. The MHS-HAP aims to prevent, where possible, and reduce the duration of Emergency Department presentations and subsequent admissions. The core function of the MHS-HAP is to divert people from admissions to the RHH Department of Psychiatry, and Mistral Place, and to reduce bed block for complex presentations that do not require an inpatient admission. The MHS-HAP also aims to reduce the average length of stay and readmissions of complex consumers. The MHS-HAP aligns with broader

State and national reforms, including the Rethink Plan and the Fifth National Mental Health and Suicide Prevention Plan.

The August 2019 revision provides \$2.005 million in the Service Plan to the THS for the following:

- Integration Implementation Team
- Recruitment Support
- Expert Clinical Technical Advice, and
- Expansion of Community Clinical Program - New Hospital Avoidance Services.

Specific 2019-20 funding details for this commitment are available in the funding schedule under the THS Operational Grants.

Additional Elective Procedures and Surgery - Australian Government funded

The Australian Government under the *Project Agreement for the Community Health and Hospital program Tasmania 2018-19 Initiatives* is providing \$5 million to provide additional elective procedures and surgery operations to reduce the number of Tasmanians waiting on waiting list and the time they have waited.

Refer Appendix 4 for further details and funding amounts.

Existing Election Commitments and Other Major Initiatives

180 more Nursing Graduates across Tasmania

Building on the success of the 2014 election commitment, where transition to practice placements have increased each year, this initiative will fund an additional 30 nursing positions each year, which will see an additional 180 nursing positions offered over six years (2018-19 to 2023-24). \$2.8 million will be provided for this initiative in 2019-20.

Community Rapid Response

Commencing in 2018-19, funding of \$6.9 million was provided over six years to extend the Community Rapid Response Service pilot program in the North into a permanent part of the health system. This program supports people who need short-term intermediate care that can be safely delivered in the community or in the home.

Funding was also provided to roll out a three-year pilot program to the Greater Hobart Area (\$5.6 million) and the North West Coast (\$5.6 million). Evaluation of the new pilot programs will occur after two years.

In total \$5.5 million is provided in 2019-20 for this initiative.

Palliative Care

Palliative Care initiatives provided funding of \$132 000 to Palliative Care Tasmania and \$800 000 for Palliative Care Clinical Nurse Educators over two years from 2018-19. This will enable the important work of Palliative Care Tasmania in continuing to assist families to provide a caring and supportive environment, deliver End of Life Care projects focused on staff training and development of care support models. The 2019-20 Budget will include \$400 000.

Eight Bed Acute Medical Unit at the North West Regional Hospital

Commencing in 2018-19, funding of \$28.3 million was provided to open eight new acute medical beds at the North West Regional Hospital, including four ED stay beds and four surgical beds for elective surgery patients who need to stay overnight. \$4.9 million will be provided in 2019-20.

Eight Beds on Ward 4K at the Launceston General Hospital

The 2019-20 Budget provides funding for \$19.1 million over four years to fully staff and open eight new beds on ward 4K at the Launceston General Hospital, on completion of the redevelopment. \$3.6 million will be provided in 2019-20.

Part D: Funding Allocation and Activity Schedule – Purchased Volumes and Grants

2019-20 Activity and Funding Schedule

Table 1.1			
Tasmanian Health Service	Measure	Activity	Funding (\$'000)
Activity Funding			
Admitted			
Acute (Excluding Elective Surgery)	NWAU	85 302	437 941
Acute Elective Surgery	NWAU	20 694	106 243
Acute Elective Surgery - Women's Health	NWAU	534	2 742
Acute - Scopes	NWAU	3 188	16 368
Acute Mental Health	NWAU	6 398	32 847
Acute Mental Health - Hospital in the Home (South)	NWAU	646	3 316
Sub-Acute and Non-Acute	NWAU	6 516	33 453
John L Grove	NWAU	669	3 435
Non-admitted			
Outpatients	NWAU	18 862	96 838
Emergency Department	NWAU	20 503	105 262
Total Activity Funding		163 312	838 445
Block Grants for Activity Based Funded Hospitals			
Blood ¹	Block Funded		7 310
Hospital Boarders	Block Funded		95
Home and Community Care (HACC)	Block Funded		203
Home Ventilation - ABF Block payment model	Block Funded		2 637
Non-ABF Activity ¹	Block Funded		89 536
Organ Procurement	Block Funded		273
Non Admitted - Community Rapid Response ²	Block Funded		2 396
Patient Travel Assistance Scheme (PTAS)	Block Funded		8 561
Supplementation			
Sub & Non-Acute	Block Funded		3 597
John L Grove	Block Funded		1 564

Table 1.1 (continued) Tasmanian Health Service	Measure	Activity	Funding (\$'000)
Emergency Department (inclusive of RHH ED Pressures - \$5M for Staff)	Block Funded		18 035
Outpatients ¹	Block Funded		10 037
Transition Care Program	Block Funded		3 467
Teaching, Training and Research (TT&R)	Block Funded		45 101
Total Block grants for Activity Based Funded Hospitals			192 812
THS Operational Grants			
Mersey Community Hospital Funding ²	Grant		28 823
Primary Health ¹	Grant		42 638
Primary Health – National Efficient Cost Hospitals	Grant		47 951
Stand Alone Mental Health Facilities	Grant		21 417
Child and Adolescent Mental Health Service	Grant		10 726
Mental Health Services	Grant		55 490
Mental Health Services – New Hospital Avoidance Program (HAS)			
Integration Implementation Team	Grant		450
Expert Clinical Technical Advice	Grant		325
Expansion of Community Clinical Program – New HAS	Grant		800
Recruitment Support	Grant		430
Alcohol and Drug Services	Grant		13 308
Alcohol and Drug Services Detoxification Unit (SMHS)	Grant		2 589
Oral Health ¹	Grant		21 601
Child Health & Parenting Service (CHaPS)	Grant		12 974
Cancer Screening ¹	Grant		6 150
Forensic Medical Services	Grant		1 553
Private Patient Scheme Subsidy ¹	Grant		26 000
Statewide Ops Command Centre	Grant		1 500
Medical Cannabis	Grant		920
Nurse Graduates Program	Grant		2 836
Palliative Care Clinical Nurse Educators	Grant		400
Interstate Charging ¹	Grant		34 124

Table 1.1 (continued)			
Tasmanian Health Service	Measure	Activity	Funding (\$'000)
Enhancing Retrieval and Referral Services	Grant		144
Capital Expenditure	Grant		7 500
Total Operational Grants			340 649
TOTAL Tasmanian Health Service			1 371 906

Notes:

1 Because of an allocation issue with Australian Government funds, these figures have been update. This change does not affect the overall THS funding envelope.

2 The balance of the \$5.53 million Election Commitment available for Non Admitted - Community Rapid Response is included in the NWAU funding for Outpatients - Non Admitted Patients.

3 \$83.7 million is provided in MCH Funding. The balance of \$54.9 million is incorporated into the THS NWAU activity target of 163 314.

2019-20 Funding Source

Table 1.2	
Funding Source	Funding (\$'000)
State Funding ¹	928 724
Australian Government Funding ²	443 182
Sub Total	1 371 906
THS Retained Revenue ³	186 222
Pharmaceutical Benefits Scheme	64 944
Sub Total	251 166
Total	1 623 072

Notes:

1 State Funding includes State ABF, State Block and \$83.7 million provided for Mersey Community Hospital.

2 Australian Government Funding includes Australian Government ABF and Block.

3 THS Retained Revenue Includes funding for National Partnership Agreements (NPAs), Commonwealth Own Purpose Expenditures (COPEs), private funding agreements and operationally driven revenue from patient fees etc (excluding PBS).

2019-20 Budget and New Commitments

Table 1.3	
Budget and New Commitments¹	Funding (\$'000)
Activity Based Funding	
Mental Health Hospital in the Home	3 317
Mental Health Services Hospital Avoidance Program	800
Demand for Health Services	45 000
Women's Health Package ²	2 000
Total Activity Based Funding	51 117
Australian Government Project Funding	
Additional Elective procedures and Surgeries ³	5 000
Total Australian Government Funding	5 000
Total Budget Commitments	56 117

Notes:

1 Budget and New Commitments includes specific funding announcements made by the government since the 2018-19 Budget and Forward Estimates was released. Election Commitment funding is contained within the Service Plan activities, but is not itemised in this table.

2 The Women's Health Package is \$2 million in State Funding. Under NHRA funding arrangements, approximately an additional \$1.6 million will be generated in Australian Government ABF revenue.

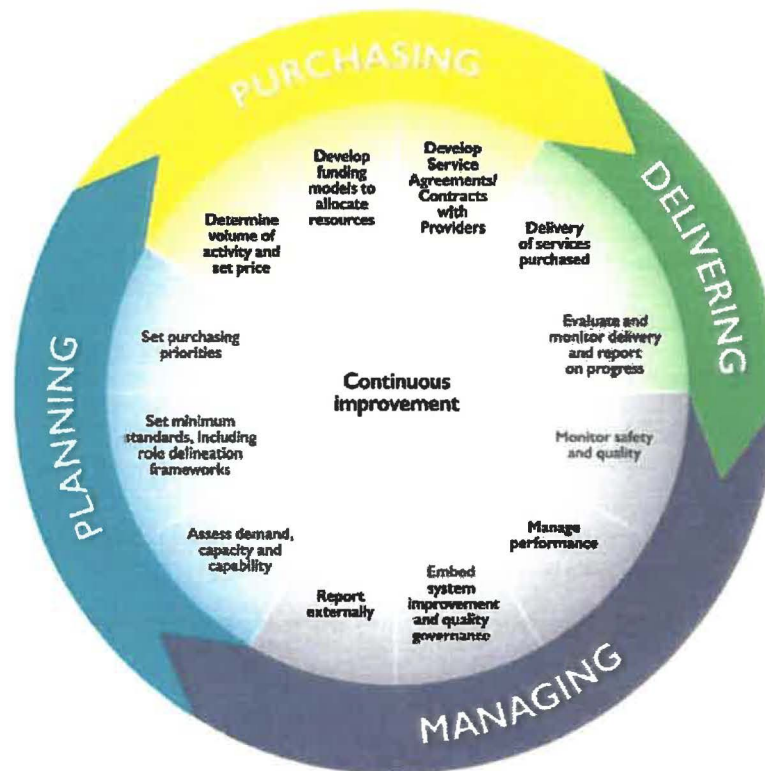
3 The Australian Government under the Project Agreement for the Community Health and Hospital program Tasmania 2018-19 Initiatives is providing \$5 million to provide additional elective procedures and surgery operations to reduce the number of Tasmanians waiting on waiting list and the time they have waited. Refer Appendix 4 for further details and funding amounts.

NWAU Estimates 2019-20

Table 1.4						
Annual NWAU Estimate 2019-20						
Tasmanian Health Service	Acute Admitted Incl. Elective Surgery	Admitted Mental Health	Sub-acute and Non-acute (admitted)	Emergency	Non-admitted	Total
RHH, LGH, NWRH and MCH	109 718	7 044	7 185	20 503	18 862	163 312

Part E: Performance

The Service Plan and Performance Framework are instruments that assist the Department in its role as system manager. There are a number of components of system management that together with these enabling instruments, inform and complement each other within an integrated management system. Information gathered about the system informs the strategies used to improve it in a cyclical process as illustrated below.



This Service Plan is accompanied by a Performance Framework that provides a high level of transparency and accountability across the THS and the Department, and will be used to drive better outcomes for Tasmanians.

Performance management and the *Tasmanian Health Service Act 2018*

The Act sets out the obligations of the Department and the THS. The Ministerial Charter provides further practical elaboration of those obligations, including the Minister's expectations of the Department and the THS.

In addition to obligations under the Act, the Performance Framework draws upon key learnings from a range of national and international inquiries, that clearly demonstrate the link between poor patient outcomes and a range of organisational failures. Accordingly, the Performance Framework will include additional information about underlying risk factors to provide a comprehensive view of performance.

Roles and responsibilities of the Secretary and the Executive

The Secretary

- The Act invests the Secretary with the function of:

- monitoring delivery of health services, and health support services, by the THS in accordance with the Service Plan
- ensuring the THS Executive performs the functions and powers of the Executive and the THS.

The Executive

- The functions of the Executive are to:
 - administer and manage the THS
 - manage, monitor, and report to the Secretary on, the administration and financial performance of the THS, as required by the Secretary
 - establish appropriate management and administrative structures for the THS
 - any other functions specified by the Secretary.

Ministerial Charter

On 1 July 2018 the Ministerial Charter came into effect. It sets out the following:

Overall expectations

- The Minister expects the Secretary and THS to work in support of continued improvements in the quality of healthcare in Tasmania
- A robust and integrated culture of research, innovation, high performance and excellence will be fostered.

Specific expectations of the Secretary

- implement the governance framework to support performance monitoring and management of the THS
- develop a consultation and engagement framework that ensures that the views, advice, input, feedback and involvement of consumers, carers, their families, the broader community, clinicians and other partners are sought and integrated into the design and evaluation of health services
- exercise the Secretary's statutory powers, including the power to give directions to the THS in relation to the performance of its functions or exercise of its powers, as necessary.

Specific expectations of the Tasmanian Health Service

- operate as a single statewide service to deliver high quality and safe health services to Tasmanians
- deliver services safely to the levels and standards specified in the Service Plan within the level of funding provided by government
- develop and maintain clear operational governance and accountability structures that ensure that there is appropriate delegated local decision-making
- develop positive organisational cultures that focus on improving the experience and outcomes for Tasmanians and which promote high standard of conduct and ethical behaviour.

The Performance Framework

Performance Objectives

The Performance Framework will provide a high level of transparency and accountability across the THS and the Department, and will continue to drive better outcomes for Tasmanians.

The Performance Framework will incorporate reporting against underlying factors identified by the Auditor General's Emergency Department Audit as being of concern, and which are being addressed by the joint THS/Department implementation of the Auditor General's recommendations.

The objectives of the Performance Framework are to monitor, report and respond to THS performance with the aim of ensuring that the following are provided:

- high quality and safe care
- timely and equitable access to care
- efficient and sustainable services
- the right volume of services
- effective financial management
- strong governance, leadership and culture.

The key components of the Performance Framework are:

- clear identification of domains of performance
- descriptions of the underlying performance risks
- clear identification of KPI
- regular reporting of performance against KPI and the underlying performance risks
- a mandated, regular, structured discussion of performance by State Health Service Joint Executive
- a clearly structured process for escalations and actions where KPI targets are not met
- a clearly structured process for monitoring and reporting of performance of escalation actions.

The Performance Framework will focus on:

- KPI for the Service Plan
- factors underpinning performance against KPI
- achievement of government priorities and funded initiatives
- other factors as deemed relevant by the Minister or the Secretary.

Part F: Key Performance Indicators

The Department and THS will continue to focus on a range of KPI to measure, monitor and assess performance and activity and to support patient safety and health service quality.

KPI have been grouped under a number of domains described in the *Australian Health Performance Framework 2017* to better organise information and thinking around the complexity of health services delivery. The domains and associated KPI are categorised and numbered below:

- **Effectiveness** – care, intervention or action achieves the desired outcome from both the clinical and patient perspective.
 - 1. Breast cancer detection
- **Safety** - mitigate risks to avoid unintended or harmful results.
 - 2. Hospital Safety – reduced risk of hospital acquired infections
 - 3. Hospital Safety – mental health seclusion
 - 4. Hospital Safety – reportable events
- **Appropriateness** – service is person centered and culturally appropriate. Consumers are treated with dignity, confidentiality and encouraged to participate in choices related to their care.
 - 5. Consumer experience
- **Continuity of care** – ability to provide uninterrupted care or service across programs, practitioners and levels over time. Coordination mechanisms work for health care providers and patients.
 - 6. Mental Health transition from inpatient to community care
 - 7. Acute Care transition from inpatient to community care
 - 8. Ambulance offload delay
- **Accessibility** – people can obtain health care at the right place and right time, taking account of different population needs and the affordability of care.
 - 9. Elective Surgery waiting list reduction – surgery within recommended time
 - 10. Elective Surgery waiting list reduction – treat in turn
 - 11. Patient flow from Emergency Departments
 - 12. Emergency Department service provision
- **Efficiency and sustainability** – the right care is delivered at a minimum cost and human and physical capital and technology are maintained and renewed, while innovation occurs to improve efficiency and respond to emerging needs.
 - 13. Service activity
 - 14. Financial control
 - 15. Admitted patient episode coding

In addition to the Service Plan KPI performance monitoring may also include KPI contained in the Department's Monitoring Suite, progress towards milestones contained in performance improvement plans and additional information provided by the THS.

2019-20 Key Performance Indicator Schedule

KPI No.	Key Performance Indicator	Target
Effectiveness		
1	Breast cancer detection	
1.1	Eligible women screened for breast cancer	36 149
1.2	Clients assessed within 28 days of a screen-detected abnormality	Not less than 90 per cent
Safety		
2	Hospital Safety – reduced risk of hospital acquired infections	
2.1	Hand Hygiene compliance	Not less than 80 per cent
2.2	Healthcare associated staphylococcus aureus (including MRSA) bacteraemia infection rate per 10 000 patient days	Not more than 2.0
3	Hospital Safety – mental health seclusion	
3.1	Mental Health inpatient seclusion rate (events per 1 000 patient days)	Less than 8
4	Hospital Safety – reportable events	
4.1	Initial Reportable Event Briefs sent to the Department's Clinical Governance Officer within 48 hours	Not less than 80 per cent
4.2	Reportable Event Briefs sent to the Department's Clinical Governance Officer within 70 calendar days	Not less than 80 per cent
Appropriateness		
5	Consumer experience	
5.1	Consumer experience – per cent of clients surveyed	TBD
5.2	Consumer experience – per cent of responses expressing satisfaction	TBD
Continuity of care		
6	Mental health transition from inpatient to community care	
6.1	Re-admissions within 28 days	Not more than 14 per cent
6.2	Post discharge community care follow up within seven days	Not less than 85 per cent
7	Acute care transition from inpatient to community care	
7.1	Discharge summaries transmitted within 48 hours of separation	Not less than 100 per cent

KPI No.	Key Performance Indicator	Target
8	Ambulance offload delay	
8.1	Ambulance offload delay - within 15 minutes (all specified facilities)	Not less than 85 per cent
8.2	Ambulance offload delay - within 30 minutes (all specified facilities)	Not less than 100 per cent
Accessibility		
9	Elective Surgery waiting list reduction – surgery within recommended time	
9.1	Elective Surgery Category 1 – admit within recommended time	100 per cent
10	Elective Surgery waiting list reduction – treat in turn	
10.1	Elective Surgery – treat in turn rates - Category 2	Not less than 60 per cent
10.2	Elective Surgery – treat in turn rates - Category 3	Not less than 60 per cent
11	Patient flow from Emergency Departments	
11.1	Emergency patients with an ED length of stay less than four hours (all specified facilities)	Not less than 90 per cent
11.2	Patients admitted through the ED with an ED length of stay less than eight hours (all specified facilities)	Not less than 90 per cent
11.3	ED patients with an ED length of stay less than 24 hours (all specified facilities)	Not less than 100 per cent
12	Emergency Department service provision	
12.1	ED presentations seen within recommended time - Triage 1	Not less than 100 per cent
12.2	ED presentations seen within recommended time – all Triage categories (all specified facilities)	Not less than 80 per cent
12.3	ED presentations who do not wait to be seen	No more than 5 per cent
Efficiency and sustainability		
13	Service activity	
13.1	NWAUs	163 312
13.2	Elective surgery admissions (baseline)	14 500
13.3	Women's Health Initiative – Elective surgery admissions	458
13.4	Australian Government – Additional elective procedures and surgery funding	Refer Appendix 4 ¹
13.5	Dental Weighted Activity Units (DWAUs)	44 153

KPI No.	Key Performance Indicator	Target
14	Financial control	
14.1	Variation from funding - full year projected	Expenditure within funding allocation
15	Admitted patient episode coding	
15.1	Admitted patient episode coding (clinical coding) including contracted care – timeliness within 42 days of separation (State-wide)	Not less than 100 per cent
15.2	Admitted patient episode coding (clinical coding) including contracted care – accuracy within 30 days of advice of error from the Department (State-wide)	Not less than 100 per cent

Notes:

1 The Australian Government under the Project Agreement for the Community Health and Hospital program Tasmania 2018-19 Initiatives is providing \$5 million to provide additional elective procedures and surgery operations to reduce the number of Tasmanians waiting on waiting list and the time they have waited. Refer Appendix 4 for further details and funding amounts.

Appendix I. Safety and Quality: Sentinel Events and Hospital Acquired Complications (HACs)

To improve patient safety and support greater efficiency in the health system, the 2017 NHRA Addendum incorporated a pricing signal for Safety and Quality. The pricing signal effects the NEP and the NEC funding models and were progressively implemented from 1 July 2017 and lead to a range of objectives for delivery.

Sentinel Events

Sentinel events are a subset of adverse patient safety events that are wholly preventable and result in serious harm to, or death of, a patient. The first version of the Australian sentinel events list was endorsed by Australian Health Ministers in 2002 and in 2017 the national set of eight sentinel event was introduced for funding in both ABF and block funded hospitals. The ASSQHS reviewed the Australian sentinel events list on behalf of the states, territories and the Australian Government and, the updated Australian sentinel events list was endorsed by Australian Health Ministers in December 2018.

The national set of ten sentinel events are:

- Surgery or other invasive procedure performed on the wrong site resulting in serious harm or death
- Surgery or other invasive procedure performed on the wrong patient resulting in serious harm or death
- Wrong surgical or other invasive procedure performed on a patient resulting in serious harm or death
- Unintended retention of a foreign object in a patient after surgery or other invasive procedure resulting in serious harm or death
- Haemolytic blood transfusion reaction resulting from ABO blood group incompatibility resulting in serious harm or death
- Suspected suicide of a patient in an acute psychiatric unit or acute psychiatric ward
- Medication error resulting in serious harm or death
- Use of physical or mechanical restraint resulting in serious harm or death
- Discharge or release of an infant or child to an unauthorised person
- Use of an incorrectly positioned oro-/nasogastric tube resulting in serious harm or death.

All admitted episodes of care in ABF Hospitals (all ABF streams) will see the NWAU set to zero for sentinel events. For ABF block funded hospitals, the funding deduction associated with a sentinel event will be calculated by multiplying the NEP by the NWAU for that episode and that amount deducted from the ABF block payment. The NHFB and the State will make the adjustments during the final reconciliation phase of the annual NHRA payment for ABF NWAU and ABF Block payments

Hospital Acquired Complications

A HAC refers to a complication for which clinical risk mitigation strategies may reduce (but not necessarily eliminate) the risk of that complication occurring. The national list of 16 HAC was developed through a comprehensive process that included reviews of the literature, clinical engagement and testing of the concept with public and private hospitals.

The August 2016 Ministerial Direction and 2017 Addendum to the NHRA requires IHPA to develop a risk adjustment methodology 'to consider different patient complexity levels or specialisation across jurisdictions and hospitals'.

The funding approach for HAC requires that the funding level for all HAC across every hospital be reduced to reflect the extra cost of a hospital admission with a complication. This additional cost may be as a result of a more complex episode of stay or due to an increase in the length of stay than would have otherwise occurred. It is necessary to determine the value of the incremental cost relating to the HAC and use this as the basis of the funding adjustment. The methodology used to determine the incremental cost of a HAC uses similar principles to that adopted for the national cost models, in that it uses linear regression to predict the cost of an episode. The Diagnosis Related Group (DRG) and length of stay were adopted in the predictive model as these characteristics represented the most significant cost drivers.

From July 2018 all DRG hospital separations in ABF hospitals will have their payment reduced where a HAC occurs within the acute admitted episode of care.

The presence of a HAC increases the complexity of an episode of care or the length of stay in hospital. This, in turn, drives an increase in the cost of care for that episode. The funding approach recognises this by explicitly linking funding adjustments to the incremental cost of a HAC.

When calculating the reduction in funding, a risk adjustment takes account of the increased predisposition of some patient cohorts to experiencing a HAC during their hospital stay and adjusts the reduction in funding accordingly by categorising them as Low, Moderate or High complexity patients (refer Table below).

List of funding adjustments for hospital acquired complications

Hospital Acquired Complication	Complexity Group		
	Low	Moderate	High
	%	%	%
1. Pressure injury	12.10	2.80	1.70
2. Falls resulting in fracture or other intracranial injury	2.50	1.40	0.30
3. Healthcare associated infection	8.30	2.40	1.60
4. Surgical complications requiring unplanned return to theatre	13.00	10.40	8.80
5. Unplanned intensive care unit admission	Nil	Nil	Nil
6. Respiratory complications	15.60	10.40	8.10
7. Venous thromboembolism	11.00	7.90	6.70
8. Renal failure	20.50	9.60	6.10
9. Gastrointestinal bleeding	9.10	7.30	6.40
10. Medication complications	8.70	4.80	2.80
11. Delirium	9.10	6.80	5.40
12. Persistent incontinence	3.40	2.60	2.00
13. Malnutrition	6.50	5.50	4.60
14. Cardiac complications	15.60	10.40	8.10
15. Third and fourth degree perineal laceration during delivery	Nil	Nil	Nil
16. Neonatal birth trauma	Nil	Nil	Nil

Appendix 2. Tasmanian Funding Framework

The 2019-20 Tasmanian ABF Model is based on the national ABF model developed by the IHPA to fund public hospital services. This model is based on the NWAU and NEP. All ABF activity is priced at the NEP for 2019-20 (\$5 134) and the NWAU version for 2019-20.

Principles of the Tasmanian ABF Model

To increase transparency and allocate funding to where resources are required, the Tasmanian ABF Model aims to:

- increase the level of public hospital activity for a given level of inputs through technical efficiency
- ensure public hospital resources are allocated to those activities which maximise health outcomes through allocative efficiency
- provide incentives for technological and clinical innovations that lead to better health outcomes
- ensure that public hospitals are funded on a comparable basis for the activity they provide, and that unavoidable differences in costs between hospitals are taken into account through equitable funds distribution and
- provide incentives to support continuous improvement in patient safety and quality.

Purchasing Health Services

The Service Plan determines the price at which the Department purchases services from the THS, and the purchasing model determines the volume and complexity of services that are purchased. In terms of the ABF model:

- There are three public hospitals funded through the Tasmanian ABF model (Royal Hobart, Launceston General and North West Regional). The Tasmanian ABF model is based largely on the national ABF model but includes some modifications to reflect the local Tasmanian environment
- While funded through the Agreement, the Mersey Community Hospital, public hospital services have been included in the NWAU estimates in the Tasmanian ABF model with a balance in funding between ABF contribution and the NPA allocation being provided as a supplementation or block grant
- 23 public hospitals are funded through block funding arrangements. This consists of 18 small regional and rural hospitals and five specialist public psychiatric hospitals. Given the high fixed costs facing smaller hospitals and economies of scale, these facilities would not be financially viable in an ABF model and
- The ABF model determines the volume of services that the Department agrees to purchase from the THS, as articulated through the Service Plan. The volume of activity purchased is informed by projected demographic modelled data, health priorities identified in the SoPI, One State, One Health System, Better Outcomes – White Paper, State Government commitments and known/forecast service developments in negotiation with the THS.

Tasmanian ABF Model Categories

The Tasmanian ABF Model funding categories are:

Activity Based Funding

In 2019-20, the Tasmanian ABF Model will fund the following hospital services on an activity basis:

- Admitted acute services including elective surgery and mental health
- Admitted sub and non-acute services (including “admitted” Transitional Care Program patients)
- Non-admitted outpatient services
- Emergency Department services.

Block Grants and Operational Grants

For services and initiatives provided where existing data does not accurately describe current activity or the service is not in scope of the NHRA, the service will be funded through a specific grant.

Admitted

Activity Based Funding Admitted Acute

The IHPA has determined the Australian Refined Diagnosis Related Group (AR-DRG) v9.0 classification system will be used to classify and calculate NWAU price weights for acute admitted services under the national ABF model which Tasmania has adopted.

Activity data at AR-DRG v9.0 level is used to set the acute activity volume and complexity of acute admitted services to be funded, where the admitting care type is ‘Acute including qualified newborn’ and the treatment is eligible for an NWAU weighting. The only exception to using the admitting care type is in the instance where an ‘unqualified newborn’ becomes qualified during the same episode of care. This is identified in the iPatient Manager (iPM) admissions system when the Admission care type is Neonate (unqualified) and the discharge care type of ‘Acute including qualified newborn’.

The acute inpatient services NWAU are based on the IHPA advice for 2019-20.

Table 1 – Pricing for Acute admitted

Stream	Activity Measure	Classification	Price per Unit \$
Inpatient	NWAU	AR-DRG v9.0	5 134

Further details pertaining to the Acute NWAU adjustments and NWAU can be found in the *Tasmanian Funding and Purchasing Model Guidelines 2019-20*.

Activity Based Funding Sub and Non-Acute

Sub and Non-Acute activity includes patients admitted in the iPM admission system under the care types of Rehabilitation, Psychogeriatric, Geriatric Evaluation & Management, Social, Nursing Home Type and non-residential care clients admitted under Respite.

The Australian National Subacute and Non-Acute Patient (AN-SNAP) classification will be used as the primary classification system for Sub and Non-Acute patient services under the National and Tasmanian ABF models. However, as there have been difficulties experienced in implementing AN-SNAP across the

THS, the DRG or acute inpatient funding model will be used instead of the AN-SNAP classes where admitted data cannot be assigned to an AN-SNAP class.

NWAU Price weights for AN-SNAP 4 can be found in Appendix I of the NEP determination 2019-20.

Table 3 - Pricing for Sub and Non-Acute

Stream	Activity Measure	Classification	Price per Unit \$
Sub and Non-Acute	NWAU	AN-SNAP v4	5 134

Table 4 – Supplementation Funding for Sub and Non-Acute

Block Payments Sub & Non-Acute	\$'000
Sub & Non-Acute Supplementation	3 597

Further details pertaining to the Sub and Non-Acute NWAU and NWAU adjustments can be found in the *Tasmanian Funding and Purchasing Model Guidelines 2019-20*. Non-Admitted Patient Funding.

Activity Based Funding Outpatients

The IHPA has determined the non-admitted outpatient care will be classified using Tier 2 Version 5.0 for 2019-20. Tasmania has adopted the IHPA classification.

The Tasmanian ABF Model treats the following categories as non-admitted activity:

- Public Specialist and General outpatient services
- Private (Outside Referred Patient) and Compensable (Motor Accident Insurance Board, DVA etc.) Specialist and General outpatient services
- All Bulk Billed admitted service events for which the doctor and patient have elected to treat the patient as non-admitted. These are broadly categorised as Medical Benefits Scheme Type B procedures. These are non-admitted patients that the THS has chosen to record on the admission system to enable categorisation for statistical and clinical data purposes. These services are classified using a map between the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM) and the Tier 2 clinic class.

NWAU price weights for Tier 2 Non-Admitted Care classification version 5.0 can be found in Appendix K of the NEP determination 2019-20.

Table 5 - Pricing for Outpatients

Stream	Activity Measure	Classification	Price per Unit \$
Outpatients	NWAU	Tier2 v5	5 134

Table 6 – Supplementation Funding for Outpatients

Block Payments for Outpatients	\$'000
Outpatients Supplementation	10 037

Further details pertaining to the Non-admitted NWAU and NWAU adjustments can be found in the *Tasmanian Funding and Purchasing Model Guidelines 2019-20*.

Activity Based Funding Emergency Department

The IHPA has determined the ED Classification System - Urgency Related Groups (URG) version 1.4 will be used to classify and calculate NWAU price weights for ED care under the 2019-20 National ABF model. As Tasmania has adopted the National ABF model ED services will be classified under URG version 1.4.

NWAU Price weights for Tier2 Non-Admitted Care classification version 1.4 can be found in Appendix K of the NEP determination 2019-20.

Table 7 - Pricing for Emergency Department

Stream	Activity Measure	Classification	Price per Unit \$
Emergency Department	NWAU	URG v 1.4	5 134

Further details pertaining to the Emergency Department NWAU and NWAU adjustments can be found in the *Tasmanian Funding and Purchasing Model Guidelines 2019-20*.

Table 8 – Supplementation Funding for Emergency Department

Block Funding for Emergency Department	\$'000
Emergency Department Supplementation	13 035
RHH immediate boost to enable the ED to recruit new staff	5 000

Appendix 3. National Efficient Growth Funding Cap

From July 2017 until 30 June 2020, the Australian Government will fund 45 per cent of the efficient growth in public hospital services at ABF facilities, as stated in the Addendum to the NHRA. Efficient growth funding is based on growth of both activity (measured in NWAU), and price (measured by the NEP). Calculations are performed by the NHFB.

From 2017-18, annual growth in the Australian Government's NHRA funding is capped at 6.5 per cent. The funding cap is applied through the 'national funding cap' and 'soft cap' methodology, agreed as part of the Addendum to the NHRA. Further details pertaining to the 'national funding cap' and 'soft cap' methodology can be found in the *Tasmanian Funding and Purchasing Model Guidelines 2019-20*.

With State Government funding to the THS being capped at the amount specified in the State Budget, over achievement by the THS of NWAU targets will result in the THS receiving only the efficient growth funding from the Australian Government at 45 per cent of NEP.

Appendix 4. Additional Elective procedures and surgery operations – Australian Government funded

The Australian Government under the *Project Agreement for the Community Health and Hospital program Tasmania 2018-19 Initiatives* is providing \$5 million for additional elective procedures and surgery operations to reduce the number of Tasmanians waiting on waiting list and the time they have waited. For 2019-20 the Statewide Surgical and Perioperative Services Committee proposed to allocate the \$5 million for additional elective procedures and surgery by region according to each region's percent of Category I over-boundary colonoscopy patients. The Committee agreed North and North West would allocate \$500 000 of their portion of funds to provide additional surgery arising for some patients as a consequence of the colonoscopies findings, to be delivered on top of current North and North West elective surgery . Due to capacity limits at RHH, the South will deal with additional elective surgery arising from the colonoscopies findings within their current surgery target by prioritising patients by urgency. To ensure efficient allocation of the funds to areas of highest need, the Committee will review the split of funds across colonoscopies and elective surgery in December 2019 and re-allocate as necessary.

As described in Table A1, in 2019-20 this initiative will fund an additional 2 248 elective colonoscopies plus an estimated 18 elective surgeries (bowel resections being the most common consequence of colonoscopies) subsequently required. It is expected that the additional funding will have a positive impact on the number of people waiting for colonoscopies and the time they have waited. – Funds will be reimbursed to the THS upon evidence of completion for the recognised procedure and funds will be provided to the THS monthly in arrears. Activity will only be funded, where the admitting care type is 'Acute including qualified newborn' and the pay class is not of the type 'Bulk Billed (ORP)'.

Table A1 – Additional elective procedures and surgery operations – Australian Government Funded

	South	North	North West	THS Total
Over-boundary Cat I colonoscopies as at 5 Aug 2019	1 026	861	98	1 985
% of over-boundary Cat I colonoscopies	51.70%	43.40%	4.90%	100%
Share of \$5 million NPA	\$2 584 383	\$2 168 766	\$246 851	\$5 000 000
Allocated to elective surgery (to be reviewed Dec 2019)	\$0	\$448 905	\$51 095	\$500 000
Allocated to colonoscopies (to be reviewed Dec 2019)	\$2 584 383	\$1 719 861	\$195 756	\$4 500 000
Estimated no. colonoscopies	1 291	859	98	2 248
Estimated no. bowel resections	0	16	2	18