

June 2018

Tasmanian Health Service 2018-19 Service Plan

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Service Commitment

The Tasmanian Health Service 2018-19 Service Plan is in accordance with the *Tasmanian Health Service Reform Act 2018* (the Act). The content and process for its preparation is consistent with the requirements outlined in Sections 9 and 10 of the Act.

The Secretary, Department of Health and Tasmanian Health Service (THS) Executive agree to work in collaboration to achieve the common goal of the establishment of a public sector health system that delivers safe, high quality health services and health support services so as to improve, promote, protect and maintain the health of Tasmanians.

Signed by:



Michael Pervan
Secretary
Department of Health

Date signed: 7/8/18

Approved by:



The Honourable Michael Ferguson MP
Tasmanian Minister for Health

Date signed: 6/8/18

Tasmanian Health Service 2018-19 Service Plan

The THS Service Plan ('the Service Plan') applies from 1 July 2018 to 30 June 2019. 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:** Funding Allocation and Activity Schedule
- **Part D:** Performance Framework
- **Part E:** Key Performance Indicators

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 for a financial year.

If the Minister approves a proposed amendment of a Service Plan under subsection (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 (6).

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

Agreements, Standards and Requirements

Financial Management Standard

In accordance with Section 30 of the Act, the THS must manage its budget, as outlined in 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 must comply with the following financial instruments:

- *Public Account Act 1986*
- *Financial Management and Audit Act 1990*
- Treasurer's Instructions
- Australian Accounting Standards

To ensure compliance, the THS should:

- Clearly define the financial objectives of the organisation and ensure they are consistent with the Government and responsible Ministers' expectations;
- Ensure that the financial objectives are clearly articulated within the THS and disseminated throughout the organisation;
- Establish appropriate oversight committees including Audit and Risk and Finance and Performance Committees;
- Ensure all financial aspects of the THS are monitored and appropriate actions are taken when issues are identified;
- Ensure appropriate financial risk management processes exist throughout the organisation, and
- Ensure there is an effective system of internal controls for all financial management system and processes.

National and Other Agreements

The 2018-19 THS funding allocation includes funding provided under a range of National Partnership Agreements (NPAs), Commonwealth Own Purpose Expenditure (COPEs) payments and other agreements. These agreements may generate their own specific program, financial and performance reporting requirements that, while not encapsulated in the Service Plan, require THS compliance.

Hospital Funding and Health Reform Agreement

The National Health Reform Agreement (NHRA) was entered into by the Commonwealth and all states and territories in August 2011. It sets out the shared intention of all parties to work in partnership to improve health outcomes for all Australians and ensure the sustainability of the Australian health system.

The Council of Australian Governments (COAG) has reaffirmed that providing universal health care for all Australians is a shared priority and agreed a Heads of Agreement for public hospitals funding from 1 July 2017 to 30 June 2020. The Agreement preserves important parts of the existing system including Activity Based Funding (ABF), the National Efficient Price (NEP), and the National Efficient Cost (NEC). There is a focus on actions to improve patient safety and the quality of services, and reduce unnecessary hospitalisations. The Commonwealth will continue its focus on reforms in primary care that are designed to improve patient outcomes and reduce avoidable hospital admissions. See

<http://www.coag.gov.au/agreements>

The addendum to the NHRA implements the arrangements outlined in the Heads of Agreement as agreed by COAG in April 2016.

http://www.federalfinancialrelations.gov.au/content/national_health_reform.aspx

National Partnership Agreement: Mersey Community Hospital

As of 1 July 2017, the State Government resumed ownership of the Mersey Community Hospital (MCH) and became responsible for delivering on outcomes and outputs assigned for implementation, and for reporting on the delivery of services to the Commonwealth Government.

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

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 ABF payment under the NHRA or any subsequent agreement for an agreed National Weighted Activity Unit (NWAU) provided at the MCH or elsewhere. In 2018-19, the NWAU 18 amount under the Service Plan has been set at 11 400 across all ABF services streams.

Safety and Quality

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 and the associated accreditation scheme became mandatory for all hospitals from 1 January 2013. Accreditation of Mental Health Services is against the National Standards for Mental Health Services.

The addendum to the NHRA includes a commitment for the Commonwealth 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 (HACs), and avoidable hospital readmissions. This will deliver better health outcomes, improve patient safety and support greater efficiency in the health system.

The 2018-19 Tasmanian Funding Model applies the national safety and quality pricing adjustments for HACs and zero funding of Sentinel Events.

More details regarding HACs and Sentinel Events are provided in *Appendix I*.

Data Compliance and Provision

Since the implementation of 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.

The Department submits a range of data to national and state 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, various National Partnership Agreements 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:**
 - ICD-10-AM Australian Coding Standards
 - Tasmanian coding instructions and directions
 - Casemix Technical Bulletins
 - AN-SNAP, URG classification business rules
- **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

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 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:

- **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
- **Service Plan** - the Minister for Health approves the Service Plan that is to apply for the THS each financial year

The Secretary 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 those actions under the Performance Framework, and
- Responsibility for developing the Service Plan, including key performance indicators, 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 as 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 THS Executive, is accountable to Government via the Secretary (through the Performance Framework) for performing its functions and exercising its powers in a satisfactory manner. It must act in accordance with the requirements of the Service Plan.

The functions of the THS are to:

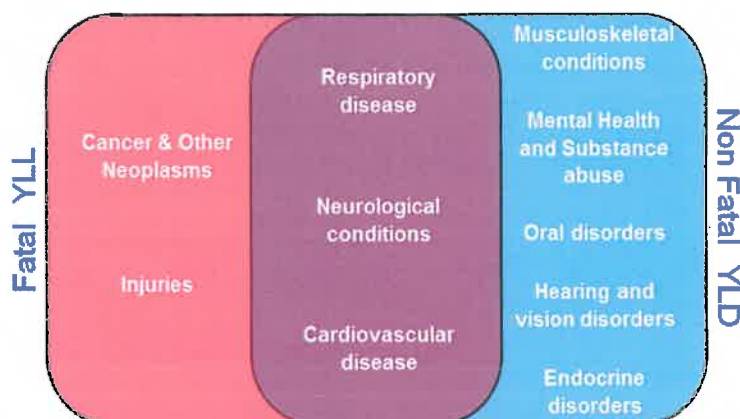
- Ensure that the broad policy expectations of the Minister, as specified in the Ministerial Charter, are achieved;
- Provide the health services and health support services that it is required to provide under the Service Plan, and to provide those services to the specified quality standards and within 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 THS's funding allocation, as determined by the Service Plan, and its other funds, so as to ensure:
 - the efficient and economic operation of the 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 of health services and health support services, 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 planning and coordination, across the state as a whole, of the provision of relevant services.

Part B: Health Planning

The Statement of Purchaser Intent (SoPI) (2018-19) articulates, in detail, the health priorities of the Department for Tasmania at a strategic policy direction level.

The expectation is that service capacity and capability planning and implementation will target the chronic conditions that provide the highest burden of disease for Tasmanians as shown in the figure below.

The conditions that contribute significantly to both fatal and non-fatal burdens of disease are Respiratory, Neurological and Cardiovascular diseases.



The underlying risk factors that contribute to the disease burden also need to be addressed. A detailed analysis of risk factors is provided in the SoPI (2018-19) which include:

- Smoking
- Overweight and obesity
- Alcohol consumption
- Dietary risks
- Physical inactivity
- Environmental risks

The Department is also progressing work in the following areas:

- Extension of the TRDF/CSP to support re-balancing the delivery of services along the continuum of care
- Complex patients, with specific reference to system level configurations for multi-morbid patients
- Unwarranted variations in practice
- Low value care

These are important directions for the Department and it is expected that there will be active engagement and joint planning with the THS in the ongoing development of these focus areas.

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

2018-19 Activity and Funding Schedule

Tasmanian Health Service	Measure	Activity	Funding (\$'000)
Activity Funding (excluding Mersey Community Hospital) - Admitted			
Acute (excluding Elective Surgery)	NWAU	76 882	385 333
Elective Surgery ¹	NWAU	23 803	120 143
Mental Health	NWAU	6 377	31 961
Sub and Non-Acute	NWAU	6 827	34 217
Activity Funding – Non Admitted			
Outpatients	NWAU	17 379	87 105
Emergency Department	NWAU	16 783	84 118
Sub Total		148 051	742 877
Mersey Community Hospital - Admitted			
Acute (excluding Elective Surgery)	NWAU	5 422	N/A
Elective Surgery ¹	NWAU	931	N/A
Mental Health	NWAU	73	N/A
Sub and Non Acute	NWAU	262	N/A
Mersey Community Hospital – Non Admitted			N/A
Outpatients	NWAU	1 424	N/A
Emergency Department	NWAU	3 288	N/A
Sub Total		11 400	N/A
Total Activity Funding		159 451	742 877
Block Grants for ABF Hospitals			
Blood	Block Funded		4 897
Boarders	Block Funded		327
Commonwealth Initiative for Organ Donation	Block Funded		134
Home and Community Care (HACC)	Block Funded		198
Home Ventilation Services	Block Funded		2 573
Non-ABF Activity (see table below for detail)	Block Funded		66 315
North West Cancer Centre	Block Funded		4 823
Nurse Graduates	Block Funded		1 645
Palliative Care Clinical Nurse Educators	Block Funded		400
Organ Procurement	Block Funded		198
Patient Travel Assistance Scheme (PTAS)	Block Funded		10 601
Radiation Oncology Capital Equipment	Block Funded		1 025
Sub & Non-Acute Admitted Supplementation	Block Funded		14 089
Transition Care Program	Block Funded		7 810
Teaching, Training and Research	Block Funded		43 534
Non Admitted Community Rapid Response	Block Funded		623
John L Grove (top up)	Block Funded		985
Total Block Grants			160 177

Operational Grants			
Transition Supplementation Grant	Grant		39 984
Mersey Community Hospital	Grant		80 880
Primary Health	Grant		112 270
Mental Health - Non -acute care facilities	Grant		81 292
Alcohol and Drug	Grant		15 509
Oral Health	Grant		26 928
CHAPS	Grant		12 657
Cancer Screening	Grant		6 488
Forensic Medical Services	Grant		1 515
State-wide Operations Command Centre	Grant		1 500
Medical Cannabis	Grant		920
Nurse Graduates Program	Grant		1 135
Interstate Charging	Grant		20 500
Enhancing Retrieval and Referral Services	Grant		144
Capital Expenditure	Grant		7 500
Total Operational Grants			409 222
Total Funding			1 312 276

1. Elective surgery funding includes a preliminary allocation associated with the State Government announced that 500 admissions are to be specifically targeted at those patients who are most over boundary, those who are potentially most disadvantaged and those that have the highest burden of disease. The final list of 500 will be jointly agreed between the Department and the THS. Once agreed, the elective surgery funding allocation may require amendment.

Non-Activity Based Services (included in Activity and Funding Schedule)

Service	Funding (\$'000)
Primary and Community Health Service and THS Support	34 804
Home and Community Care Program	20 481
Adult Day Care Centre Service	2 707
Sexual Health Services and Assault	2 622
State-wide Spectacle Assistance Scheme and Prosthesis	1 604
Integrated Care Centres (South and North)	1 400
MSOAP and COAG Special Funding	1 093
Medical Retrieval Service	1 040
Other Non-Activity Based Services	564
Total	66 315

Election Commitments¹ (included in Activity and Funding Schedule)

Election Commitments	Funding (\$'000)
Block and Operational Grants	
Nurse Graduates - 180 more across Tasmania – South (90)	823
Nurse Graduates - 180 more across Tasmania – North (60)	548
Nurse Graduates - 180 more across Tasmania - North West (30)	274
Mistral Place - 10 Beds	1 203
Palliative Care Nurse Educators	400
Total Block and Operational Grants	3 248
Activity Funding	
New 8 bed Acute Medical Unit - NWRH	2 407
Non Admitted - Community Rapid Response - South	1 079
Non Admitted - Community Rapid Response - North	1 079
Non Admitted - Community Rapid Response - North West	1 079
Elective Surgery Boost	20 000
Total Activity Funding	25 644
Total	28 892

1. Excludes capital expenditure commitments.

NWAU Estimates 2018-19

Tasmanian Health Service	Admitted Acute	Admitted Mental Health	Admitted Sub and Non-acute	Emergency	Outpatients	Total
RHH, LGH and NWRH	100 685	6 377	6 827	16 783	17 379	148 051
Mersey Community Hospital	6 353	73	262	3 288	1 424	11 400
NWAU Total	107 038	6 450	7 089	20 071	18 803	159 451

Part D: Performance Framework

The Service Plan and Performance Framework are instruments that assist the Department in undertaking 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 to form an integrated management system. Information gathered about the system informs the strategies used to improve it in a cyclical process as illustrated below.



A robust system must be in place for monitoring and reporting on the quality of services to ensure that the services purchased under the Service Plan are being delivered and that they are safe and of high quality. Performance issues also need to be identified so that appropriate action can be taken and direction provided to ensure that THS can meet its performance obligations. The Performance Framework is the instrument used to achieve these aims.

The 2018-19 Performance Framework provides a holistic approach to performance will be taken with more comprehensive performance monitoring and analysis that will no longer focus solely on the achievement of the Key Performance Indicators (KPIs) contained within Part F of the Service Plan. It will also include an increased focus on:

- Safety and quality;
- Achievement of government priorities and funded initiatives;
- Achievement of purchased volumes and targets, and
- Celebrating successful strategies and enabling shared learning throughout the system.

In order to achieve this, the suite of Service Plan KPIs will be underpinned by a range of monitoring activities and indicators coupled with regular system scanning to identify areas of improvement, significant concern, clinical risk or sentinel events that will inform performance discussions. These activities will be underpinned by transparent performance criteria that will guide the determinations regarding escalation and de-escalation.

Part E: Key Performance Indicators

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

Key Performance Indicators (KPIs) 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 KPIs are:

- **Effectiveness** – care, intervention or action achieves the desired outcome from both the clinical and patient perspective.
 1. Elective Surgery waiting list reduction – surgery within recommended time
 2. Elective Surgery waiting list reduction – treat in turn
 3. Elective Surgery waiting list reduction – maximum waiting days
 4. Breast cancer detection
- **Safety** - mitigate risks to avoid unintended or harmful results.
 5. Hospital Safety – reduced risk of hospital acquired infections
 6. Hospital Safety – mental health seclusion
 7. 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.
- **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 the patients.
 8. Patient flow from Emergency Departments
 9. Mental Health transition from inpatient to community care
 10. Acute Care transition from inpatient to community care
- **Accessibility** – People can obtain health care at the right place and right time, taking account of different population needs and the affordability of care.
- **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.
 11. Emergency Department service provision
 12. Ambulance offload delay
 13. Service activity
 14. Financial control
 15. Admitted patient episode coding

2018-19 Key Performance Indicator Schedule

KPI No.	Key Performance Indicator	Target
Effectiveness		
1	Elective Surgery waiting list reduction – surgery within recommended time	
1.1	Elective Surgery – admit within recommended time * Quarterly trajectory targets to be agreed to achieve 90% by 2022 (Liberal Party election policy – Building your future)	Not less than 90%
2	Elective Surgery waiting list reduction – treat in turn	
2.1	Elective Surgery – treat in turn rates - Category 2	Not less than 60%
2.2	Elective Surgery – treat in turn rates - Category 3	Not less than 60%
3	Elective Surgery waiting list reduction – maximum waiting days	
3.1	Elective Surgery – maximum wait days - Category 1	Not more than 30
3.2	Elective Surgery – maximum wait days - Category 2	Not more than 100
3.3	Elective Surgery – maximum wait days - Category 3	Not more than 400
4	Breast cancer detection	
4.1	Eligible women screened for breast cancer	Not less than 33 380
4.2	Clients assessed within 28 days of a screen-detected abnormality	Not less than 90%
Safety		
5	Hospital Safety – reduced risk of hospital acquired infections	
5.1	Hand Hygiene compliance	Not less than 80%
5.2	Healthcare associated staphylococcus aureus (including MRSA) bacteraemia infection rate per 10 000 patient days	Not more than 2.0
6	Hospital Safety – mental health seclusion	
6.1	Mental Health inpatient seclusion rate (events per 1 000 patient days)	Less than 8
7	Hospital Safety – reportable events	
7.1	Initial Reportable Event Briefs sent to the Department's Clinical Governance Officer within 48 hours	Not less than 80%
7.2	Reportable Event Briefs sent to the Department's Clinical Governance Officer within 70 calendar days	Not less than 80%
Continuity of care		
8	Patient flow from Emergency Departments	
8.1	Emergency patients with an ED length of stay less than four hours (all specified facilities) * Quarterly trajectory targets to be agreed to achieve 90% by 2022 (Liberal Party election policy – Building your future)	Not less than 90%
8.2	Patients admitted through the ED with an ED length of stay less than eight hours (all specified facilities) * Quarterly trajectory targets to be agreed to achieve overall target	Not less than 90%

KPI No.	Key Performance Indicator	Target
8.3	ED patients with an ED length of stay less than 24 hours (all specified facilities) * Quarterly trajectory targets to be agreed to achieve overall target	Not less than 100%
9	Mental health transition from inpatient to community care	
9.1	Re-admissions within 28 days	Not more than 14%
9.2	Post discharge community care follow up within 7 days	Not less than 85%
10	Acute care transition from inpatient to community care	
10.1	Discharge summaries transmitted within 48 hours of separation	Not less than 100%
Efficiency and sustainability		
11	Emergency Department service provision	
11.1	Emergency department presentations seen within recommended time - Triage 1	Not less than 100%
11.2	Emergency department presentations seen within recommended time – all Triage categories (all specified facilities) * Quarterly trajectory targets to be agreed to achieve overall target	Not less than 80%
11.3	Emergency department presentations who do not wait to be seen	No more than 5%
12	Ambulance offload delay	
12.1	Ambulance offload delay - within 15 mins (all specified facilities)	Not less than 85%
12.2	Ambulance offload delay - within 30 mins (all specified facilities) * Quarterly trajectory targets to be agreed to achieve overall target	Not less than 100%
13	Service activity	
13.1	National Weighted Activity Units (NWAUs) ¹	151 628
13.2	Elective surgery admissions ²	17 500
13.3	Dental Weighted Activity Units (DWAUs)	50 100
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%
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%

1. Includes 11 400 NWAU associated with the MCH under the NPA.

2. Of the 17 500 admissions, the State Government announced that 500 are to be specifically targeted at those patients who are most over boundary, those who are potentially most disadvantaged and those that have the highest burden of disease. The list of 500 will be jointly agreed between the Department and the THS.

Appendix I. Safety and Quality: Sentinel Events and HACs

The NHRA Safety and Quality framework is to be progressively implemented in both the NEP and the NEC funding models from 1 July 2017 and lead to a range of objectives for delivery.

Non-payment by the Commonwealth and State began for a range of sentinel events as from 1 July 2017. All admitted episodes of care in ABF Hospitals (all ABF streams) will see the NWAU set to zero and for block-funded hospitals, the funding deduction associated with a sentinel event will be calculated by multiplying the NEPI8 by the NWAU 18 for that episode and that amount deducted from the ABF block payment. The Administrator, National Health Funding Body (NHFB), and the State will make the adjustments during the final reconciliation phase of the annual NHRA payment to ABF NWAU and Block payments.

A payment adjustment for an agreed set of HACs from 1 July 2018 for the acute admitted episodes, the NEP 18 funding model will make adjustment to the acute admitted episodes when a HAC is identified. The NEP 18 pricing and funding approach balances the likelihood that some patients will be at higher risk of experiencing an adverse event while recognising that “all hospitals have scope to improve safety and quality”. This will see the acute NWAU allocated to the acute admitted episode (in both ABF and ABF block funded facilities) reduced to reflect the extra cost of an acute hospital admission with a HAC.

Sentinel Events

Sentinel events are a subset of adverse events that result in death or serious harm to patients. The national set of eight sentinel events, agreed to by Australian Health Ministers in 2002, comprise of:

- Procedures involving the wrong patient or body part resulting in death or major permanent loss of function;
- Suicide of a patient in an inpatient unit;
- Retained instruments or other material after surgery requiring re-operation or further surgical procedure;
- Intravascular gas embolism resulting in death or neurological damage;
- Haemolytic blood transfusion reaction resulting from ABO [blood type] incompatibility;
- Medication error leading to the death of a patient reasonably believed to be due to incorrect administration of drugs;
- Maternal death associated with pregnancy, birth and the puerperium; and
- Infant discharged to the wrong family.

Hospital separations after 30 June 2017 in both ABF and block funded hospitals that include a sentinel event are not funded by either the Commonwealth or State Government funding models.

For acute admitted episodes that occur at ABF hospitals the NWAU (18) for episodes with a sentinel event will be set to zero and for block funded hospitals, the funding deduction associated with a sentinel event will be calculated by multiplying the NEPI8 by the NWAU 17 for that episode.

Hospital Acquired Complications (HACs)

Hospital Acquired Complications (HACs) are complications which occur during a hospital stay and for which clinical risk mitigation strategies may reduce (but not necessarily eliminate) the risk of their occurrence.

The 2012 ACSQHC and IHPA established joint working party developed an agreed Australian list of HACs. The national list of 16 HACs was developed through a comprehensive process that included reviews of the literature, clinical engagement and testing of the concept with public and private hospitals.

From July 2018 all acute hospital separations in ABF funded hospitals will have their funding 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 1).

Table 1: List of funding adjustments for hospital acquired complications

Hospital Acquired Complication	Complexity Group		
	Low	Moderate	High
1. Pressure injury	12.60%	7.30%	4.10%
2. Falls resulting in fracture or other intracranial injury	2.50%	1.30%	0.40%
3. Healthcare associated infection	8.30%	1.60%	0.80%
4. Surgical complications requiring unplanned return to theatre	12.40%	7.20%	6.20%
5. Unplanned intensive care unit admission	Nil	Nil	Nil
6. Respiratory complications	15.40%	9.50%	6.90%
7. Venous thromboembolism	11.50%	8.30%	6.30%
8. Renal failure	21.20%	7.30%	6.40%
9. Gastrointestinal bleeding	9.70%	7.30%	6.40%
10. Medication complications	8.00%	3.50%	1.70%
11. Delirium	9.20%	6.90%	5.50%
12. Persistent incontinence	2.60%	2.20%	1.60%
13. Malnutrition	6.20%	4.70%	3.80%
14. Cardiac complications I	0.50%	8.00%	6.30%
15. Third and fourth degree perineal laceration during delivery	Nil	Nil	Nil
16. Neonatal birth trauma	Nil	Nil	Nil

No funding adjustment for 'Third and fourth degree perineal laceration during delivery' (15) and 'Neonatal birth trauma' (16) will be applied in 2018-19 due to small patient cohorts or other issues which have prevented development of a robust risk adjustment approach at this time.

No funding adjustment for 'Unplanned intensive care unit admission' (5) will be applied in 2018-19 as it cannot be identified in current data sets.

Appendix 2. Tasmanian Funding Framework

The 2018-19 Tasmanian Funding 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 18 for 2018-19 (\$5 012) and the NWAU version for 2018-19 is NWAU18.

Principles of the Tasmanian Funding Model

To increase transparency and allocate funding to where resources are required, the Tasmanian funding 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 funding model;

- There are three public hospitals funded through the Tasmanian ABF model (Royal Hobart, Launceston General and North West Regional Hospitals). 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 a National Partnership Agreement (NPA), 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;
- Twenty three public hospitals are funded through block funding arrangements. This consists of eighteen 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 purchasing 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 Statement of Purchaser Intent (SoPI, White Paper Health Reform priorities, State Government commitments and known/forecast service developments in negotiation with the THS.

Funding Model Categories

The Tasmanian Funding Model funding categories are:

Activity Based Funding (ABF)

In 2018-19, the Tasmanian Funding 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 National Health Reform Agreement, the service will be funded through a specific grant.

Admitted

ABF Admitted Acute

The IHPA has determined the Australian Refined Diagnosis Related Group (AR-DRG) version 9.0 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 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 NWAU 18. Acute inpatient NWAU price weights can be found at in Appendix H of the NEP determination 2018-19.

Table 1 – Pricing for Acute admitted

Stream	Activity Measure	Classification	Price per Unit \$
Inpatient	NWAU	AR-DRG v9.0	5 012

Further details pertaining to the Acute NWAU adjustments and NWAU can be found in the *Tasmanian Funding and Purchasing Model Guidelines 2018-19*.

ABF 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 (GEM), Social, Nursing Home Type and non-residential care clients admitted under Respite.

The Sub 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.

As not all activity identified as Sub and Non Acute is in scope of the National Health Reform Agreement (e.g. the care type of "Other"), the Department has applied a blended approach for Sub and Non Acute in 2018-19 with:

- \$34.2 million funded via ABF;
- \$14.1 million via a Sub and Non Acute supplementation grant;
- \$7.8 million via a Transition Care Program supplementation grant, and
- 985 000 as a John L Grove "top up".

The grants are based on historical costs and are the difference between the estimated costs in 2018-19 less any ABF funding and the Own Source Revenue amounts.

NWAU Price weights for AN-SNAP 4 can be found in Appendix I of the NEP determination 2018-19.

Table 3 - Pricing for Sub and Non Acute admitted

Stream	Activity Measure	Classification	Price per Unit \$
Sub and Non Acute	NWAU	AN-SNAP v4	5 012

Table 4 – Block Funding for Sub and Non Acute admitted

Block Payments Sub & Non-Acute Inpatients	\$'000
Sub & non-Acute Supplementation	\$22 885

Further details pertaining to the Sub and Non Acute NWAU and NWAU adjustments can be found in the *Tasmanian Funding and Purchasing Model Guidelines 2018-19*. Non-Admitted Patient Funding

ABF Outpatients

The IHPA has determined the non-admitted, outpatient care will be classified using the Tier 2 Version 5.0 for 2018-19. As Tasmania has adopted the national ABF model, outpatient services will be classified under the Tier 2 classification system Version 5.0, for 2018-19

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

- Public Specialist and General outpatient services
- Private (Outside Referred Patient) and Compensable (MAIB, 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 MBS Type B procedures. These are non-admitted patients that THS has chosen to record on the admission system to enable categorization 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 at in Appendix K of the NEP determination 2018-19.

Table 5 - Pricing for Non-Admitted Patients

Stream	Activity Measure	Classification	Price per Unit \$
Non-Admitted Patients	NWAU	Tier2 v5	5 012

Further details pertaining to the Non-admitted NWAU and NWAU adjustments can be found in the *Tasmanian Funding and Purchasing Model Guidelines 2018-19*.

ABF Emergency Department

The IHPA has determined the Emergency Department Classification System - Urgency Related Groups (URG) version 1.4 will be used to classify and calculate NWAU price weights for Emergency Department care under the 2018-19 National ABF model. As Tasmania has adopted the National ABF model Emergency Department services will be classified under Urgency Related Groups (URG) version 1.4.

NWAU Price weights for Tier2 Non-Admitted Care classification version 1.4 can be found at in Appendix K of the NEP determination 2018-19.

Table 6 - Pricing for Emergency Department Patients

Stream	Activity Measure	Classification	Price per Unit \$
Emergency Department Patients	NWAU	URG v 1.4	5 012

Further details pertaining to the Emergency Department NWAU and NWAU adjustments can be found in the *Tasmanian Funding and Purchasing Model Guidelines 2018-19*.

Appendix 3. National Efficient Growth Funding Cap

From July 2017 until 30 June 2020, the Commonwealth Government will fund 45% of Efficient Growth in public hospital services at ABF facilities as stated in the Addendum to the National Health Reform Agreement (NHRA) 2017. Efficient growth funding is based on growth of NWAUs, and calculations are performed by the National Health Funding Body. With the state component being capped, over achievement of NWAU targets will result in the THS receiving only the efficient growth funding from the Commonwealth Government at 45% of NEP until the 6.5% cap has been exceeded.

In 2017-18, the overall Australian Government NHRA funding is capped at 6.5% with growth in Australian Government funding based on 2016-17 funding levels. The funding cap will be 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 2018-19*.