



June 2017

# 2017-18 Service Agreement between the Minister for Health and the Tasmanian Health Service

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## Service Commitment

This Agreement is in accordance with the *Tasmanian Health Organisations Act 2011* (the Act). The content and process for its preparation and agreement is consistent with the requirements outlined in sections 44 and 45 of the Act.

The parties 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:

  
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The Honourable Michael Ferguson MP  
Tasmanian Minister for Health

Date signed: 26 June 2017

  
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John Ramsay  
Chair of the Governing Council  
of the THS  
Date signed: 27 June 2017

# Service Agreement 2017-18

This Agreement is between the Minister for Health (the Minister) and the THS Governing Council (THS GC). It applies from 1 July 2017 to 30 June 2018. It does not override existing laws, agreements, public sector codes, statutes, government policies or contracts.

The evaluation of THS performance against the requirements of this Agreement will be undertaken as outlined in the Performance Framework (refer Part C of this Agreement).

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

- comply with the requirements of this Agreement;
- 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 in its role as system manager.

This Agreement consists of:

- Part A Tasmanian Public Health System – Accountabilities.
- Part B THS Profile.
- Part C Performance Framework.
- Part D Statement of Purchaser Intent.
- Part E 2017-18 Priorities.
- Part F Key Performance Indicators.
- Part G Funding Allocation and Activity Schedules.

## Variation of the Service Agreement

As outlined in section 44 of the Act, this Agreement may at any time, before or during the financial year, be amended by agreement in writing between the Minister and the THS GC, or be amended by notice in writing by the Minister to the THS GC if the Minister and the THS GC are unable to agree as to the amendment.

This Agreement will be jointly reviewed with the THS periodically within the financial year as required, to ensure it accurately reflects the circumstances of the THS and the requirements of the Minister across the entire financial year.

## Financial Management Standard

In accordance with Section 11 of the Act, the THS GC must manage its budget, as outlined in this Agreement to ensure the efficient and economic operation and delivery of health services and use of its resources. Accordingly, it is critical that the THS GC has strong financial management and accountability.

The THS GC must comply with the following financial instruments:

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

To ensure compliance, the THS GC 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.

## **Safety and Quality**

It has been proven that safe and quality health care is also cost-effective health care, therefore both the Quality Governance Framework and the Key Performance Indicators detailed in this Service Agreement are based on the same Dimensions of Quality that are known to produce less expensive health care. Learnings and improvements in safety and quality should be shared within and between services to support overall improvement in the health system.

The use of clinical indicators is consistent with the three core principles of the Australian Safety and Quality Framework for Health Care for safe and high quality care: consumer centred, driven by information and organised for safety. Framework requirements show a clear link between clinical indicators and quality of services expected to be delivered by the Tasmanian Public Health System. If the requirements are not met, there is potential for harm to occur and/or for failure to learn from adverse events and therefore the system manager needs to have continuous oversight and ability to stipulate improvements required in the delivery of health care.

## **Data Provision**

Since the implementation of Activity Based Funding (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 this Agreement 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.

## **National and Other Agreements**

The 2017-18 THS funding allocation may include revenue provided under a range of National Partnership Agreements (NPAs), Commonwealth Own Purpose Expenditure payments (COPEs) and other agreements. These agreements may generate their own specific program, financial and performance reporting requirements that, while not encapsulated in this Agreement, require THS compliance.

# **Part A: Tasmanian Public Health System - Accountabilities**

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 this Agreement) is delivered under the Act. For the purposes of this Agreement, the high level accountabilities of the Minister, the Department and the THS are summarised below.

## **Minister for Health**

The Minister is ultimately accountable for the performance of the THS in delivering services efficiently and safely. The Act provides performance management powers to the Minister alone, rather than the Minister and Treasurer. Apart from the Minister's powers which are shared with the Treasurer and the Minister's power to dissolve the THS GC, the Department exercises the powers of the Minister under an instrument of delegation. These delegated powers relate to the operational management of the THS, subject to any Ministerial direction through the Department.

The Minister has other functions and roles relevant to the regulation of the entire Tasmanian health system, through administration of legislation in relation to areas such as drugs and poisons regulation, private hospital licencing, radiation licencing, and so on. These are also primarily managed by the Department on the Minister's behalf.

## **The Department of Health and Human Services**

The Secretary of the Department is directly accountable to the Minister for the delegated powers exercised by the Department in respect of the THS. The Secretary advises the Minister on health services planning, purchasing and the performance of health services.

The overarching role of the Department is to exercise its system manager powers to provide oversight, policy direction and purchasing for the Tasmanian health system on behalf of the Minister to ensure that the health system is being managed safely, effectively and efficiently in the interests of the people of Tasmania.

The Department's key functional accountabilities in respect of the THS are:

### **Planning**

- effective strategic planning of health services across the State.

### **Standards and Regulation**

- Ministerial Policy: requires the THS to implement specified policies such as clinical governance frameworks and casemix infrastructure policies (including the DHHS Casemix Policy);
- Corporate plan: review and recommend to the Minister any amendments to plans prepared by the THS; and
- monitoring financial performance.

## **Service Delivery**

- provide support services to the THS in areas such as finance, human resources and corporate support.

## **Purchasing and Performance**

- **Service Agreement:** agree or determine for the THS by 30 June, including services to be provided by or on behalf of the THS and funding for those services, performance standards, performance targets and performance measures, and standards of patient care and service delivery, and
- **performance monitoring:** performance escalation of unsatisfactory performance which may require a performance improvement plan, appointment of ministerial representatives to the THS GC, or appointment of a performance improvement team.

## **The Tasmanian Health Service**

The THS is a State Service agency and its Chief Executive Officer (CEO) is the Head of Agency for the purposes of key public sector legislation. Similar to the Secretary and Department, the THS and CEO are subject to a wide range of legislative requirements under various Acts. These include the *State Service Act 2000*, *Financial Management and Audit Act 1990* and many others.

The THS, through their Governing Council, is accountable to the Minister and the Treasurer. The THS CEO is appointed by the Premier on the recommendation of the THS GC and is accountable to the THS GC for the administration and management of the THS.

The organisation's key statutory functions are, in summary to:

- improve and maintain the health of persons as required by the service agreement;
- conduct and manage hospitals and health services under THS control;
- ensure effective provision of health services that are purchased by the THS;
- manage the THS funding and budget efficiently and economically;
- consult and collaborate with other providers of health services;
- provide training and education relevant to the provision of health services;
- undertake research and development relevant to the provision of health services;
- collect and provide health data for research, reporting, and prescribed purposes, and
- perform any other prescribed function in any applicable Act.

The THS GC's key functional accountabilities are to the Minister and the Treasurer, to:

- ensure the THS operates consistently with the Ministerial Charter, service agreement including funding levels, business plan, corporate plan, Ministerial policies, and reporting requirements;
- monitor THS performance against performance measures in the service agreement;
- formulate, and ensure the implementation of, policy in respect of THS operations;
- provide advice to the Minister regarding capital investment requirements and service planning;
- ensure that corporate and clinical governance procedures are in place;
- establish audit and risk sub-committee to comply with any Treasurer Instructions;
- advise the Minister of issues arising with the corporate plan or the financial viability of the THS;
- prepare, subject to the Ministers' approval, and operate in accordance with:
  - corporate plan: a planning period of not less than 4 financial years, including agreed financial and non-financial performance targets, an activity plan, HR strategy etc., and
  - business plan: budget and plan to meet the requirements of the annual service agreement.



The Chair of the THS GC has no specific statutory functions and is the leader and spokesperson of the THS GC in respect of the delivery of these accountabilities.

## Part B:THS Profile

The primary role of the THS is to provide and coordinate public sector health services and health support services across Tasmania. These services are provided in a range of inpatient, outpatient, community health, residential aged care and in-home settings.

Services delivered by the THS include acute, subacute, emergency, non-admitted, primary health care, palliative care, oral health, cancer screening, mental health and alcohol and drug services, and community-based child health services for children 0 – 5 years and their families. The services provided are flexible enough to target specific needs at the different stages of a patient's health journey, in order to provide an integrated, holistic and patient-centred approach to health care delivery.

The THS operates four major hospitals, each with a specific role in the system:

- the Royal Hobart Hospital is the principal referral hospital for residents of Southern Tasmania and provides a number of tertiary services for the State;
- the Launceston General Hospital is the principal referral hospital for the North and North West of Tasmania and provides a number of tertiary services for residents of those areas;
- the North West Regional Hospital in Burnie provides acute general hospital services in the North West Region; and
- the Mersey Community Hospital at Latrobe is a dedicated elective surgery centre for all Tasmanians and will continue to provide a mixture of general hospital services to the local community.

Sub-acute inpatient care is provided at the major hospitals and the THS' network of rural hospitals (including multi-purpose services and multi-purpose centres). The rural hospitals also provide some emergency care as well as a wide range of community health services. Some rural facilities also provide residential aged care.

The THS also provides a range of services at the community level that includes allied health, community nursing (including specialised nursing), home care, palliative care, dementia services, specialised case management services, aids and appliances and health promotion programs. These services are generally provided from community health centres and rural facilities, but can also be provided in patients' homes, schools and workplaces.

Appendix One outline the specific services delivered under the following programs:

- Mental Health Services.
- Alcohol and Drug Services.
- Correctional Primary Health Services
- Forensic Mental Health Services.
- Oral Health Services.
- Cancer Screening and Control Services.
- Child Health and Parenting Service.
- Primary Health Services.

## Part C: Performance Framework

Under the Act, the THS GC is accountable to the Minister for Health and the Treasurer for the performance of its powers and functions. This includes ensuring that the THS performs its functions and exercises its powers in a satisfactory manner and the monitoring of THS performance against the requirements of the service agreement.

The Department is responsible to the Minister in relation to the Act's administration, and the Minister has delegated a number of performance related functions and powers to the Secretary of the Department in this context. This is consistent with the State's role as 'system managers' of the public hospital system, which includes system-wide public hospital performance.

The *Performance Framework* (2017) describes the relevant provisions of the Act as well as outlining how they will be practically implemented. It provides a single, overarching administrative process through which the legislative framework established by the Act is translated into a consistent and transparent approach for the identification, monitoring and management of THS performance, including performance against the requirements of the service agreement. It provides the THS with certainty regarding responses to identified performance issues, establishes a structure around the legislative performance interventions available and describes processes through which the escalation and de-escalation of identified performance issues occurs.

Whilst its primary focus is on the early identification and remediation of performance issues, equally, strong performance will be highlighted and acknowledged. The Minister and the Secretary are committed to working with the THS GC and the THS to drive high levels of performance whilst at the same time ensuring that performance issues are identified and acted upon in a timely manner.

While all efforts will be made to ensure the *Performance Framework* is consistently applied, it is not in itself a legislative requirement. The Act provides the responsible Ministers with all required powers in relation to the performance management of the THS: they can at any time act in accordance with those powers, outside of the processes described in the Framework.

The THS and the THS GC must comply with the requirements of the *Performance Framework*. A copy of the *Performance Framework* can be located at [http://www.dhhs.tas.gov.au/thhs/service\\_agreements](http://www.dhhs.tas.gov.au/thhs/service_agreements).

## Part D: Statement of Purchaser Intent (SoPI)

As system manager and purchaser of services, the Department has a clear responsibility to ensure it is focussing on the health needs of the population of the State of Tasmania.

A key mechanism for system management is through informed, appropriate purchasing. The nature and volume of services purchased will impact on the effectiveness and value-for-money of the Tasmanian health system. However, purchasing is a necessarily transactional process, and so must be contextualised to be effective as a mechanism to enact Government policy in health, and to ensure that purchasing decisions reflect the application of a longer term strategy. As part of this purchasing process, the Department must also signal as far as possible its future purchasing intentions to support service providers' planning capacities.

The *Statement of Purchaser Intent* (SoPI) document acts as the bridge between the strategic priorities of the Health System and the transactional activity of purchasing.

The SoPI serves 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 next five years;
- it assists the THS with its forward planning;
- it articulates purchasing intent in specific and measurable terms in order that the Department is able to clearly ascertain and account for what is being purchased;
- it creates the basis for the service agreement between the Minister for Health and the THS GC, and
- it is a living document that will be updated and amended as we improve our understanding and articulation of the needs of the State.

The SoPI (2017-18) articulates the purchasing intentions of the DHHS in the following broad groupings:

- chronic disease
- elective surgery
- additional Government priorities

The chronic disease purchasing intentions of the SoPI (2017-18) are shaped primarily by the greatest burden of disease for Tasmanians with specific focus on those conditions that account for 80% of the burden for both fatal and non-fatal categories.

Elective surgery will focus on provision of sufficient volume to maintain wait lists at the targeted levels via the Tasmanian Health Assistance Package (THAP) and Rebuilding Health Services Tasmania (RHST) funding as at 30 June 2017.

The One State, One Health System, Better Outcomes – *'White Paper: Delivering Safe and Sustainable Clinical Services'* (June 2015) Health Reform identified a number of services where key changes are required to ensure the state-wide delivery of evidence-based, quality and safe care. Specific purchasing actions have been identified as recommended in the White Paper.

Actions in relation to the management of demand in Emergency Departments and improved whole-of-hospital patient flow will be consistent with actions announced under the Patients First Initiative (Stages 1 and 2).

Further information on specific SoPI (2017-18) priorities is provided at Part E of this Agreement.

## Part E: 2017-18 Priorities

In 2017-18, the THS is required to prioritise services (both acute and community based) that address the following conditions. The priorities include those that are to be delivered by the THS consistent with the priorities outlined in SoPI (2017-18) and additional priorities that have been agreed between the Department and the THS as part of the 2017-18 Service Agreement development process for joint progression in 2017-18.

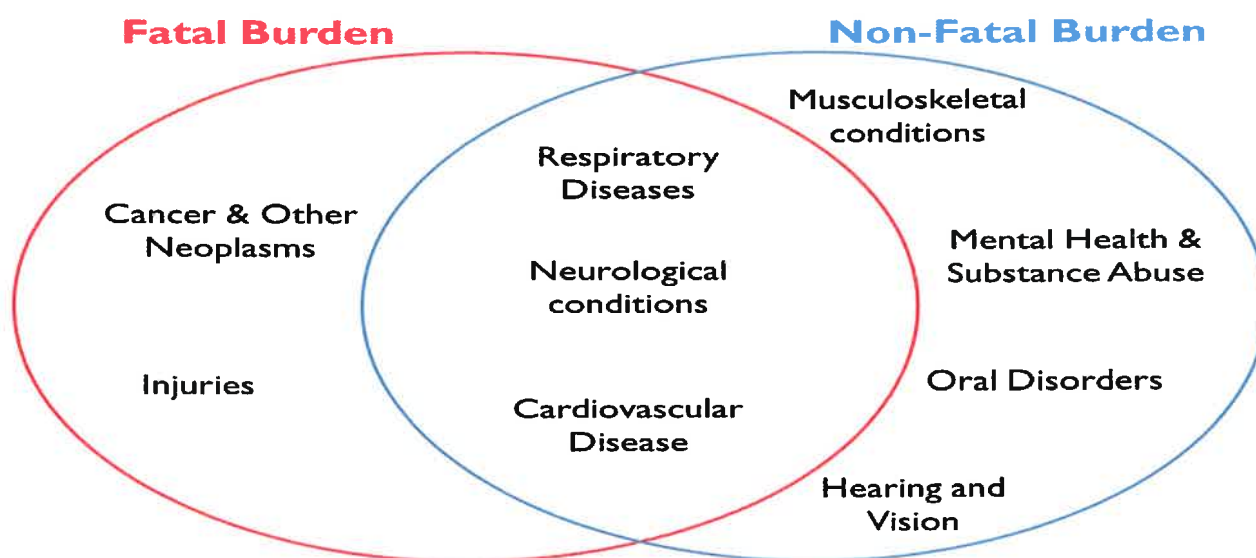
Consistent with the processes outlined in the *Performance Framework*, progress against the implementation of all priorities will be subject to regular monitoring and reporting throughout the year.

### SoPI Priorities

#### Chronic Disease

The initial focus of the SoPI is on the chronic diseases that account for 80% of the Fatal and 80% of the Non-Fatal burden of disease. Due to its prevalence and well evidenced links with other chronic diseases, diabetes has also been included as a future priority.

The diagram below details the specific diseases and whether they contribute to the fatal, non-fatal burden or both:



It is expected that the THS as provider will prioritise activity and services related to these conditions. The strategic plans associated with the Models of Care (MoC) relating to these conditions and how the THS will provide adequate levels of care for these conditions should be detailed in the THS Corporate Plan.

#### Elective Surgery

The Elective Surgery Reform Strategy, developed in June 2015, is aimed at the targeted use of Tasmanian Health Assistance Package (THAP) funding to reduce the problem of long waiting patients, while using Rebuilding Health Services (RHS) funding to invest in strengthening capacity and improved scheduling and treat in turn performance for patients who have not waited so long. The use of both time limited funding sources intelligently and in parallel will allow both long waits and waiting times for newer patients to be managed downwards, towards clinically appropriate waiting times that can be managed into the future.

Phases 1 and 2 of the Strategy (2015-16 and 2016-17) have delivered significant reductions in the number of patients waiting longer than the recommended time for their surgery and performance improvements in KPIs relating to longest waiting patients (maximum wait times and the average number of overdue days). However, with the cessation of THAP funding in 2016-17, it is essential that alongside those improvements, the THS continues to use RHS and baseline funding to maximise reductions in long duration waits, and to improve the proportion of patients treated in turn as per the AIHW and Royal Australasian College of Surgeons “National definitions for elective surgery urgency categories”.

Phase 3 of the Strategy (2017-18) will maintain a concurrent focus on:

- the purchase of approximately 16 200 elective surgery admissions (an average of 1 350 per month) in order to maintain an acceptable baseline level of activity and a stable and sustainable waiting list;
- continued reductions to the number of patients waiting the longest and continued performance improvements in KPIs relating to longest waiting patients;
- improvements in treat in turn rates in line with the National definition.

The targets established in the 2017-18 service agreement for the above KPIs are consistent with those outlined in the Strategy for achievement by June 2018.

In addition to the above, in 2017-18 the Department will work with the THS to progress the development of an elective surgery purchasing model based on the case mix within the waiting list.

## **Additional Government Priorities**

The priorities articulated below are derived from existing government priorities as stated in the White Paper, announcements and initiatives.

### **Pain Management and Rheumatology Services**

By 30 June 2018 the THS will have established Level 4 Pain Management and Rheumatology services in the North West of the State.

### **Injuries – Suicide Reduction**

By 30 June 2018, ensure that a minimum of 90% of patients who have attempted suicide, are referred for follow up by contracted community sector organisations or public mental health services within 48 hours of discharge from the public acute hospital (either Emergency Department or inpatient setting).

This will be monitored each quarter by auditing patient records in the acute public hospitals.

### **Injuries – Trauma**

\$165 000 is provided for the development of Trauma related capacity along the full continuum of care from retrieval through to and including rehabilitation post discharge. This funding is to be used at the discretion of the Statewide Trauma Service to build capacity to improve care for trauma patients across the State and across all clinical disciplines that provide care to Trauma patients.

A plan for the use of the funds will be developed by the Statewide Trauma Service, endorsed by the THS Executive and provided to the Secretary DHHS within thirty (30) days of signing this agreement. The plan must be made for attention the Deputy Secretary Planning, Purchasing and Performance.

Apart from implementation details and how the funding will be used, the plan should also include how the Statewide Trauma Service expects to demonstrate progress to the Department.

On approval of the plan by the Department, the funds will be released to the THS.

During the course of the term of this Agreement, the Department reserves the right to request periodic updates on progress.

It is expected that a second tranche of funding be made available for the 2018/19 financial year. This will be contingent upon the Department being satisfied that adequate progress has been made by the Statewide Trauma Service in building capacity across all disciplines along the full continuum of care for Trauma patients.

### **Patients First**

As part of the One State, One Health System, Better Outcomes plan, the Tasmanian Government is taking action to manage demand in Emergency Departments and to improve whole-of-hospital patient flow.

Stage 1 of the Patients First initiative, announced in April 2016, included 18 specific actions aimed at improving patient flow issues across the Launceston General Hospital (LGH) and the Royal Hobart Hospital (RHH). The areas of focus include timely movement of patients to the right place at the right time, staff training and recruitment, developing a state-wide clinical handover framework, better supporting long stay patients, use of rural facilities, and more efficient discharge.

In recognition of continuing demand pressures in Emergency Departments state-wide, Stage 2 of the Patients First initiative, announced in February 2017, includes a number of recurrent bed openings across the State to further improve whole-of-hospital patient flow. These bed openings and associated activity are reflected in the Funding Allocation and Activity Schedules provided at Part G of this Agreement

The Department will continue to provide routine reporting to the Minister for Health, outlining:

- the impact of Stage 1 and 2 initiatives on performance against existing patient flow Key Performance Indicators as established in the 2016-17 Service Agreement;
- additional performance indicators, targeted at the measurement of specific outcomes under Stage 2 initiatives, and
- status updates on THS implementation of all actions announced under Stages 1 and 2.

### **Sector Purchasing**

It is expected that the THS as provider will support the ongoing updating and expansion of the Tasmanian Role Delineation Framework by providing timely and reasonable access to clinical and strategic executive input. The Department is willing to work with the THS to expand alternative models of care delivery that shift the locus of care from the acute setting to the community / primary care sectors.

## **Joint DHHS/THS Priorities**

### **THS cost structures**

Internal THS budgets are currently allocated at cost centre level and are based on historical allocations. A project will be undertaken to analyse underlying patient episode cost structures and the expenditure and budget allocation associated with each cost centre and identify any misalignment. This will inform the development of future internal budget allocations, facilitate further analysis of the potential to deliver efficiencies and assist in the identification of cost drivers underpinning the overall THS funding allocation.

### **Revenue**

The THS generates revenue from a range of sources, including national ABF, Private Practice Scheme Patients, DVA and Compensable Patients. A project will be undertaken to analyse revenue generating activities and identify opportunities to improve/strengthen revenue capture.

### **Readiness for the National Pricing for Safety and Quality Framework**

During 2017-18, the Department and the THS will work together to:

- improve the data quality and linkages between coded data and self-reported datasets so that accurate reporting of data for pricing for safety and quality can occur;
- incorporate risk adjustment processes developed by the Independent Hospital Pricing Authority (IHPA) and data cleansing prior to reporting jurisdictional data, and
- develop appropriate business processes for reporting and validating data.

### **Outpatient data review**

The THS collects data on outpatients and outpatient clinics across the state. A project will be undertaken to improve/strengthen data capture to provide better evidence for the planning and provision of outpatient services. This will inform the development of any future key performance indicators.



## Part F: Key Performance Indicators

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

KPIs have been grouped under a number of quality dimensions to better organise information and thinking around the complexity of health services delivery. The dimensions include:

- **Acceptability** – health services are respectful and responsive to user needs, preferences and expectations.
- **Accessibility** – health services are obtained in the most suitable setting in a reasonable time and distance.
- **Effectiveness** – health services are provided based on scientific knowledge to achieve desired outcomes.
- **Efficiency** – resources are optimally used in achieving desired outcomes.
- **Safety** - mitigate risks to avoid unintended or harmful results.

### 2017-18 Key Performance Indicator Schedule

| Performance Domain | KPI No.     | KPI Name   | KPI Target   |
|--------------------|-------------|--|--|
| Acceptability      | <b>AC1</b>  | Consumer experience - % of clients surveyed  | To be included in 2017-18 dependent on ACSQHC core common questions        |
|                    | <b>AC2</b>  | Consumer experience – discharge planning   |  |
| Accessibility      | <b>ACC1</b> | Percentage of Triage I emergency department presentations seen within recommended time         | 100%<br>(all specified facilities)   |
|                    | <b>ACC2</b> | Percentage of all emergency department presentations seen within recommended time              | 80%<br>(all specified facilities)  |
|                    | <b>ACC3</b> | Percentage of all emergency department presentations who do not wait to be seen                | ≤5%<br>(all specified facilities)  |
|                    | <b>ACC4</b> | Percentage of all emergency patients with an ED length of stay less than four hours            | 80%<br>(all specified facilities)  |
|                    | <b>ACC5</b> | Percentage of patients admitted through the ED with an ED length of stay less than eight hours | 90%<br>(all specified facilities)  |
|                    | <b>ACC6</b> | Percentage of all ED patients with an ED length of stay less than 24 hours                     | 100%<br>(all specified facilities)   |
|                    | <b>ACC7</b> | Elective Surgery – Category I treat in turn rates  | Sep 17: 60%<br>Dec 17: 60%<br>Mar 18: 60%<br>Jun 18: 60%<br>(State-wide)   |
|                    | <b>ACC8</b> | Elective Surgery – Category I admitted within the recommended time                             | Sep 17: 90%<br>Dec 17: 95%<br>Mar 18: 100%<br>Jun 18: 100%<br>(State-wide) |
|                    | <b>ACC9</b> | Elective Surgery – Category I maximum overdue days   | Sep 17: 40<br>Dec 17: 40<br>Mar 18: 5<br>Jun 18: 5<br>(State-wide)         |

| Performance Domain | KPI No.      | KPI Name   | KPI Target  |
|--------------------|--------------|--|---|
|                    | <b>ACC10</b> | Elective Surgery – Category 2 treat in turn rates  | Sep 17: 60%<br>Dec 17: 60%<br>Mar 18: 60%<br>Jun 18: 60%<br>(State-wide)          |
|                    | <b>ACC11</b> | Elective Surgery – Category 2 admitted within the recommended time   | Sep 17: 80%<br>Dec 17: 80%<br>Mar 18: 90%<br>Jun 18: 95%<br>(State-wide)          |
|                    | <b>ACC12</b> | Elective Surgery – Category 2 maximum overdue days   | Sep 17: 125<br>Dec 17: 115<br>Mar 18: 110<br>Jun 18: 100<br>(State-wide)          |
|                    | <b>ACC13</b> | Elective Surgery – Category 3 treat in turn rates  | Sep 17: 60%<br>Dec 17: 60%<br>Mar 18: 60%<br>Jun 18: 60%<br>(State-wide)          |
|                    | <b>ACC14</b> | Elective Surgery – Category 3 admitted within the recommended time   | Sep 17: 80%<br>Dec 17: 85%<br>Mar 18: 90%<br>Jun 18: 95%<br>(State-wide)          |
|                    | <b>ACC15</b> | Elective Surgery – Category 3 maximum overdue days   | Sep 17: 400<br>Dec 17: 400<br>Mar 18: 400<br>Jun 18: 400<br>(State-wide)          |
|                    | <b>ACC16</b> | Percentage of all Aged Care Assessment Team (ACAT) clients, with a First Clinical Intervention within the allocated priority timeframe in all settings | 90%<br>(State-wide)   |
|                    | <b>ACC17</b> | Proportion of 'Emergency' clients managed on the same day that they are triaged (Oral Health)  | 80%<br>(State-wide)   |
|                    | <b>ACC18</b> | Percentage of clients assessed within 28 days of screening mammogram   | >90%<br>(State-wide)  |
|                    | <b>ACC19</b> | Eligible women screened for breast cancer  | Number of women screened YTD is more than same time two years ago<br>(State-wide) |
| Effectiveness      | <b>EF1</b>   | 28 Day re-admission rate (Mental Health)   | ≤14%<br>(State-wide)  |
|                    | <b>EF2</b>   | Acute 7 day post discharge community care (Mental Health)  | 85%<br>(State-wide)   |
|                    | <b>EF3</b>   | 28 Day Readmission Rate – all patients (excludes mental health patients)   | <5%<br>(State-wide)   |

|            |             |  |  |
|------------|-------------|--|--|
| Efficiency | <b>EFF1</b> | Admitted patient episode coding (clinical coding) including contracted care - timeliness   | 100% within 42 days of separation<br>(State-wide)                              |
|            | <b>EFF2</b> | Admitted patient episode coding (clinical coding) including contracted care - accuracy   | 100% within 30 days of advice of error from the Department<br>(State-wide)     |
|            | <b>EFF3</b> | Ambulance offload delay - 15 minutes   | 85% within 15 mins (all specified facilities)                                  |
|            | <b>EFF4</b> | Ambulance offload delay - 30 minutes   | 100% within 30 mins (all specified facilities)                                 |
|            | <b>EFF5</b> | Hospital initiated postponements (HIPs)  | Sep 17: 12.0%<br>Dec 17: 11.4%<br>Mar 18: 10.7%<br>Jun 18: 10%<br>(State-wide) |
| Safety     | <b>SAF1</b> | Hand Hygiene compliance  | 80%<br>(all specified facilities)  |
|            | <b>SAF2</b> | Healthcare associated staphylococcus aureus (including MRSA) bacteraemia infection rate  | ≤2.0 per 10 000 patient days<br>(all specified facilities)                     |
|            | <b>SAF3</b> | Seclusion rates  | ≤8 per 1 000 patient days<br>(State-wide)                                      |
|            | <b>SAF4</b> | Percentage of discharge summaries transmitted within 48 hours of separation  | 100%<br>(State-wide)   |
|            | <b>SAF5</b> | Percentage of Initial Reportable Event Briefs sent to the Department's Clinical Governance Officer within the Ministerial policy on Safety Event Management              | 80%<br>(State-wide)  |
|            | <b>SAF6</b> | Percentage of Reportable Event Brief Investigation Reports sent to the Department's Clinical Governance Officer within the Ministerial policy on Safety Event Management | 80%<br>(State-wide)  |
| Activity   | <b>ACT1</b> | National Weighted Activity Units (NWAUs)   | 142 543<br>(State-wide)  |
|            | <b>ACT2</b> | Elective surgery admissions  | 16 200<br>(State-wide)   |
|            | <b>ACT3</b> | Dental Weighted Activity Units (DWAUs)   | 59 980<br>(State-wide)   |
| Finance    | <b>FIN1</b> | Variation from funding - full year projected   | Expenditure within funding allocation<br>(State-wide)                          |

## **Part G: Funding Allocation and Activity Schedules**

The Tasmanian Funding Model translates the type and volume of activity the Department wishes to purchase into a funding allocation to the THS. The Model allocates funding to the THS based on the activity and services to be provided. It informs the Department's planning and purchasing functions regarding the affordable activity configuration within approved funding allocations.

The Model, separates ABF allocations into four work streams i.e. acute inpatients, sub-acute and non-acute inpatients, emergency department, and outpatients. It allows funding for non-Activity Based Funding (ABF) services and activity through block grants. The model combines the ABF and non-ABF elements to identify a single total recommended funding allocation for the THS.

Details of the funding and pricing framework used are contained in Appendix 2.

Funding of \$1.236 billion is provided by the Australian and Tasmanian State Governments and is based on the budgeted sources of funding as detailed in the 2017-18 State Budget Papers, with some adjustments to reflect updated Commonwealth revenue estimates. The THS provides additional services which are funded through self-generated revenue which is estimated to be \$193.8 million in 2017-18.

## 2017-18 Activity and Funding Schedule

| Tasmanian Health Service  | Measure      | Activity       | Funding: (\$'000) |
|---|--------------|----------------|-------------------|
| <b>Activity Funding</b>   |              |                |                   |
| Inpatients (Excl Elective Surgery)                              | NWAU         | 75,531         | 370,855           |
| Inpatients Elective Surgery                                     | NWAU         | 17,443         | 85,643            |
| Inpatients RHST Elective Surgery                                | NWAU         | 4,073          | 20,000            |
| Inpatients Mental Health  | NWAU         | 6,817          | 33,473            |
| Emergency Department  | NWAU         | 15,764         | 77,400            |
| Outpatients - Non Admitted Patients                             | NWAU         | 16,792         | 82,447            |
| Sub & Non-Acute Inpatients                                      | NWAU         | 6,124          | 30,068            |
| <b>Total Activity Funding</b>                                   |              | <b>142,543</b> | <b>699,886</b>    |
| <b>Block Grants for Activity Based Funded Hospitals</b>         |              |                |                   |
| Sub & Non-Acute Inpatients Supplementation <sup>1</sup>         | Block Funded |                | 13,647            |
| Teaching, Training and Research Grant                           | Block Funded |                | 37,310            |
| Blood Products  | Block Funded |                | 7,897             |
| Interstate Charging   | Block Funded |                | 20,000            |
| North West Cancer Centre  | Block Funded |                | 5,886             |
| Nurse Graduates - Additional Transition to Practice             | Block Funded |                | 2,610             |
| PTS BC Enhancing Retrieval and Referral Services                | Block Funded |                | 269               |
| Organ Donor   | Block Funded |                | 146               |
| Boarders  | Block Funded |                | 216               |
| Non-activity Based Services <sup>2</sup>                        | Block Funded |                | 49,794            |
| Transition Grant  | Block Funded |                | 37,914            |
| <b>Total Block grants for Activity Based Funded Hospitals</b>   |              |                | <b>175,689</b>    |
| <b>THS Operational Grants</b>                                   |              |                |                   |
| Mersey Community Hospital                                       | Grant        |                | 78,140            |
| Primary Health  | Grant        |                | 127,102           |
| Mental Health (Excl Mental Health Inpatient Services)           | Grant        |                | 68,113            |
| Alcohol and Drug Services                                       | Grant        |                | 15,086            |
| Oral Health   | Grant        |                | 25,739            |
| Forensic Medical Service  | Grant        |                | 1,478             |
| Cancer Screening and Control                                    | Grant        |                | 7,097             |
| Organ Donation Promotion  | Grant        |                | 1,374             |
| Patient Transport Assistance Scheme (PTAS) <sup>3</sup>         | Grant        |                | 8,684             |
| One THS   | Grant        |                | 7,500             |
| Equipment Replacement <sup>4</sup>                              | Grant        |                | 7,500             |
| Child Health and Parenting Service                              | Grant        |                | 12,004            |
| Medical Cannabis Controlled Access Scheme - Paediatric Epilepsy | Grant        |                | 990               |
| <b>Total Operational Grants</b>                                 |              |                | <b>360,805</b>    |
| <b>TOTAL Tasmanian Health Service</b>                           |              |                | <b>1,236,381</b>  |

### Notes:

<sup>1</sup> Supplementation provided in recognition that the cost for the THS to deliver Sub & Non-Acute services is higher than the NEP

<sup>2</sup> Block funding for Non-activity based services, see table 'Non-activity Based Services' for breakdown.

<sup>3</sup> PTAS includes funding for both service delivery and administration.

<sup>4</sup> Replacement cost for plant and equipment items with a value over \$10 000. These replacement costs are not included in the activity NWAU funding.

## Funding Sources

The four main funding sources contributing to the THS Service Agreement funding are:

- State Funding
- Australian Government funding
- THS Retained Revenue
- Pharmaceutical Benefits Scheme

The funding source table displays the funding available to the THS.

| Funding Source                                    | Funding (\$'000) |
|---|------------------|
| Revenue from the Tasmanian Government             |                  |
| Activity and Block Funding <sup>1</sup>           | 725,873          |
| Mersey Community Hospital Funding                 | 78,140           |
| Total Revenue from the Tasmanian Government       | 804,013          |
| Revenue from the Australian Government            |                  |
| Activity Based Funding <sup>2</sup>               | 332,621          |
| Block Funding <sup>3</sup>                        | 61,739           |
| National Partnership Funding                      | 4,223            |
| Commonwealth Own Purpose Expenditure              | 33,785           |
| Total Revenue from the Australian Government      | 432,368          |
| Total Tasmanian and Australian Government Revenue | 1,236,381        |
| Other Source of Revenue                           |                  |
| THS Own Source <sup>4</sup>                       | 150,307          |
| Pharmaceutical Benefits Scheme                    | 43,549           |
| Total Other Source of Revenue                     | 193,855          |
| Total Funding                                     | 1,430,236        |

### Notes:

<sup>1</sup> The 2017-18 Budget Papers included a provision of \$20 million within Finance General for a range of health initiatives to be delivered by the THS. These are the Statewide Operations and Command Centre (\$1.5 million), the Launceston General Hospital Ward 4D Boost (\$2.14 Million), Royal Hobart Hospital Repatriation Hospital Support Package \$11.36 million and the John L. Grove Rehabilitation Centre (\$5 million). The Activity and Block Funding Component of the Revenue from the Tasmanian Government includes the \$5 million for the John L. Grove Rehabilitation Centre. The remainder of the initiatives funded through Finance General will be included via an amendment to the 2017-18 Service Agreement during the course of the year in accordance with section 44 of Tasmanian Health Organisations Act 2011. The Activity and Block Funding Component of the Revenue from the Tasmanian Government excludes the \$5.4million for the Purchaser's Reserve.

<sup>2</sup> The Australian Government ABF revenue has been adjusted to reflect the NWAU volumes that have been purchased in the 2017-18 service agreement.

<sup>3</sup> Funding adjusted to reflect a revised amount provided by the Australian Government.

<sup>4</sup> THS own source revenue differs from the budget papers. It is a projection based on actual revenue flows with adjustments for inflation and other known changes. It includes an additional \$1.4 million which is a target for the THS to generate additional own source revenue in 2017-18.



## Tasmanian Health Service Budget Commitments

| Budget Commitments  | Funding (\$'000) |
|---|------------------|
| <b>Block Funded</b>   |                  |
| John L Grove  | 5,000            |
| Patients First Roy Fagan 10 x Beds                              | 2,500            |
| Patients First New Norfolk 7 x Beds                             | 430              |
| Medical Cannabis Controlled Access Scheme - Paediatric Epilepsy | 990              |
| Frontline Staff Costs   | 3,600            |
| <b>Total Block Funded</b>                                       | <b>12,520</b>    |
| <b>Activity Based Funding</b>                                   |                  |
| Patients First LGH Ward 4D 12 x Beds                            | 4,200            |
| Patients First LGH 3 x Isolation Beds                           | 2,600            |
| Patients First RHH 2 x ICU Beds                                 | 3,600            |
| Patients First Hobart Private 8 x Beds                          | 1,770            |
| Patients First NWRH 4 x Short Stay Beds                         | 1,600            |
| Patients First NWRH 4 x Surgical Beds                           | 1,400            |
| <b>Total Activity Based Funding</b>                             | <b>15,170</b>    |
| <b>Total Budget Commitments <sup>1</sup></b>                    | <b>27,690</b>    |

### Notes:

<sup>1</sup> Excludes funding initiatives allocated within Finance-General section of the budget papers except for John L Grove funding of \$5 million.

## Non-Activity Based Funded Activity

| Non-activity Based Services  | Funding (\$'000) |
|--|------------------|
| Other Non Activity Based Funding   | 19,043           |
| Community Based Services Operated from the Major Hospitals               | 13,201           |
| Pathology, Pharmacy, & Imaging services unable to be matched to activity | 5,465            |
| Rural Hospital Costs Incurred by Major Hospitals                         | 4,809            |
| Special Investigations Unit RHH  | 2,730            |
| Sexual health services RHH   | 2,199            |
| Forensic Pathology RHH   | 1,818            |
| Community Equipment scheme   | 529              |
| <b>Total Non-activity Based Services</b>                                 | <b>49,794</b>    |

## 2017-18 NWAU estimates

As part of the National Health Reform Agreement, States and Territories are required to include in Services Agreements the anticipated level of National Weighted Activity Units (NWAUs) to be produced by Local Hospital Networks (the THS in the case of Tasmania).

The NWAU is a measure of Health Service activity expressed as a common unit, against which the National Efficient Price (NEP) is paid by the Australian Government. It provides a way of comparing and valuing each public hospital service, whether they are admissions, emergency department presentations or outpatient episodes, weighted for clinical complexity and cost.

### NWAU Estimates

| Annual NWAU Estimate 2017-18 |                                       |                        |                      |           |              |         |
|------------------------------|---------------------------------------|------------------------|----------------------|-----------|--------------|---------|
| Tasmanian Health Service:    | Acute Admitted Incl. Elective Surgery | Admitted Mental Health | Sub-acute (admitted) | Emergency | Non-admitted | Total   |
| NWAU Total                   | 97,047                                | 6,817                  | 6,124                | 15,764    | 16,792       | 142,543 |



# Appendix I.

## Mental Health Services

### Mental Health Reform

In Australia, there has been major mental health reform in the last 30 or more years. This has mainly focused on the shift from institutional to community care, use of services provided by non-government organisations, recognition of mental health as equal to physical health, and efforts to support person-centred recovery.<sup>1</sup>

In Tasmania over the last 20 years there has been a greater focus on support and care in the community and an increasing role for community sector organisations. This has included strengthening of community based mental health teams across the state and across the life span, development of new residential, rehabilitation and psycho-social mental health services, and more recently a growth in programs that have a mental health promotion and prevention focus.

Currently there are three key reforms relevant to the Tasmanian mental health service system; the Tasmanian Government's mental health reform as outlined in the *Rethink Mental Health Plan 2015-2025*, the rollout of the National Disability Insurance Scheme (NDIS) in Tasmania and the Australian Government's mental health reforms focussed on primary mental health care and building on the role of Primary Health Networks – Primary Health Tasmania and including the development of a fifth national mental health plan.

The fifth national mental health plan is currently being developed. The overarching focus of the plan will be to improve both system and service level integration at the regional level. Improvements in integration will lead to people with mental illness, their carers and communities, experiencing higher quality, seamless care, and a more efficient use of mental health resources.

The fifth national mental health plan will not replace state and territory plans. It looks to complement them to facilitate Commonwealth and jurisdictions working together to achieve common goals.

In October 2015, the Tasmanian Government released the *Rethink Mental Health Plan 2015-2025*. This is the Government's ten year plan to deliver a co-ordinated and integrated mental health system and to improve the mental health and wellbeing of Tasmanians.

The Rethink Mental Health Plan brings together promotion of positive mental health, prevention of mental ill-health and care and supports for people with mental illness into one strategic framework. It sets a reform agenda to improve the mental health and wellbeing of Tasmanians and outlines ten key directions for reform:

1. Empowering Tasmanians to maximise their mental health and wellbeing
2. A greater emphasis on promotion of positive mental health, prevention of mental health problems and early intervention
3. Reducing stigma
4. An integrated Tasmanian mental health system
5. Shifting the focus from hospital based care to support in the community

<sup>1</sup> The review of policy documents and related literature – informing the development of Tasmania's long-term plan for mental health, The University of Melbourne and The University of Queensland, August 2014.

6. Getting in early and improving timely access to support (early in life and early in illness)
7. Responding to the needs of specific population groups
8. Improving quality and safety
9. Supporting and developing our workforce
10. Monitoring and evaluating our action to improve mental health and wellbeing

The rollout of these reforms may necessitate a revision of the Service Agreement components relevant to the delivery of mental health services through the THS.

### **Services to be delivered**

The THS will deliver specialist mental health treatment services. Specific services to be provided:

- Acute inpatient and hospital based services (including outpatient services) provided at the Royal Hobart Hospital, Launceston General Hospital and North West Regional Hospital:
- Inpatient and extended treatment services providing state-wide service capacity:
- State-wide Triage Telephone Service
- Community based services
- Other services:
  - Huntington's Disease Services
  - Consultation and Liaison

## **Forensic Mental Health Services**

### **Services to be delivered**

Forensic Mental Health Services (FMHS) is a specialist area of the mental health field providing highly specialised interventions and clinical activities through community and inpatient mental health care for people generally aged 18 years and over experiencing a mental health disorder. These clients are involved with or at risk of becoming involved with the criminal justice system and in some extremely high risk cases, the service may also manage civil mental health patients. Services are delivered state-wide and in the following streams. Operation of inpatient services is determined by the requirements of the *Mental Health Act 2013*:

- Inpatient Forensic Mental Health Services providing state-wide service capacity
- Community Forensic Mental Health Services

## **Alcohol and Drug Services**

### **Alcohol and Drug Service Reform**

A new Tasmanian AOD Service System Framework is being developed by DHHS (through the Mental Health, Alcohol and Drug Directorate) in partnership with the Tasmanian Health Service, Primary Health Tasmania (PHT) and the Alcohol, Tobacco and Other Drugs Council and in consultation with key stakeholders. It will identify strategies and actions to build an integrated and seamless AOD service system in Tasmania.

The completion of this work and development of the final Framework may necessitate a revision of the Service Agreement components relevant to the delivery of alcohol and drug services through the THS.

### **Services to be delivered**

The THS will deliver, through the Alcohol and Drug Service (ADS) a range of specialist treatment services targeted at Tasmanian's who are affected by alcohol, tobacco and other drug use. These services are delivered on a state-wide basis.

Specific treatment services to be provided will include:

- Consultation Liaison Services
- Opioid Pharmacotherapy
- Psychosocial Intervention
- Smoking Cessation
- Withdrawal Management

## **Correctional Primary Health Services**

### **Services to be delivered**

Correctional Primary Health Services (CPHS) provides primary health care and treatment and specialist referral for men and women held within the Tasmanian Prison Services.

Health services provided include: emergency care, general health assessments, medical officer consultations, diagnosis and treatment, specialist psychiatric consultations and treatment, mental, emotional, suicide and self-harm assessments, drug and alcohol assessments, treatment and referral; opioid substitution, health promotion, inpatient care with six beds for primary health care and observation and outpatient nursing clinics. In addition to this dental services are provided by Oral Health Services Tasmania and physiotherapy and optometry services are also available.

These services are provided across a range of correctional facilities:

- Risdon Prison Complex
- Ron Barwick Minimum Security Prison
- Mary Hutchinson Women's Prison

Hobart and Launceston Remand Centres which are transitional centres aimed at managing the flow of prisoners entering into the prison system through the courts and are intended as short term management facilities.

Tasmanian Prison Services (operated by the Department of Justice) is responsible for the management of the Prison facilities, as outlined above, and as such retains ultimate control over prisoner/detainees access to health services.

Primary health care and treatment services are also delivered to Ashley Youth Detention Centre which is managed by Children and Youth Services. CPHS is responsible for the provision of healthcare to detainees within this centre.

## **Oral Health Services**

### **Services to be delivered**

The THS will deliver the following specific oral health services through Oral Health Services Tasmania (OHST):

- Episodic dental services for adults
- General dental services for adults
- Prosthetics dental services
- Child and adolescent dental services
- Clinical placement program
- Admitted day surgery dental services
- Special care dental services
- Health promotion and community education

The delivery of oral health services in Tasmania is partially supported through Commonwealth funding via a National Partnership Agreement.

## **Cancer Screening and Control Services**

### **Services to be delivered**

Cancer Screening & Control Services (CS&CS) comprises four work areas: Breast Screen Tasmania (BST), the Cervical Cancer Prevention Program (CCPP) and Tasmanian Cervical Screening Register (TCSR), the Recruitment and Community Engagement Unit (RACE), the Tasmanian elements of the National Bowel Cancer Screening Program (NBCSP); and the Cancer Screening and Control Services' Directorate which is responsible for the support, executive management and oversight of the screening programs and cancer control interventions.

- Breast Screen Tasmania
- The Tasmanian Cervical Screening Register
- The CS&CS Recruitment and Community Engagement Unit
- The Tasmanian component of the National Bowel Cancer Screening Program (NBCSP)

BreastScreen Tasmania and the Tasmanian Cervical Cancer Prevention Program are joint Commonwealth, State and Territory programs partially funded through the National Healthcare Agreement. Cancer Screening and Control Services is also supported by Commonwealth NPA Specified Projects – Schedule D – National Bowel Cancer Screening Program Participant Follow-Up Function and the Project Agreement for the Expansion of the BreastScreen Australia Program, and from the McGrath Foundation for Breast Care nursing.

## **Child Health and Parenting Service**

### **Services to be delivered**

The Child Health and Parenting Service (CHaPS) operates under a state-wide basis delivering community-based child health services for children 0 – 5 years and their families. CHaPS also offer an enuresis intervention clinic to school aged children.

CHaPS aims to ensure that their services are:

- Appropriate to the family needs
- Prioritised according to need and
- Provided in the most appropriate setting for the family

CHaPS deliver services to the community from child health centres, child and family centres and home visits where appropriate. Centres are located in sites across the state. Some are co-located with other services (education/health) and others are single service CHaPS sites.

Specific services include:

- Growth and Developmental screening and surveillance
- Feeding assessment and support
- Wetaway Program
- A limited child development service in the North West of the State

Parental support related to:

- Sleep and settling
- Parent-infant/child interaction
- Perinatal wellbeing (from a universal platform)
- Developmentally appropriate parenting and behaviour management strategies
- Parenting advice and information
- Referrals to other health professionals where indicated

Community development related to:

- Strong Families, Safe Kids
- Early Intervention initiatives and promoting links with other services in a whole of government approach to supporting families
- Representing Tasmania at national and regional forums (e.g. National Council of Community Child Health, Australasian Child Health and Parenting Association)

## Primary Health Services

### Services to be delivered

The THS will deliver primary health services. These include a range of health promotion, early intervention, care and assessment, inpatient and outpatient treatment, residential aged care<sup>1</sup> and community health services to individuals, groups and communities across Tasmania. Services may be targeted to the general population or to particular age groups (such as aged persons or young people)<sup>2</sup>. Other services are provided for specific health conditions (such as dementia or palliative care or people with chronic diseases).

Services to be provided include:

### THS sub-acute inpatient care at the following locations:<sup>3</sup>

- Midlands Multi-Purpose Health Centre
- New Norfolk District Hospital
- Smithton District Hospital
- King Island Hospital and Community Health Centre
- West Coast District Hospital
- St Mary's Community Health Centre
- Deloraine District Hospital<sup>3</sup>
- Flinders Island Multi-Purpose Centre<sup>4</sup>
- North East Soldiers Memorial Hospital (Scottsdale)<sup>4</sup>
- Beaconsfield District Health Service
- George Town Hospital and Community Health Centre<sup>4</sup>
- St Helens District Hospital and Community Centre<sup>4</sup>

- Campbell Town Health and Community<sup>4</sup>

**Funded sub-acute inpatient care at the following locations:**

- Toosey Aged and Community Care
- Swansea Community Health Centre
- Tasman MPS
- Huon Eldercare
- Esperance MPC

**Community health and community care services<sup>5</sup> are located at/provided from the following locations:<sup>6</sup>**

- Brighton Community Health Centre
- Bruny Island Community Health Centre
- Central Highlands Community Health Centre
- Clarence Plains Community Health Centre
- Cygnet Community Health Centre
- Glenorchy Community Health Centre
- Huonville Community Health Centre
- New Norfolk Community Centre
- Risdon Vale Community Health Centre
- Sorell Community Health Centre
- Spring Bay Community and Health Centre
- Swansea Community Health Centre
- Kingston Community Health Centre
- Launceston Community Health Centre
- Ravenswood Community Health Centre
- Westbury Community Health Centre
- St Marys Community Health Centre
- Devonport Community Health Centre
- Central Coast Community Health Centre
- Burnie Community Health Centre
- James Muir Community Health Centre
- West Coast Community Health Services

**Residential aged care services at the following locations:<sup>7</sup>**

- Beaconsfield District Health Service
- Campbell Town Multi-Purpose Health Service
- Midlands Multi-Purpose Health Centre
- West Coast District Hospital
- Flinders Island Multi-Purpose Centre
- King Island Hospital and Community Centre

**Adult Day Centres at the following locations:<sup>8</sup>**

- Beaconsfield District Health Service
- Westbury Community Health Centre
- Campbell Town Health Service
- Latrobe
- King Island MPC
- HealthWest (Queenstown, Rosebery)

- Wynyard
- Ulverstone

**Integrated Care Centres (ICCs) at the following locations:**

- Clarence ICC, Rosny
- Northern Integrated Care Service (NICS), Launceston

**State-wide Primary Health services**

- Contracted medical services
- Health Promotion services
- Youth Health services
- Palliative Care Services
- Community Options Services (COS)
- Home Care services
- TasEquip (Community Equipment Scheme)
- State-wide Orthotic and Prosthetic Service Tasmania (OPST)
- Aged Care Assessment Teams (ACATs)<sup>9</sup>

**Regional Primary Health services**

- Community Dementia Service North
- Dementia Support Service NW
- Community Rehabilitation Unit (CRU) South
- Neurological Support Service (Parkinson's) South

**Notes:**

- 1 Residential aged care services in these facilities are funded by the Commonwealth through a variety of site-specific agreements, including those that use the multi-purpose service model.
- 2 The THS is a service provider under the Tasmanian Home and Community Care (HACC) Program. The THS delivers HACC services in accordance with the Program Requirements provided by the Department to the THS.
- 3 A mix of community health and care services is also offered from these sites.
- 4 Denotes a partnership with UTAS as teaching site.
- 5 Including but not limited to: Community health nursing which includes but is not limited to clinics, diabetes consultancy, continence consultancy, wound management and personal care via health care assistants and community allied health services which include but are not limited to physiotherapy, occupational therapy, speech pathology, psychology, podiatry and community health social work and also include Allied Health Assistants in some settings and disciplines e.g. Foot Care Assistants in podiatry. Chronic disease programs and health prevention activities may also be available.
- 6 Not all services may be offered at all locations.
- 7 Residential aged care services in these facilities are funded by the Commonwealth through a variety of site-specific agreements, including those that use the multi-purpose service model.
- 8 Adult Day Centres cater for frail aged, socially isolated and younger disabled persons in the community. They provide group and individual lifestyle and leisure assessments and programs to maintain and enhance the quality of life for clients attending. Some Adult Day Centres are funded by the Commonwealth, including King Island and HealthWest.
- 9 Aged Care Assessment Teams are Commonwealth funded. The current agreement expires on 30 June 2018.

## Appendix 2 - Tasmanian Funding Model Parameters

The Tasmanian Funding Model has moved from funding activity using a Tasmanian Inlier Weighted Unit and a Tasmanian Price in 2016-17 to the National Weighted Activity Unit (NWAU) and National Efficient Price in 2017-18. The NWAU is based on the Independent Hospital Pricing Authority (IHPA) price and cost models for 2017-18. All ABF activity is priced at the National Efficient Price for 2017-18 (\$4,910) and the NWAU version for 2017-18 is NWAU17.

### 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 hospital activity for a given level of inputs through technical efficiency
- ensure 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 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
- provide incentives to support continuous improvement in patient safety and quality.

### Purchaser's Reserve

The Purchaser's Reserve will be allocated during the course of the 2017/18 financial year at the discretion of the DHHS (as Purchaser) in consultation with the THS (as Provider). The Reserve will be used for purposes such as, but not exclusively for, improvement initiatives, contingency funding or other services.

### Purchasing health services

Service agreements between the DHHS and THS are based on the Department's funding and purchasing models. In broad terms, the funding model determines the price at which the department purchases services from the THS, and the purchasing model determines the volume of services that are purchased. In terms of the funding model:

- There are three public hospitals funded through the Tasmanian ABF model. The Tasmanian ABF model is based largely on the national ABF model but includes some modifications to reflect the local Tasmanian environment. Note: Tasmanian public hospitals funded activity includes activity contracted to private hospitals.
- Twenty four public hospitals including Mersey Community Hospital are funded through block funding arrangements. This consists of one medium hospital, nineteen 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.
- The purchasing model determines the volume of services that the department agrees to purchase from the THS, as articulated through the service agreement. The volume of activity purchased is informed by projected demographic modelled data, health priorities identified in the Statement of Purchasers Intent (SOPI), white paper priorities, State Government commitments and known/forecasted service developments in negotiation with the THS.



## **Funding Model Categories**

The Tasmanian Funding Model funding categories are:

### **Activity Based Funding (ABF)**

In 2017-18, the Tasmanian Funding Model will fund the following hospital services on an activity basis:

- All admitted acute inpatient services including Elective Surgery and Mental Health
- Sub and non-acute admitted inpatients
- Non-admitted/Outpatient service events
- Emergency Department service events

### **Block Funding for ABF hospitals**

For services and initiatives provided by ABF hospitals where existing data does not accurately describe current activity, the service will be block funded. ABF hospital services to be block funded in 2017-18 are:

- Teaching, Training, and Research
- Blood Products
- Interstate Charging
- North West Cancer Centre
- Transition to Practice Nurses
- Enhancing Retrieval and Referral Services
- Organ Donor
- Boarders
- Patients First
- Non-hospital activity Based Services
- Transition Grant

### **Grant Funding**

In 2017-18, the following services will be provided with a funding grant:

- Mersey Community Hospital
- Primary Health Services (includes rural hospitals)
- Mental Health Services (excluding mental health inpatient services)
- Alcohol and Drug Services
- Oral Health Services, partly delivered with Commonwealth funding
- Forensic Medical Services
- Cancer Screening and Control, partly delivered with Commonwealth funding
- Patient Travel Assistance Scheme
- One THS
- Equipment Replacement
- Child Health and Parenting Service

## Inpatient Funding

The IHPA has determined the Australian Refined Diagnosis Related Group (AR-DRG) version 8.0 classification system will be used to classify and calculate price weights for inpatient services under the national ABF model which Tasmania has adopted.

Activity data at (AR-DRG) v8.0 level is used to set the 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 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. In this instance, the discharge care type of 'Acute including qualified newborn' is used.

Price weights are based on the Independent Hospital Pricing Authority (IHPA) 2017-18 price weights associated with AR-DRG version 8 for acute inpatient services. Where a separation meets the definition of activity data (above), its price weight is determined by its AR-DRG. Price weights Inpatients can be found at <https://www.ihipa.gov.au/sites/g/files/net636/f/nep.pdf> in Appendix H of the NEP determination 2017-18.

**Table 1 – Pricing for Inpatients**

| Stream    | Activity Measure | Classification | Price per Unit \$ |
|-----------|------------------|----------------|-------------------|
| Inpatient | NWAU             | AR-DRG v8.0    | 4,910             |

Where it is deemed the average price weight does not meet cost, adjustments are made to price weights. Adjustments are detailed below and applied in the following order:

1. Paediatric Adjustment; then
2. Specialist Psychiatric Age Adjustment; then
3. Patient Remoteness Area Adjustment; then
4. Indigenous Adjustment; then
5. Radiotherapy Adjustment; then
6. Dialysis Adjustment; then
7. Intensive Care Unit (ICU) Adjustment; then
8. Private Patient Service Adjustment; then
9. Private Patient Accommodation Adjustment; then
10. Multidisciplinary Clinic Adjustment; then
11. Emergency Care Age Adjustment

Circumstances in which adjustments are to be applied are described in **Table2**

**Table 2: Adjustments**

| Name  | Context  | Amount to be applied   |
|---|--|--|
| <b>Paediatric Adjustment</b>  | Is in respect of a person who:<br>(a) is aged up to and including 17 years; and<br>(b) is admitted to a <i>Specialised Children's Hospital</i> (Appendix E).   | Refer to column headed 'Paediatric Adjustment' in the tables of Admitted Acute Price Weights (Appendix H).                                   |
| <b>Specialist Psychiatric Age Adjustment</b><br>(≤ 17 years, in MDC 19 or 20)     | Is in respect of a person who is aged 17 years or less at the time of admission, with a mental health-related principal diagnosis (Major Diagnostic Category [MDC] 19 or 20) and has one or more Total Psychiatric Care Days recorded. | Admitted Acute Patient: 28 per cent<br>(except patients admitted to a <i>Specialised Children's Hospital</i> , who will receive 10 per cent) |
| <b>Specialist Psychiatric Age Adjustment</b><br>(≤ 17 years, not in MDC 19 or 20) | Is in respect of a person who is aged 17 years or less at the time of admission, with a principal diagnosis which is not mental health-related (not in MDC 19 or 20) and has one or more Total Psychiatric Care Days recorded.         | Admitted Acute Patient: 46 per cent<br>(except patients admitted to a <i>Specialised Children's Hospital</i> , who will receive 44 per cent) |
| <b>Specialist Psychiatric Age Adjustment</b><br>(> 17 years, not in MDC 19 or 20) | Is in respect of a person who is aged over 17 at the time of admission, with a principal diagnosis which is not mental health-related (not in MDC 19 or 20) and has one or more Total Psychiatric Care Days recorded.                  | Admitted Acute Patient: 32 per cent  |
| <b>Outer Regional Adjustment<sup>1</sup></b>                                      | Where an ABF Activity:<br>Is in respect of a person whose residential address is within an area that is classified as being <i>Outer Regional</i> .  | Admitted Acute or Admitted Subacute Patient: 8 per cent  |
| <b>Remote Area Adjustment<sup>1</sup></b>   | Is in respect of a person whose residential address is within an area that is classified as being <i>Remote</i> .  | Admitted Acute or Admitted Subacute Patient: 20 per cent   |
| <b>Very Remote Area Adjustment<sup>1</sup></b>                                    | Is in respect of a person whose residential address is within an area that is classified as being <i>Very Remote</i> .   | Admitted Acute or Admitted Subacute Patient: 25 per cent   |
| <b>Indigenous Adjustment</b>  | Is in respect of a person who identifies as being of Aboriginal and/or Torres Strait Islander origin.  | Admitted Acute, Admitted Subacute, Emergency Department, Emergency Service or Non-admitted Patient: 4 per cent                               |

| Name                                     | Context  | Amount to be applied  |
|--|--|---|
| Radiotherapy Adjustment                  | Is in respect of an Admitted Acute Patient with a specified ICD-10-AM 10 <sup>th</sup> edition radiotherapy procedure code recorded in their medical record. <sup>2</sup>  | Admitted Acute Patient: 27 per cent   |
| Dialysis Adjustment                      | Is in respect of an Admitted Acute Patient with a specified ICD-10-AM 10 <sup>th</sup> edition renal dialysis code who is not assigned to the AR-DRG L61Z Haemodialysis or AR-DRG L68Z Peritoneal Dialysis. <sup>2</sup> | Admitted Acute Patient: 25 per cent   |
| Intensive Care Unit (ICU) Adjustment     | (a) Is not represented by a newborn/neonate AR-DRG identified as 'Bundled ICU' in the tables of Price Weights (Appendix H); but<br>(b) Is in respect of a person who has spent time within a Specified ICU. <sup>3</sup> | 0.0427 NVAU(17)/hour spent by that person within the Specified ICU.   |
| Private Patient Service Adjustment       | Is in respect of an Eligible Admitted Private Patient.<br><br>Where an ABF Activity:   | Admitted Acute Patient: Refer to column headed 'Private Patient Service Adjustment' in the table of Price Weights at Appendix H.<br><br>Admitted Subacute Patient: Refer to Appendix F for applicable adjustment. |
| Private Patient Accommodation Adjustment | Is in respect of an Eligible Admitted Private Patient.   | Admitted Acute or Admitted Subacute Patient: Refer to Appendix F for applicable adjustment.   |
| Multidisciplinary Clinic Adjustment      | Is in respect of a non-admitted service event where three or more health care providers (each of a different speciality) are present, as identified using the non-admitted 'multiple health care provider indicator'.    | Non-admitted Patient: 55 per cent   |
| Emergency Care Age Adjustment            | Is in respect of an Emergency Department or Emergency Service patient, with the rate of adjustment dependent on the person's age.  | Emergency Department or Emergency Service Patient who is aged:<br>- 65 to 79 years: 14 per cent<br>- Over 79 years: 21 per cent   |

## Non-Admitted Patient Funding

The IHPA has determined the Tier 2 Non-Admitted Care Services version 4.1 classification system will be used to classify and calculate price weights for non-admitted services under the national ABF model which Tasmania has adopted.

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

- Public outpatient service events
- Private outpatient (Outside Referred Patient) service events
- 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 Type B procedures. These are non-admitted patients that THS has chosen to admit to record and enable categorization for statistical and clinical data purposes. These services are classified using AR-DRG version 8 which is mapped to a Tier 2 clinic for funding purposes.

Price weights for Tier2 Non-Admitted Care classification version 4.1 can be found at <https://www.iHPA.gov.au/sites/g/files/net636/f/nep.pdf> in Appendix K of the NEP determination 2017-18.

**Table 5 - Pricing for Non-Admitted Patients**

| Stream                | Activity Measure | Classification | Price per Unit \$ |
|-----------------------|------------------|----------------|-------------------|
| Non-Admitted Patients | NWAU             | Tier2 v4.1     | 4,910             |

## Emergency Department Patient Funding

The IHPA has determined the Emergency Department Classification System - Urgency Related Groups (URG) version 1.4 will be used to classify and calculate price weights for Emergency Department services under the national ABF model which Tasmania has adopted.

Price weights for Tier2 Non-Admitted Care classification version 4.1 can be found at <https://www.iHPA.gov.au/sites/g/files/net636/f/nep.pdf> in Appendix K of the NEP determination 2017-18.

**Table 6 - Pricing for Emergency Department Patients**

| Stream                        | Activity Measure | Classification | Price per Unit \$ |
|-------------------------------|------------------|----------------|-------------------|
| Emergency Department Patients | NWAU             | URG v 4.1      | 4,910             |

## Sub-acute and Non-acute Admitted Patients

In 2012, the Independent Hospital Pricing Authority (IHPA) determined the Australian National Sub-acute and Non-acute Patient (AN-SNAP) classification will be used to classify Sub-acute and non-acute patient services under the national ABF model. All jurisdictions are required to make steps toward introducing AN-SNAP (version 4). The THS has been transitioning to AN-SNAP since 1st July 2015. However, difficulties have been experienced in implementing AN-SNAP across the THS.

In recognition that the cost for the THS to deliver sub-acute services is higher than the NEP, the DHHS has applied a blended approach for sub-acute and non-acute in 2017-18 with \$30.06 million funded via ABF and a block supplementation grant of \$13.6 million. The Supplementation grant is based on historical costs and is the difference between the estimated cost in 2017-18 less the ABF funding amount.



Price weights for AN-SNAP 4 can be found at <https://www.ihsa.gov.au/sites/g/files/net636/f/nep.pdf> in Appendix I of the NEP determination 2017-18.

**Table 3 - Pricing for Sub-acute and Non-acute admitted patients.**

| Stream                  | Activity Measure | Classification | Price per Unit \$ |
|-------------------------|------------------|----------------|-------------------|
| Sub-Acute and Non-Acute | NWAU             | AN-SNAP v4     | 4,910             |

**Table 4 – Block Funding for Sub-acute and Non-acute admitted patients**

| Block Payments Sub & Non-Acute Inpatients  | \$'000 |
|--|--------|
| Sub & Non-Acute Inpatients Supplementation | 13,647 |

### Block Funding for ABF Hospitals

In instances where activity based funding is not appropriate, the THS will be funded via block funds for specific services. The following hospital services will be block-funded in 2017-18:

- Non-activity based services costs that fall outside the scope of the National Health Cost Data Collection (NHCDC) eg ancillary services that cannot be matched to a patient. Funding is based on 2015-16 NHCDC Tasmanian costs, indexed at 2.5% per annum.
- Teaching, Training, and Research, based on 2015-16 NHCDC Tasmanian costs, indexed at 2.5% per annum.
- Blood Products, based on the 2015-16 THS blood expenditure indexed at 2.5% per annum.
- Transition to Practice Nurses
- Enhancing Retrieval and Referral Services
- Interstate Charging - Based on estimated 2017-18 expenditure
- North West Cancer Centre
- Patients First
- Transition Grant

### Operational Grants for THS Services

The following THS services will be funded through an operational block grant in 2017-18. The funding amounts are based on historical cost of delivering these services with adjustments for indexation and known changes to service delivery:

- Mersey Community Hospital 1
- Primary Health Services (includes rural hospitals)
- Child Health and Parenting Service 2
- Mental Health Services (excluding mental health inpatient services)
- Oral Health Services partly delivered with Commonwealth funding
- Alcohol and Drug Services
- Forensic Medical Services
- Cancer Screening and Control Services partly delivered with Commonwealth funding
- Patient Travel Assistance Scheme – based on estimated 2016-17 expenditure.

<sup>1</sup> Funding based on new agreement

<sup>2</sup> Funding for the Child Health and Parenting Service is based on agreed budget amounts transferred from DHHS to the THS

## **Efficient Growth Funding and Commonwealth Funding Cap**

In 2017/18, the Commonwealth Government will fund 45% of Efficient Growth in public hospital services at Activity Based Funding (ABF) facilities as stated in the National Health Reform Agreement (NHRA) 2011. Efficient growth funding is based on growth of National Weighted Activity Units (NWAUs), and calculations are performed by the National Health Funding Body on behalf of the Administrator of the National Health Funding Pool. Over achievement of NWAU targets will result in the THS receiving only the efficient growth funding from the commonwealth at 45% of NEP.

In 2017-18 overall Commonwealth NHRA funding is capped at 6.5% growth on 2016-17 funding levels with final 2016-17 funding levels being determined in December 2017 after patient level NWAU data has been reconciled.

## **Pricing for Safety and Quality**

In February 2017, the Commonwealth Minister for Health, acting under section 226 of the National Health Reform Act 2011 directed IHPA to undertake implementation of three recommendations of the COAG Health Council relating to sentinel events, HACs and avoidable readmissions.

Consistent with the Ministerial Direction, the scope of measures for sentinel events will include all episodes of care (all streams) in both ABF and block funded hospitals while the scope of measures for HACs will include acute admissions across all public hospitals in both ABF and block funded hospitals.

### **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;
- hemolytic 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 will not be funded by both either the state or Commonwealth funding models. In ABF hospitals, separations where a sentinel event occurs will be assigned zero NWAU (17) and will not attract State or Commonwealth funding.

### **Hospital Acquired Complications**

Hospital Acquired Complications (HAC) 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. Identification of most HACs is dependent upon the use of the Condition Onset Flag (COF). The COF is used to indicate whether a diagnosis was present on admission to hospital or occurred during an episode of care.

IHPA and the Commission established a Joint Working Party in 2012 which developed an agreed Australian list of HACs through a clinician-led process. HACs were selected using the criteria of preventability, patient impact (severity), health service impact and clinical priority. There has been subsequent field-testing in

selected public and private hospitals, as well as further clinical refinement of the HACs list. The list of HACs (including a detailed specification of ICD-10-AM codes) is available on the Commission website.

On 30 November 2016 IHPA provided advice to the COAG Health Council that from 1 July 2018 IHPA will reduce the funding level, for all hospital acquired complications across every hospital to reflect the extra cost of a hospital admission, subject to the results of a shadow year from 1 July 2017.

1. During 2017-2018 the Department will provide direction and monitoring of the use of the COF to the THS;
2. assess the impact on funding to both ABF and Block facilities; and
3. in collaboration with the THS prepare a response to the HAC model to IHPA.

### **Avoidable Hospital Readmissions**

Avoidable Hospital Readmission means readmission to hospital for a condition or conditions arising from complications of the management of the condition for which the patient was originally admitted.

During 2017-2018, IHPA will develop a pricing model to act as a pricing trigger to reduce the incidence of avoidable hospital readmission. This work will be underpinned by the Australian Commission on Safety and Quality in Health Care (ACSQHC) developing a list of clinical conditions that should be considered avoidable readmissions and appropriate timeframes for avoidable readmission for each of the conditions selected. The developed conditions and definitions will be presented to COAG Health Council in June 2017. No pricing or funding approach to avoidable hospital readmissions will be implemented until after the completion of this program of work by ACSQHC and IHPA this is expected to occur after 1 July 2018.