Tasmanian Government

Tasmanian Health Service 2021-22 Service Plan (September 2021)

Amendments (September 2021)

Page/s	Sections
n/a	Removal of preface included in original 2021-22 Service Plan.
n/a	Minor adjustments to language tense throughout Service Plan document to reflect progression since commencement of original 2021-22 Service Plan on 1 July 2021.
4	**Safety and Quality** Addition of reference to updated National Safety and Quality Health Service standards 2021. Additional information included regarding the Multi-Purpose Services Aged Care Module.
8	**Provision of Health Services and Health Support Services under Contractual Arrangements** Additional information included for Healthscope (Tasmania) Pty Ltd.
15	**Part B: Health Planning** Addition of information regarding the *Department of Health Strategic Priorities 2021 – 2023*. Update to *Our Healthcare Future* information to reflect progress made with the initiative.
17	**Part C: Election Commitments** Removal of sentence relating to State Budget release. Additional of 'Election Commitments' and 'Other Initiatives' information. Amendment to 'Elective Surgery' section to reflect *Statewide Elective Surgery Four-Year Plan 2021-25* release.
21	**Part D: Funding Allocation and Activity Schedule – Purchased Volumes and Grants** Funding Tables have been amended to reflect: 1. Update to the 2021-22 activity and funding schedule 2. Update to the 2021-22 Funding Source information 3. Variation to Total Activity target – 190 722
26	**Part E: Performance** Amendments to wording to reflect updates to performance management process and THS Performance Framework.
29	**Part F: Key Performance Indicators** Information updated as per the following: 1. Removal of reference to elective surgery KPIs requiring finalisation Key Performance Indicator Schedule updated as follows: 2. Inclusion of four new KPIs, reflecting targeted objectives attached to the Statewide Elective Surgery Four-Year Plan 2021-25, as follows: • 9.1 – Seen on time – all triage categories. Target – 74 per cent. • 10.1 – Average overdue wait time for those waiting beyond recommended time. Target – 60 days. • 10.2 – Number of patients waiting overboundary. Target – 1 941. • 10.3 – Number of patients waiting prior to 2019. Target – zero. 3. Variation to the annual target for KPI 13.1: • 13.1 National weighted activity units (NWAUs). Target – 190 722 4. Increase to the annual target for KPI 13.2 to reflect additional elective surgery procedures:

	• 13.2 Elective surgery admissions. Target – 22 800. 5. Notes to Key Performance Indicator Schedule amended.
38	**Appendix 3. Tasmanian Funding Framework** Supplementation Grant table updated.

Contents

Approval

The Tasmanian Health Service (THS) 2021-22 Service Plan (the Service Plan) has been developed in accordance with the *Tasmanian Health Service Act 2018* (the Act) and is administered by the Minister for Health (the Minister).

In accordance with the Act, the THS and Secretary carry out their functions consistent with the Ministerial Charter issued under the Act. The THS provides the health services and health support services required under the Service Plan, to the standards and within the budget set out in the Service Plan.

The Secretary and THS are given distinct but complementary roles and functions in the Act, each aimed at ensuring the Tasmanian community's public health system is well managed, providing the right care to the Tasmanian community, in the right place, at the right time.

Signed by:

Kathrine Morgan-Wicks

Secretary, Department of Health

Date signed: 31 May 2021

Approved by:

The Honourable Jeremy Rockliff MP

Tasmanian Minister for Health

Date signed: 30 June 2021

Amendments

Pursuant to section 11(2)(a), of the *Tasmanian Health Service Act 2018*, the Minister for Health approved amendments to the Service Plan on the following dates:

Amendment 1 – Approved by The Honourable Jeremy Rockliff MP, Tasmanian Minister for Health
(7 / 09 / 2021)

Tasmanian Health Service 2021-22 Service Plan

The Service Plan applies from 1 July 2021 to 30 June 2022. 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 to 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 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:** Election Commitments
- **Part D:** Funding Allocation and Activity Schedule
- **Part E:** Performance
- **Part F:** Key Performance Indicators

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

Amendments to the Service Plan

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

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

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

Standards, Requirements and Agreements

Financial Management Standards

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

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

- *Tasmanian Health Service Act 2018*
- *Financial Management Act 2016*
- *Audit Act 2008*
- *Financial Agreement Act 1994*
- Treasurer's Instructions
- Australian Accounting Standards

As an Accountable Authority under the *Financial Management Act 2016*, the Secretary is responsible to the Minister for the financial management of the THS, including:

- ensuring that expenditure by the THS is in accordance with the law
- ensuring the effective and efficient use of resources in achieving the Government's objectives
- ensuring that appropriate stewardship is maintained over the assets of the THS and the incurring of liabilities of the THS
- ensuring that the THS's financial management processes, records, procedures, controls and internal management structures are appropriate
- ensuring the custody, control and management of, and accounting for, all public property, public money, other property and other money in the possession of, or under the control of, the THS
- ensuring the proper collection of all money payable to, or collectable under, any law administered by the THS
- conducting reviews of fees and charges collected by or payable to the THS; and
- meeting the audit requirements of the Auditor-General.

Safety and Quality

The Australian Commission on Safety and Quality in Health Care

The National Safety and Quality Health Service (NSQHS) Standards, and associated Australian Health Service Safety and Quality Accreditation (AHSSQA) Scheme, were developed by the Australian Commission on Safety and Quality in Health Care (ACSQHC), community, technical expert and stakeholder consultation to drive the continuous improvement of the quality and safety of health care in Australia. The NSQHS Standards (2012) became mandatory for all hospitals, day procedure centres and public dentists from 1 January 2013.

The THS is required to be accredited to the relevant NSQHS Standards (2nd edition) (2017) (updated 2021) by an approved accrediting agency. This includes:

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

Aged Care Accreditation

The Australian Government's *Aged Care Quality and Safety Commission Act 2018* established the Aged Care Quality and Safety Commission (ACQSC). The ACQSC's Aged Care Quality Standards (Quality Standards) (2019) came into effect for organisations providing Commonwealth subsidised aged care services from 1 July 2019, following the Aged Care Royal Commission and in response to the Aged Care Legislation Amendment (Single Quality Framework) Principles 2018.

The ACQSC is the appointed independent accreditation body for aged care services and assess approved providers' compliance to the Quality Standards to provide assurance to recipients of aged care services. The Quality Standards strengthen the focus upon client centred care requiring providers to work with their consumers to ensure they receive safe, high quality care shaped to the clients needs, goals and preferences. The Quality Standards apply to residential care; home care; and flexible care in the form of short-term restorative care. In addition, the ACSQHC developed the Multi-Purpose Services Aged Care Module (the MPS Aged Care Module) in collaboration with the Australian Government, state and territory departments of health, and the Commission's Multi-Purpose Services Project Advisory Committee. The MPS Aged Care Module describes, in six actions, the requirements of the Aged Care Quality Standards not covered by the NSQHS Standards. It is only applicable to eligible MPS and was endorsed by the Australian Health Minister's Advisory Council on 7 February 2020.

The Quality Standards also apply to care provided in a person's own home or the community, including short-term restorative care delivered in a home setting, and care delivered under the Commonwealth Home Support Programme (CHSP) as set out in the ACQSC Guide to Assessment of CHSP Services depending upon the types of care and services being delivered.

Professional Training Accreditation

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

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

Sentinel Events and Hospital Acquired Complications

The addendum to the National Health Reform Agreement (NHRA) includes a commitment for the Australian Government and state and territory governments to implement a number of reforms designed to improve patient safety and support greater efficiency in the health system, by reducing sentinel events,

hospital acquired complications (HACs), and avoidable hospital readmissions. This will deliver better health outcomes, improve patient safety and support greater efficiency in the health system.

The 2021-22 Tasmanian Activity Based Funding (ABF) 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 2.

Data Compliance and Provision

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

For 2021-22 there are six ABF patient service categories which are being used nationally and have their own classification system. These are:

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

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

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

- Coding and Classification Standards:
    - ICD-10-AM (International Statistical Classification of Diseases and Related Health Problems, Eleventh Edition, Australian Modification)
    - ACHI Australian Classification of Health Interventions
    - Australian Coding Standards
    - Australian National Subacute and Non-Acute Patient (AN-SNAP), Australian Emergency Care Classification (AECC), Urgency Disposition Groups (UDG) and Tier 2 classification business rules
    - Tasmanian directions:
        - Tasmanian Casemix Technical Bulletins
        - Tasmanian ABF Policy Instruction
- Costing: Australian Hospital Patient Costing Standards
- Counting: data definitions outlined in Tasmanian:
    - Admission and Transfer Discharge Policy Manual

- Hospital Admitted Care Types Guidelines
- Health Data Dictionary

More detail can be found at:

www.health.tas.gov.au/intranet/system/activity_based_funding_abf

www.ihpa.gov.au/publications/pricing-framework-australian-public-hospital-services-2021-22

www.ihpa.gov.au/publications/national-efficient-price-determination-2021-22

www.ihpa.gov.au/publications/national-efficient-cost-determination-2021-22

Provision of Health Services and Health Support Services under Contractual Arrangements

The THS is required to provide the health services and health support services set out in Column 2 of the table below to the corresponding party Column 1 pursuant to contractual arrangements entered between that party and the THS from time to time.

Column 1 (Party)	**Column 2 (health services and/or health support services)**
Commonwealth of Australia	*Health Services* The provision of such medical services, paramedical services and any other services which fall within the meaning of paragraphs (b), (c) and (f) of the definition of "health service" in s 3 of the Act as may be required to treat and/or stabilise and/or evacuate patients from Australia's Antarctic Territory and/or the Southern Ocean region to a public hospital in Tasmania. Such services are to include where appropriate the provision of medical services comprising professional advice or diagnostic services either remotely or in person. *Health support services* The provision of a health support service within the meaning of paragraph (b) of the definition of 'health support service' in the Act being the supply of a service in the form of training of Commonwealth personnel in Antarctic and remote medicine and/or the sterilisation of the entity's medical and scientific equipment for use in the Antarctic and Southern Ocean region to the Party in its capacity as a provider of health services.
Any party that is a provider of health services (within the meaning of the definition of 'health service' in s.3 the Act)	The provision of a health support service within the meaning of paragraph (b) of the definition of 'health support service' in the Act being the supply of a good or substance, in the form of Ant venom extracts for use in venom immunotherapy and diagnosis of allergy, to the party in its capacity as a provider of health services.
Healthe Care Burnie Pty Ltd	The provision of such medical services, paramedical services and any other services which fall within the meaning of paragraphs (b), (c) and (f) of the definition of "health service" in s 3 of the Act as may be required in a medical emergency to stabilise patients of the North West Private Hospital and/or transfer those patients from the North West Private Hospital to a public hospital
Healthscope (Tasmania) Pty Ltd	*Health Services*

	The provision of services which fall within the meaning of paragraphs (b), (c) and (f) of the definition of "health service" in s 3 of the Act as may be required to provide Continence Nursing Services, Stomal Therapy Nursing Services and Endoscopic Retrograde Cholangic Pancreatography (ERCP) Endoscopy Services to patients of the Hobart Private Hospital Private. *Health support services* The provision of a health support service within the meaning of paragraph (b) of the definition of 'health support service' in the Act being the supply of a service, in the form of the collection, disposal and / or transfer of waste, human tissue and deceased bodies from the Hobart Private Hospital, to the Party in its capacity as a provider of health services.

National and Other Agreements

The 2021-22 THS funding allocation includes funding provided under a range of National Partnership Agreements (NPAs), Commonwealth Own Purpose Expenditure (COPEs) payments and other government sector 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.

National Health Reform Agreement

The Service Plan complies with the requirements of the 2020-25 NHRA.
www.federalfinancialrelations.gov.au/content/national_health_reform.aspx

The NHRA requires state governments, as the system managers of public hospitals, to establish service agreements (or a Service Plan in the Tasmanian context) with each Local Hospital Network. These are to include:

- the number and broad mix of services to be provided by the Local Hospital Network
- the quality and service standards that apply to services delivered by the Local Hospital Network, including the Performance and Accountability Framework and Australian Health Performance Framework
- the level of funding to be provided to the Local Hospital Networks
- the teaching, training and research functions to be undertaken at the Local Hospital Network level.

Funding Arrangements

The 2020-25 NHRA provides for a continuation of existing public hospital funding arrangements, through which the Australian Government's annual funding contribution is its prior year contribution plus 45 per cent of the efficient growth in the price and volume of activity. Annual growth in total Australian Government funding is capped at 6.5 per cent. The amount of National Health Reform (NHR) funding received by Tasmania during the five-year term of the NHRA is dependent on the annual level of public hospital activity.

Minimum Funding Guarantee

The Australian Government has agreed to extend Tasmania's existing bilateral guarantee of a minimum annual level of NHR funding growth for the term of the 2020-25 NHRA. The guarantee provides for Tasmania's NHR funding to be indexed by at least the rate of growth in the Consumer Price Index and the national population.

Health Reform

The 2020-25 NHRA includes a commitment for the Australian Government and the states to work in partnership to implement arrangements for a nationally unified and locally controlled health system to improve patient outcomes, patient experience and access to services. This commitment includes supporting innovative models of care and trialling new funding arrangements. This is consistent with existing Tasmanian initiatives and priorities, including the Community Rapid Response Service and the Hospital in the Home (HiTH) program.

The 2020-25 NHRA also includes principles for the six long-term reforms, being: enhanced health data, nationally cohesive health technology assessment, paying for value and outcomes, joint planning and funding at a local level, empowering people through health literacy, and prevention and wellbeing.

The Australian Government and the states will continue to work together to consider implementation of the six long-term reforms outlined in the 2020-25 NHRA and their interaction with broader health reforms, including the maintenance and expansion of reforms expedited as a result of the response to COVID-19.

High cost and highly specialised therapies

High cost and highly specialised therapies include new and emerging cellular therapies, gene therapies, stem cell therapies, 3D printing, and regenerative medicine approved for therapeutic use in public hospitals.

The 2020-25 NHRA contain specific arrangements for new high cost, highly specialised therapies recommended for delivery in public hospitals by the Medical Services Advisory Committee. Under the cross boarder or interstate charging arrangements in the 2020-25 NHRA, Tasmanian is required to meet the cost of these services (exclusive of the Commonwealth contribution component).

Tasmanian residents, based on clinical criteria, will have access to main land facilities for the following cost and highly specialised therapies in 2021-22:

- Kymriah® – for the treatment of acute lymphoblastic leukaemia in children and young adults
- Kymriah® or Yescarta® – for the treatment of diffuse large B-cell lymphoma, primary mediastinal large B-cell lymphoma and transformed follicular lymphoma
- Qarziba® – for the treatment of high-risk neuroblastoma
- Luxturna™ – for the treatment of inherited retinal disease

Private patients in public hospitals

The 2020-25 NHRA specifies that the Australian Government and states' funding models will be financially neutral with respect to all patients, regardless of whether they elect to be treated as private or public patients.

Project Agreement for the Community Health and Hospitals Program

During the 2019 Federal Election campaign, the Australian Government announced it would provide $20 million over four years to provide for additional elective surgery and endoscopy procedures in

Tasmania. An initial payment of $5 million was provided to Tasmania in 2018-19 for activity in 2019-20 and future years.

In November 2019 the Australian Government announced the remaining $15 million for this commitment would be payable in 2019-20. The Australian Government provided Tasmania with the flexibility for activity purchased with this funding to be performed in 2020-21 and future years.

National Partnership on COVID-19 Response

In response to the COVID-19 pandemic, the National Partnership on COVID-19 Response (NPCR) was implemented on 13 March 2020 to provide states and territories with financial assistance to effectively respond to the COVID-19 outbreak.

The NPCR will remain in place for the period of the activation of the *Australian Health Sector Emergency Response Plan for Novel Coronavirus 2019* as declared by the Australian Health Protection Principal Committee (AHPPC), and then for sufficient additional time to allow for the final reconciliation of any payments made under the agreement.

More details regarding the NPCR are provided in Appendix 1.

National Partnership Agreement: Mersey Community Hospital

This NPA on Transfer of the Mersey Community Hospital (the Mersey NPA) facilitated the transfer of the Mersey Community Hospital (MCH) to the Tasmanian Government. On 1 July 2017, the State Government resumed ownership of the MCH and became responsible for providing public hospital services at the MCH and for reporting on the delivery of those services to the Australian Government.

The Australian Government provided a financial contribution to Tasmania of $736.6 million to support the implementation of the Mersey NPA.

MCH activity is now included in the Tasmanian total National Weighted Activity Unit (NWAU) values for the NHRA payments. However, to ensure 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 the agreed funding profile described in the Mersey NPA. Any activity delivered at the MCH above the agreed funding profile will be eligible for ABF payments.

National Partnership Agreement: Public Dental Services for Adults

The NPA for Public Dental Services for Adults provides additional funding to states and territories to alleviate pressure on adult public dental waiting lists. The current agreement expires on 30 June 2021. The 2021-22 Federal Budget indicates further funding will be provided in 2021-22. The Department of Health will seek to commence negotiations with the Australian Government in the near future to formalise an extension to the agreement.

Other Agreements

In addition to the above, COPEs and other government sector agreements relevant to the Service Plan include:

<u>COPEs</u>

- Aged Care Assessment Program
- Commonwealth Home Support Program

- Multi-Purpose Services Program
- Transition Care Program
- WP Holman Clinic Radiation Health Program Grant

Other government sector agreements

- Head Agreement in relation to Funding for Organ and Tissue Donation for Transplantation

Funding relating to each of these agreements is contained within the overall THS funding envelope for 2021-22.

Part A: Tasmanian Public Health System - Responsibilities

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

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

Minister for Health

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

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

The Secretary, Department of Health

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

In line with this responsibility, the Secretary is assigned several functions and powers to guide, monitor and manage the THS in undertaking its functions and powers, including;

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

Tasmanian Health Service Executive

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

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

The Tasmanian Health Service

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

The functions of the THS are to:

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

Health Executive Governance Structure

In March 2020, a new executive structure for the state's health system came into effect. The new structure saw the abolishment of the two separate Executive committees across the Department of Health (the Department) and the THS, and the establishment of one streamlined Health Executive. The new governance structure provides a clear and consistent strategic direction across the Department and THS, and strengthens systems coordination and local accountability and authority; whilst still ensuring the focus remains on delivering high quality, safe and sustainable health services for all Tasmanians.

The Health Executive is chaired by the Secretary, Department of Health, and includes 12 other members representing various functions of the Department and the THS. The new governance structure is consistent with the Act, with seven of the Health Executive membership roles deemed to comprise the THS Executive for the purposes of the Act.

As part of the new structure, executive sub-committees have been established to support the Secretary and provide focus and consistency within decision making, as well as drive improved and more timely decisions by the Health Executive, and monitoring of the delivery of key projects, outcomes and risks. Of

relevance to the Service Plan is the System Performance and Forecasting Committee (SPFC) which is responsible for providing strategic oversight and direction of the Departments performance management responsibilities. The SPFC utilises input from experts and clinical leaders to identify, assess and prioritise emerging performance concerns and oversee the appropriate interventions to address underperformance. In 2021-22 the newly formed SPFC are overseeing a review of all Service Plan KPI and associated targets which will inform an amendment to the KPI suite.

Part B: Health Planning

Two significant initiatives have been launched by the Department with the aim of ensuring that Tasmanians receive the best possible health services, and that a balanced and sustainable health system is supported to provide the right care, in the right place, at the right time: *The Department of Health Strategic Priorities 2021-2023* and *Our Healthcare Future*.

As the *Strategic Priorities Plan* is implemented and the reforms to be undertaken through *Our Healthcare Future* are progressed and embedded in the Tasmanian health system, they will guide the planning, funding and purchasing of health care services, and inform future iterations of the Service Plan.

Department of Health Strategic Priorities 2021-2023

In August 2021, the Department launched its Strategic Priorities Plan for 2021 – 2023. The Strategic Priorities sets out the Departments priorities, actions and enablers over the two-year period to provide strategic direction to ensure that Tasmanians receive the best possible health services.

While the delivery of health services remains the Department's core business, focus will be on delivering a number of key priorities to help improve the health and wellbeing of the Tasmanian community during the two years. The six equal priority areas include:

1. Continuing to respond to the COVID-19 Pandemic
2. Improving Access and Patient Flow across our Health System
3. Delivering care in clinically recommended times
4. Reforming the delivery of care in our community
5. Prioritising Mental Health and Wellbeing; and
6. Building the Infrastructure for our Health Future.

These priorities are supported by three key internal foundation areas of focus:

1. Build and develop a sustainable and positive workforce we need now and for the future;
2. Strengthen our governance, risk and financial management, performance and accountability; and
3. Strengthen Clinical safety, quality, and regulatory oversight.

Our Healthcare Future

Our Healthcare Future is Stage Two of the Tasmanian Government's long-term reform agenda to consult, design and build a highly integrated and sustainable health service.

The Our Healthcare Future Immediate Actions and Consultation Paper released in late 2020 highlighted key issues impacting healthcare in Tasmania now and the future, and proposed three key improvement areas, including immediate actions the Tasmanian Government is taking now, and consultation questions to guide future planning: Better Community Care, Modernising Tasmania's Health System, and Planning for the Future.

On 30 July 2021, the Department released the public submissions received in response to the Our Healthcare Future Immediate Actions and Consultation Paper. The submissions were accompanied by an analysis outlining the key themes to emerge from the submissions. The analysis found:

- support for the overarching themes of the Our Healthcare Future reforms

- support for more patients to be treated in the community, where possible and appropriate, and for greater emphasis on preventative health
- acknowledged need for statewide digital transformation
- acknowledged need for long-term infrastructure, workforce and clinical services planning, to improve access to services and support new models of care.

The next step in the Our Healthcare Future reforms is to co-design a long-term plan for healthcare in Tasmania that builds on the solid foundation provided by the One State, One Health System, Better Outcomes (Stage One) reforms).

Part C: Election Commitments

The 2021-22 State Budget was released on 26 August 2021. Funding announcements made in the 2021-22 State Budget are included as follows:

Community Based Health Care

Funding of $27.5 million has been provided over four years to continue statewide Community Rapid Response Services and to pilot other hospital in the home services. This initiative supports people who need short-term intermediate care that can be safely delivered in the community or in the home. This funding consists of a $21.3 million State Government component and $6.2 million Australian Government component.

Elective Surgery - additional funding - Surgeries and Endoscopies

The 2021-22 Budget provides additional funding of $120 million over four years to deliver an additional 20 000 elective surgeries and 2 300 endoscopies to address elective surgery demand in response to the COVID-19 pandemic. This consists of a State Government component of $66 million and an estimated Australian Government Activity Based Funding component of $54 million. This funding is in addition to the $36.4 million announced for 2021-22 as part of the 2020-21 Budget. For more information refer to 'Elective Surgery' section below.

Emergency Mental Health Co-response model

The Government has committed $5.1 million over two years to pilot an Emergency Mental Health Co-response model in southern Tasmania. The Co-response Team will comprise mental health workers, including clinicians, who will travel with police and ambulance officers to attend mental health-specific "triple-0" calls. Secondary triage clinicians will be tasked with specialist mental health triage to support police and ambulance dispatch officers.

Hyperbaric Chamber Royal Hobart Hospital

Funding of $80 000 has been provided in 2021-22 to extend the functionality of the Royal Hobart Hospital's Hyper/Hypobaric Chamber. This high-tech upgrade will attract world-class research to Tasmania by supporting cutting edge aerospace and human life sciences capabilities.

Mersey Community Hospital - Rural Medical Workforce Centre

The 2021-22 Budget provides $4.3 million to establish a new Rural Medical Workforce Centre at the Mersey Community Hospital. This funding consists of $1 million in capital funding to establish the Centre, and $3.3 million in operational funding for staff to support the recruitment and retention of permanent doctors for the region.

North West Regional Hospital Second Linear Accelerator

The 2021-22 Budget provides $8.1 million over four years to fully operate a second Linear Accelerator at the North West Cancer Centre, which will double current capacity to keep up with increasing demand.

Oral Health - One Off Funding Injection

Funding of $5 million has been provided in 2021-22 to provide an additional 20 000 dental appointments statewide across emergency dental, general dental care and denture clinics.

Palliative Care Private Sector Partnerships

The 2021-22 Budget provides funding of $6.8 million over four years to provide better palliative care services, in partnership with private hospitals and service providers.

Peer Workforce Coordinator and establish Youth Peer Worker Model

Commencing in 2021-22, the Government has provided funding of $1.9 million over three years to deliver a Peer Workforce Coordinator and establish the Youth Peer Worker Model as part of the Tasmanian Peer Workforce Development Strategy for providing support to people living with mental health challenges.

Rural Hospital Boost - additional staff

Funding of $3.4 million is provided over four years to boost staffing at rural hospitals across the State, including New Norfolk District Hospital, West Coast District Hospital, St Helens District Hospital, May Shaw at Swansea and North East Soldiers Memorial Hospital at Scottsdale.

Supporting Access to Cutting Edge Treatments for Children with Cancer

Funding of $600 000 is provided in 2021-22 to ensure continued local access to clinical trials for Tasmanian children with aggressive forms of cancer. It will secure the future of Tasmania's only Children's Cancer Clinical Trials Unit.

Tasmanian Community Health and Wellbeing Networks

The 2021-22 Budget provides $4.5 million over two years, to trial three Tasmanian Community Health and Wellbeing Networks in Ulverstone, Huonville and Scottsdale. These will be managed in the local communities through the employment of a Local Health Connector, to deliver community-led health and wellbeing services focused on the needs of local people and using local community resources.

Other Initiatives

Beds and Demand – Major Hospitals

Funding of $198 million over four years will be provided to the THS to implement measures to increase beds at the Royal Hobart Hospital, Launceston General Hospital and North West Regional Hospital, fulfilling the Government's commitment announced on 4 June 2021.

More than 50 additional permanent hospital beds will be opened across the State to meet an expected increase in seasonal demand and to support the Government's elective surgery commitments. These beds will be brought online in a staged approach to ensure that they can be appropriately staffed.

Child and Adolescent Mental Health Service Review

The Government has committed $12.5 million per annum on an ongoing basis to fully fund its response to the Child and Adolescent Mental Health Services (CAMHS) Review report and recommendations. The Review recommended large scale changes in the way CAMHS operates, including in its structure, practice and culture, to better support our children and adolescents, with particular emphasis on those most vulnerable and in need of support.

Elective Surgery – additional commitment

Additional funding of $40 million over three years has been provided to increase the Government's elective surgery commitment to a total of $160 million over the Budget and Forward Estimates period. This commitment, which is fully State funded, will further reduce the waiting times experienced by members of the Tasmanian community.

Safe Staffing Model for Tasmanian District Hospitals

Funding of $18.3 million has been provided over four years to support health care professionals by implementing the safe staffing model for the Tasmanian District Hospitals, which will result in a net increase in staff statewide, as well as an increase in the mix of skills available to those seeking care in regional locations.

District hospitals play a key role in Tasmania's health system providing care in rural communities and supporting the major hospitals to meet the increasing demands on acute care services. Across Tasmania, the THS has 13 District Hospitals providing sub-acute beds, aged care and emergency beds.

Elective Surgery

The Statewide Elective Surgery Four-Year Plan 2021-25, released in August 2021, provides a focused road map for a sustainable statewide elective surgery and endoscopies program over the next four years. Commencing in 2021-22, the State Government will invest an additional $160 million, on top of the $36.4 million investment already budgeted for 2021- 22, for a total investment of $196.4 million to deliver a record program of elective surgery to slash waiting lists and deliver an additional 22 300 elective surgeries and endoscopies over four years.

While this investment is over four years, 2021-22 has been prioritised with an investment of $66.4 million, to provide an estimated additional 8 300 elective surgeries State-wide, bringing the expected total volume in 2021-22 to more than 22 800 surgeries.

Over the next four years, it is estimated that this level of investment will deliver:

- an additional 11 100 surgeries and endoscopies for the State's South, with a funding boost of $78.2 million;
- an additional 7 400 surgeries and endoscopies for the State's North, with a funding boost of $52.1 million, and
- an additional 3 700 additional surgeries and endoscopies for the State's North West, with a funding boost of $26.1 million.

In addition, in order to assist the public sector to cope with this massive investment into elective surgery, a further one-off $20 million will be made available in a fund to allow private hospitals to support our public hospitals to manage demand by;

- assisting the public hospital sector to meet the elective surgery program outlined above;
- allowing for the purchase of beds from private hospitals to improve patient flow and access to care, and
- enabling private hospitals to support public hospitals with demand in other areas, including community nursing and home care.

The four-year plan seeks to:

- Provide a clear, future-focused document that guides state-wide sustainable delivery of elective surgery
- Ensure equitable access for all patients, as determined by clinical decision-making and safety, regardless of where the patient lives or what procedure they are waiting for and enable patients to receive procedures within clinically recommended times
- Promote the implementation of best practice, evidence-based models of care that optimise patient outcomes

- Provide greater transparency to Tasmanians of the process that determines access to elective surgery
- Ensure the system is designed to adequately meet the elective surgery needs of the Tasmanian population.

The Statewide Elective Surgery Four-Year Plan 2021-25 will inform future iterations of the Service Plan in line with the planned volumes of surgeries for each year of the plan.

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

2021-22 Activity and Funding Schedule

Table 1.1 Tasmanian Health Service	Measure	No. of patients	Activity	State Funding ('000)	Commonwealth Funding ($'000)	Funding ($'000)
Activity Funding						
Admitted						
Acute Patients (Excluding Elective Surgery)	NWAU	94 320	94 320	307 056	220 855	527 911
Acute Elective Surgery	NWAU	32 364	32 364	105 360	75 782	181 142
Acute - Scopes	NWAU	4 090	4 090	13 315	9 577	22 892
Acute Facilities Mental Health	NWAU	8 236	8 236	26 814	19 286	46 100
Sub-Acute and Non-Acute	NWAU	7 846	7 846	25 543	18 372	43 915
Non-admitted						
Outpatients - Non-Admitted Patients	NWAU	20 316	20 316	66 138	47 571	113 709
Emergency Department	NWAU	23 550	23 550	76 665	55 143	131 808
Total Activity Funding		**190 722**	**190 722**	**620 890**	**446 587**	**1 067 477**
Funding Adjustments						
Anticipated impact on Commonwealth Funding for exceeding National Funding Cap	N/A	N/A	N/A		(33 671)	(33 671)
Additional State Funding for Activity exceeding National Funding Cap	N/A	N/A	N/A	33 671		33 671
Adjusted Total Activity Funding for Impact of Funding Cap	N/A	N/A	N/A	**33 671**	**(33 671)**	-
Final Activity Funding				**654 561**	**412 916**	**1 067 477**

Table 1.1 Tasmanian Health Service	Measure	No. of patients	Activity	State Funding ('000)	Commonwealth Funding ($'000)	Funding ($'000)
Block Grants for Activity Based Funded Hospitals						
RHH K-Block Commissioning	Block					18 714
RHH Supporting Access to Cutting Edge Treatments for Children	Block					600
RHH Hyperbaric Chamber	Block					80
Partnered Pharmacist Medication Charting - Statewide	Block					1 738
LGH Ward 4K	Block					9 285
LGH Ward 3D - Bed Openings	Block					11 975
Medical Cannabis	Block					920
Blood	Block					8 782
Boarders	Block					100
Home and Community Care (HACC)	Block					213
Non-ABF Activity	Block					62 757
Organ Procurement	Block					287
Patient Travel Assistance Scheme (PTAS)	Block					6 949
Admitted Acute Patients Supplementation	Block					55 415
Admitted Mental Health Patients Supplementation	Block					3 759
Sub & Non-Acute Inpatients Supplementation	Block					3 450
Emergency Department Supplementation	Block					16 537
Outpatients Supplementation	Block					13 219
NWRH Second Linear Accelerator	Block					1 150
Mersey Community Hospital - More Services and Staff	Block					1 000
Mersey Community Hospital - Rural Medical Workforce Centre	Block					500
Transition Care Program	Block					5 067
Total Block grants for Activity Based Funded Hospitals						**222 497**

Table 1.1 Tasmanian Health Service	Measure	No. of patients	Activity	State Funding ('000)	Commonwealth Funding ($'000)	Funding ($'000)
ABF Block Allocation						
Teaching, training and research				29 784	17 600	47 384
Small and Rural Hospitals	NWAU	N/A	6425	44 970	32 400	77 369
Stand Alone Mental Health Facilities				28 057	12 162	40 218
Non-Admitted Mental Health				47 856	20 572	68 428
Non-Admitted CAMHS				13 760	1 187	14 947
Non- Admitted Home Ventilation				1 524	1 247	2 771
Total ABF Block Allocation				**165 950**	**85 167**	**251 117**
THS Operational Grants						
Health Demand Funding (incl. Budget Commitment: Demand + Beds)	Grant					39 033
Allocation of Prior Year Commitments	Grant					6 847
Mersey Community Hospital Funding[1]	Grant					22 800
Palliative Care - PEN Nurses and Community Based Care and Private Sector Partnerships	Grant					2 400
Overarching Paediatric Model of Care	Grant					350
Primary Health	Grant					44 796
Primary Health - Rural Hospital Boost and Safe Staffing	Grant					5 600
Alcohol and Drug Services	Grant					9 313
Correctional Mental Health Services	Grant					2 814
Emergency Mental Health Co-Response Model	Grant					2 100

Table 1.1 Tasmanian Health Service	Measure	No. of patients	Activity	State Funding ('000)	Commonwealth Funding ($'000)	Funding ($'000)
Mental Health Service Reviews - including CAMHS	Grant					12 500
Peer Workforce Coordinator and establish Youth Peer Worker	Grant					350
Tasmanian Community Health and Wellbeing Networks	Grant					2 250
Oral Health	Grant					21 949
Oral Health Boost	Grant					4 860
CHAPS	Grant					13 633
Cancer Screening	Grant					6 437
Forensic Medical Services	Grant					1 633
Statewide Ops Command Centre	Grant					1 500
Nurse Graduates Program	Grant					2 951
Interstate Charging	Grant					28 350
Enhancing Retrieval and Referral Services	Grant					144
MedTasker Annual Costs	Grant					303
Total Operational Grants						**232 913**
TOTAL Tasmanian Health Service						**1 774 004**

Notes:

1 $89.7 million is provided in Mersey Community Hospital Funding from TasCorp. The remaining balance of $68.9 million is incorporated into the THS NWAU activity target of 190 722.

2020-21 Funding Source

Table 1.2 Funding Source	Funding ($'000)
State Funding[1]	1 276 190
Australian Government Funding[2]	497 814
Sub Total	**1 774 004**
THS Retained Revenue[3]	216 381
Pharmaceutical Benefits Scheme	93 714
Sub Total	**310 095**
Total	**2 084 099**

Notes:

1 State Funding includes State ABF, State Block and $89.7 million provided for the Mersey Community Hospital.

2 Commonwealth Funding includes Commonwealth ABF and Block. The reduced Commonwealth ABF contribution for projecting to exceed the national funding cap is also shown in this figure.

3 THS Retained Revenue includes funding for NPAs, COPEs, private funding agreements and operationally driven revenue from patient fees etc (excluding PBS).

NWAU Estimates 2020-21

Table 1.3 Annual NWAU Estimate 2020-21						
Tasmanian Health Service	**Acute Admitted Incl. Elective Surgery**	**Admitted Mental Health**	**Sub-acute and Non-acute (admitted)**	**Emergency**	**Non-admitted**	**Total**
RHH, LGH, NWRH and MCH	130 774	8 236	7 846	23 550	20 316	190 722

The NEP is $5 597 per national weighted activity unit 2021–22 (NWAU (21)).

Part E: Performance

The Service Plan and Performance Framework are instruments that assist the Department in its role as system manager. There are several components of system management that together with these enabling instruments, inform and complement each other within an integrated management system.

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

Performance management and the *Tasmanian Health Service Act 2018*

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

Roles and responsibilities of the Secretary and the Executive

The Secretary

- The Act invests the Secretary with the function of:
    - monitoring delivery of health services, and health support services, by the THS in accordance with the Service Plan
    - ensuring the THS Executive performs the functions and powers of the Executive and the THS

The Executive

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

Ministerial Charter

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

Overall expectations

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

Specific expectations of the Secretary

- implement the governance framework to support performance monitoring and management of the THS

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

Specific expectations of the Tasmanian Health Service

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

The Performance Framework

Performance Objectives

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

The Performance Framework incorporates reporting against underlying factors identified in the *Report of the Auditor-General No.11 of 2018-19: Performance of Tasmania's four major hospitals in the delivery of Emergency Department services* as being of concern, and which are being addressed by the joint THS/Department implementation of the Auditor General's recommendations.

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

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

The key components of the Performance Framework are:

- clear identification of domains of performance
- clear identification of KPI
- regular reporting of performance against KPI and the underlying performance risks
- a mandated, regular, structured discussion of performance by the Strategic Purchasing and Forecasting Committee
- a clearly structured process for interventions and actions where KPI targets are not met

- a clearly structured process for monitoring and reporting of performance of escalation actions.

The Performance Framework will focus on:

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

Part F: Key Performance Indicators

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

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

- **Effectiveness** – care, intervention or action achieves the desired outcome from both the clinical and patient perspective.

  1. Breast cancer detection

- **Safety** - mitigate risks to avoid unintended or harmful results.

  2. Hospital Safety – reduced risk of hospital acquired infections
  3. Hospital Safety – mental health seclusion
  4. Hospital Safety – reportable events

- **Appropriateness** – service is person centered and culturally appropriate. Consumers are treated with dignity, confidentiality and encouraged to participate in choices related to their care.

  5. Consumer experience

- **Continuity of care** – ability to provide uninterrupted care or service across programs, practitioners and levels over time. Coordination mechanisms work for health care providers and patients.

  6. Mental Health transition from inpatient to community care
  7. Acute Care transition from inpatient to community care
  8. Ambulance offload delay

- **Accessibility** – people can obtain health care at the right place and right time, taking account of different population needs and the affordability of care.

  9. Elective Surgery waiting list reduction – surgery within recommended time*
  10. Elective Surgery waiting list reduction*
  11. Patient flow from Emergency Departments
  12. Emergency Department service provision

- **Efficiency and sustainability** – the right care is delivered at a minimum cost and human and physical capital and technology are maintained and renewed, while innovation occurs to improve efficiency and respond to emerging needs.

  13. Service activity
  14. Financial control
  15. Admitted patient episode coding

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

2021-22 Key Performance Indicator Schedule[1]

KPI No.	Key Performance Indicator	Target	Measured Statewide or Facility Level
Effectiveness			
1	**Breast cancer detection**		
1.1	Eligible women screened for breast cancer	35 860	Statewide
1.2	Clients assessed within 28 days of a screen-detected abnormality	Not less than 90 per cent	Statewide
Safety			
2	**Hospital Safety – reduced risk of hospital acquired infections**		
2.1	Hand hygiene compliance	Not less than 80 per cent	All specified facilities
2.2	Healthcare associated infections – staphylococcus aureus bacteraemia	Not more than 1.0 per 10 000 patient days	All specified facilities
3	**Hospital Safety – mental health seclusion**		
3.1	Mental health inpatient seclusion	Less than 8 per 1 000 patient days	Statewide
4	**Hospital Safety – reportable events**		
4.1	Initial reportable event briefs provided within two business days	Not less than 80 per cent	Statewide
4.2	Root cause analyses provided within 70 calendar days	Not less than 80 per cent	Statewide
Appropriateness			
5	**Consumer experience**		
5.1	Consumer experience survey response rate	Not less than 30 per cent	All specified facilities
5.2	Consumer satisfaction with the quality of treatment and care	Not less than 80 per cent	All specified facilities
Continuity of care			

KPI No.	Key Performance Indicator	Target	Measured Statewide or Facility Level
6	**Mental health transition from inpatient to community care**		
6.1	Re-admissions within 28 days	Not more than 14 per cent	Statewide
6.2	Post discharge community care follow up within seven days	Not less than 85 per cent	Statewide
7	**Acute care transition from inpatient to community care**		
7.1	Discharge summaries transmitted within 48 hours of separation	100 per cent	Statewide
8	**Ambulance offload delay**		
8.1	Ambulance offload delay – within 15 minutes	Not less than 85 per cent	All specified facilities
8.2	Ambulance offload delay – within 30 minutes	100 per cent	All specified facilities
	Accessibility		
9	**Elective Surgery waiting list reduction – surgery within recommended time**		
9.1	Seen on time – all triage categories	74 per cent	Statewide
10	**Elective Surgery waiting list reduction**		
10.1	Average overdue wait time for those waiting beyond recommended time	60 days	Statewide
10.2	Number of patients waiting overboundary	1 941	Statewide
10.3	Number of patients waiting prior to 2019	0	Statewide
11	**Patient flow from Emergency Departments**		
11.1	Patients admitted through the ED with an ED length of stay of less than eight hours	Not less than 90 per cent	All specified facilities
11.2	Patients (non-admitted) through the ED with an ED length of stay less than 12 hours	Not less than 100 per cent	All specified facilities

KPI No.	Key Performance Indicator	Target	Measured Statewide or Facility Level
12	**Emergency Department service provision**		
12.1	ED presentations seen within recommended time – triage 1	100 per cent	All specified facilities
12.2	ED presentations seen within recommended time – all triage categories	Not less than 80 per cent	All specified facilities
12.3	ED presentations who do not wait to be seen	No more than 5 per cent	All specified facilities
Efficiency and sustainability			
13	**Service activity**		
13.1	National weighted activity units (NWAUs)	190 722	Statewide
13.2	Elective surgery admissions	22 800	Statewide
13.3	Dental Weighted Activity Units (DWAUs)	39 853	Statewide
13.4	Dental – Additional Dental Funding	12 261[2]	Statewide
14	**Financial control**		
14.1	Variation from funding – full year projected	Expenditure within funding allocation	Statewide
15	**Admitted patient episode coding**		
15.1	Clinical coding of admitted patient episodes completed on time within 42 days of separation	100 per cent	Statewide
15.2	Clinical coding errors corrected within 30 days	100 per cent	Statewide

Notes:

1 All Service Plan KPI will undergo a review, led by the Department in consultation with the THS, in 2021-22. The outcome of this review may inform future changes to the KPI.

2 The target for KPI 13.4 Dental – Additional Dental Funding reflects the 2021-22 component of the total 20 000 target for the full 2020/21 – 2022/23 period.

Appendix 1. COVID-19 Response

In response to the COVID-19 pandemic, the NPCR was implemented on 13 March 2020 to provide states and territories with financial assistance to effectively respond to the COVID-19 outbreak. Under the NPCR, in addition to an up-front advance payment, there are two sets of payments provided by the Australian Government to the State: the Hospital Services Payment, and the State Public Health Payment.

The NPCR will remain in place for the period of the activation of the *Australian Health Sector Emergency Response Plan for Novel Coronavirus 2019 (COVID-19)* as declared by the AHPPC, and then for sufficient additional time to allow for the final reconciliation of any payments made under the agreement.

Hospital Services Payment (HSP)

The HSP includes activities in-scope for payment through the NHRA that are related to the outbreak of COVID-19. Activities related to the outbreak of COVID-19 include:

- services to assess, diagnose and treat people with COVID-19 or suspected of having COVID-19, such as respiratory clinics and testing and diagnostics
- services related to factors associated with the outbreak of COVID-19, such as rescheduled elective surgery.

These include activities that can be expressed in NWAU such as services reported in a state's ABF data submission or that would normally be reported in a state's block funding submission however can be expressed as NWAU.

The Australian Government will provide a 50 per cent contribution for costs incurred by the State under the HSP.

State Public Health Payment (SPHP)

The SPHP includes activities for public health system costs not in-scope for payment through the NHRA that are related to the NHRA. Activities related to the outbreak of COVID-19 include:

- services to assess, diagnose and treat people with COVID-19 or suspected of having COVID-19, such as but not limited to:
    - expenses associated with border force, airport screening and quarantine
    - health expenditure related to costs of care outside hospitals, for example, outreach to rural, remote and/or Indigenous patients, paramedic and ambulance services, patient transport, primary and/or community care, and staffing support for aged care facilities
    - public health communications, operations and telehealth
- services related to factors associated with the outbreak of COVID-19, such as but not limited to:
    - non-clinical costs for hospital services or costs associated with service disruption
    - capital expenditure to respond to increased service demand
    - personal protective equipment
    - treatment of Medicare ineligible patients where there is no other non-out-of-pocket means of funding the patients' service
    - investment in public health activities to respond to the outbreak of COVID-19 and protect the Australian community.

The SPHP also includes a COVID-19 Vaccination Dose Delivery Payment, which provides an Australian Government contribution for each COVID-19 vaccination delivered by the states, based on an agreed fixed price per dose.

The Australian Government will provide a 50 per cent contribution for costs incurred by the State under the SPHP, with the exception of the below:

- The SPHP also includes an estimated Financial Viability Payment for all private hospitals in the State, for which the Australian Government agrees to provide the State 100 per cent of the estimated monthly funding
- All activity associated with the NPCR is considered separate to that which underpins the activity volumes outlined in this Service Plan.

Appendix 2. Safety and Quality: Sentinel Events and Hospital Acquired Complications

To improve patient safety and support greater efficiency in the health system, the 2017 NHRA Addendum incorporated a pricing signal for safety and quality. The pricing signal effects the National Efficient Price (NEP) and the National Efficient Cost (NEC) funding models and were progressively implemented from 1 July 2017 and lead to a range of objectives for delivery. These safety and quality pricing signals are continued in the 2020-25 NHRA.

Sentinel Events

In 2017, the ACSQHC undertook a review of the Australian sentinel events list on behalf of the states, territories and the Australian Government. The updated Australian sentinel events list (Version 2.0) was endorsed by Australian Health Ministers in December 2018. Further information on its development and specifications is available on the ACSQHC website.

The national sentinel events (v2.0) are:

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

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

Hospital Acquired Complications

In accordance with the 2020-25 NHRA, the funding level for admitted acute episodes and Diagnosis-related group (DRG) funded sub-acute and non-acute episodes of care will be reduced where a HAC is present. Separate adjustments have been determined for each HAC. Where an episode contains multiple HACs, the HAC with the largest adjustment determines the funding adjustment.

A HAC refers to a complication which is acquired in hospital for which clinical risk mitigation strategies may reduce (but not necessarily eliminate) the risk of that complication occurring. The list of HACs was determined by a Joint Working party of the Commission and IHPA.

Version 3.0 of the HAC list will be used for pricing in 2021–22. Further information on the HAC list including diagnosis codes used to identify each HAC, is available on the ACSQHC website.

The funding adjustment for HACs has been risk adjusted to take account of the increased predisposition of some patients to experiencing a HAC during their hospital stay and adjusts the reduction in funding accordingly.

List of hospital acquired complications

Number	Complication
1	Pressure injury
2	Falls resulting in fracture or intracranial injury
3	Healthcare associated infection
4	Surgical complications requiring unplanned return to theatre
5	Unplanned intensive care unit admission [1]
6	Respiratory complications
7	Venous thromboembolism
8	Renal failure
9	Gastrointestinal bleeding
10	Medication complications
11	Delirium
12	Incontinence
13	Endocrine complications
14	Cardiac complications
15	Third and fourth degree perineal laceration during delivery [2]
16	Neonatal birth trauma [2]

[1] No funding adjustment for 'Unplanned intensive care unit admission' will be applied in 2021–22 as it cannot be identified in current datasets.

[2] No funding adjustment for 'Third degree perineal laceration during delivery' and 'Neonatal birth trauma' will be applied in 2021–22 due to small patient cohorts or other issues that have prevented development of a robust risk adjustment approach at this time.

Avoidable hospital readmissions

Under the Addendum, IHPA is required to develop a pricing model for avoidable hospital readmissions, for implementation by 1 July 2021, following approval from the Council of Australian Governments Health Council.

Unplanned hospital readmissions are a measure of potential issues with the quality, continuity and integration of care provided to patients during or subsequent to their initial hospital admission (the index admission). Reducing the number of avoidable hospital readmissions improves patient health outcomes and decreases avoidable demand for public hospital services.

The list of clinical conditions considered to be avoidable hospital readmissions was approved by the Australian Health Ministers' Advisory Council in June 2017. The avoidable hospital readmission conditions are as follows:

- Pressure injury
- Infections
- Surgical complications
- Respiratory complications
- Venous thromboembolism
- Renal failure
- Gastrointestinal bleeding
- Medication complications
- Delirium
- Cardiac complications
- Other (constipation, nausea and vomiting)

Version 1.0 of the avoidable hospital readmissions list will be used for pricing in 2021–22. Further information on the list, including diagnosis codes used to identify each readmission condition, is available on the ACSQHC website.

The funding adjustment for avoidable hospital readmissions has been risk adjusted to account for the increased predisposition of some patients to experiencing an avoidable hospital readmission during their hospital stay and adjusts the reduction in funding accordingly with use of a risk adjustment factor.

Further information on the risk adjustment model for avoidable hospital readmissions, including the risk factors for each readmission condition, is contained in the National Pricing Model Technical Specifications 2021–22.

Appendix 3. Tasmanian Funding Framework

Principles of the Tasmanian ABF Model

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

- assists by assigning accountability for the high-level outcomes and targets to be met during the period to which the Service plan applies
- 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 considered 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 health services from the THS, and the purchasing model determines the volume and complexity of services that are purchased. In terms of the ABF model:

- There are three public hospitals funded through the Tasmanian ABF model (RHH, LGH and NWRH). The Tasmanian ABF model is based largely on the national ABF model but includes some modifications to reflect the local Tasmanian environment.
- While funded through the Mersey NPA, the MCH public hospital services have been included in the NWAU estimates in the Tasmanian ABF model with any deficit between the ABF contribution and the NPA allocation being provided as a supplementation or block grant.
- The NHRA block funding models in the Service Plan broadly define the health services to be provided by the THS through 18 small regional and rural hospitals, Six specialist public mental health hospitals (including the forensic mental health facility), eligible ambulatory community mental programs (including Child and Adolescent Mental Health Services (CAMHS), Clinical Teaching, Training and Research in the major hospitals and Non-Admitted home Ventilation Services.
- The ABF model determines the volume of services that the Department agrees to purchase from the THS, as articulated through the Service Plan. The volume of activity purchased is informed by projected demographic modelled data, One State, One Health System, Better Outcomes – White Paper, State Government commitments and known/forecast service developments in negotiation with the THS,

Tasmanian funding model

The Tasmanian Funding model is in place for 12 months and is effective on 1 July 2021. As the Tasmanian model is based on the national ABF model, which is developed by the IHPA, the Tasmanian model uses the annual National Efficient Price (NEP) and the National Efficient Cost (NEC) determinations produced by IHPA for the specific financial year.

The *Pricing Framework for Australian Public Hospital Services* outlines the principles, scope and methodology adopted by IHPA in the determinations.

Educational and training resources on the topic of ABF are available on IHPA's website.

National Efficient Price

The NEP is developed in close consultation with all Australian governments on an annual basis. The NEP is a single National price based on the average cost of public hospital activity from all states and territories. It underpins national efficient price for health care services provided by public hospitals.

This NEP is applied to admitted services, emergency and non-admitted services. ABF services are priced using a single unit of measure, the NWAU. The Tasmanian funding amount is derived using the formula.

NWAU x NEP = ABF Funding amount.

The NEP is $5 597 per national weighted activity unit 2021–22 (NWAU (21)).

Educational and training resources on the topic of ABF are available on IHPA's website.

National Weighted Activity Units

The NWAU is the national unit for counting hospital service activity, based on the complexity of patients and legitimate variations in costs. The 'average' hospital service is equivalent to one NWAU. More intensive and expensive activities are funded by multiples of NWAUs, and simpler and less expensive activities are funded by fractions of an NWAU.

The NHRA allows for a Commonwealth funding contribution for patients who elect to use their private health insurance when they are admitted to a public hospital. For 2021-22 IHPA has calculate a Tasmanian specific NWAU, which takes into account all other revenue sources available to the hospital included Health Insurance payments. The reduction in the NWAU for private patients is, on average, around 30%, but varies according to the type of DRG or AN-SNAP end class. For example, surgical DRG's generally have higher reductions due to the cost of prostheses.

Educational and training resources on the topic of ABF are available on IHPA's website.

National Efficient Cost

The NEC is for health care services provided by public hospitals where the services are too low to be fully funded on a full activity basis. The NEC cost model is determined using the in-scope activity and expenditure data for services to be block funded. The NEC model has 2 components:

- The NEC for small rural public hospitals:
    - The NEC for small rural public hospitals is the sum of the fixed cost component and the variable cost component. The fixed component is determined as:
        - $2.199 million for hospitals with an annual NWAU (20) less than or equal to 187.

        - $2.199 million less 0.029 per cent per-NWAU (20) for hospitals with an annual NWAU (20) greater than 187. There is an additional loading of 30.2 per cent for 'very remote' hospitals.
        - The variable component of the efficient cost is determined as $5 762 per-NWAU (20) for hospitals with an annual NWAU (20) greater than 187.
- Efficient cost for other hospitals:
    - Other block-funded hospitals are treated separately from the 'variable and fixed' cost model. In Tasmania these are defined as:
        - Standalone hospitals providing specialist mental health services (for example, Roy Fagan Centre, Mistral Place, Millbrook Rise, Tolosa Street, Wilfred Lopes Centre and Alcohol and Drug Services Detoxification Unit)
        - Non- admitted Mental Health services
        - Child & Adolescent Mental Health Service
        - Non- admitted Home Ventilation and
        - Teaching, Training and Research in the major hospitals.
    - The IHPA has determined that for 2021–22, the efficient cost of these hospitals and service will be based on their total in-scope expenditure reported in the Local Hospital Networks/Public hospital Establishments National Minimum Data Set (LHN/PHE NMDS) from 2018−19 and NWAU activity levels reported by the facility.

The NEC is a prospective payment for hospitals without an end of year reconciliation as occurs for NEP hospitals.

Educational and training resources on the topic of ABF are available on IHPA's website.

Block Grants and Operational Grants

For services and initiatives provided where existing data does not accurately describe current activity or the service is not in scope of the NHRA, the service will be funded through a specific grant. The block and grant funding are based on historical expenditure profiles and other known factors.

The 2021-22 Tasmanian Activity Based Funding

ABF is a method of funding hospitals, whereby they are funded based on the mix and volume of patients treated.

Classification systems within each service stream are applied uniformly across all available data. Although these systems have been developed in part to explain variation in cost between different outputs within the stream, additional systematic variation still occurs. To account for this, various adjustments are modelled and where justified, implemented into the NWAU.

Admitted - Admitted Acute

The Australian Refined Diagnosis Related Group (AR-DRG) v10.0 classification system and ICD-10-AM Eleventh Edition will be used to classify and calculate NWAU 21 price weights for acute admitted services under the national ABF model which Tasmania has adopted.

Activity data at AR-DRG v10.0 level is used to set the acute activity volume and complexity of acute admitted services to be funded, where the admitting care type is 'Acute including qualified newborn' and the treatment is eligible for an NWAU weighting. The only exception to using the admitting care type is in the instance where an 'unqualified newborn' becomes qualified during the same episode of care. This is identified in the iPatient Manager (iPM) admissions system when the Admission care type is Neonate (unqualified) and the discharge care type of 'Acute including qualified newborn'.

Further details pertaining to the Acute NWAU adjustments and NWAU can be found in the *Tasmanian Funding and Purchasing Model Guidelines 2021-22* or the NEP determination 2021-22.

Admitted - Sub and Non-Acute

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

The 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.

Further details pertaining to the Sub and Non-Acute NWAU and NWAU adjustments can be found in the *Tasmanian Funding and Purchasing Model Guidelines 2021-22* or the NEP determination 2021-22.

Admitted - Mental health care

IHPA has developed the Australian Mental Health Care Classification (AMHCC) to classify and price mental health services across admitted and non-admitted settings in the National ABF model. IHPA will use AMHCC Version 1.0 to shadow price admitted mental health services for 2021–22 and will continue to provide pricing using the AR-DRG Version 10.0 and ICD-10-AM Eleventh Edition for NEP20.

Further details pertaining to the Acute NWAU and NWAU adjustments can be found in the *Tasmanian Funding and Purchasing Model Guidelines 2021-22 or* the NEP determination 2021-22.

Non-Admitted - Outpatients

Non-admitted outpatient care will be classified using Tier 2 Version 7.0 for 2021-22. Tasmania has adopted the IHPA classification.

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

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

Further details pertaining to the price weights for Tier 2 Non-Admitted Care classification version 7.0 can be found in Appendix J of the NEP determination 2021-22.

Emergency Care

The Australian Emergency Care Classification (AECC) version 1 will be used to classify and price ED (major Hospital) and Urgency Disposition Groups (UDG) version 1.3 will be used to classify Emergency Service (ES) care under the 2021-22 National ABF model. Tasmania has adopted the National ABF model for ED and ES services.

NWAU Price weights for AECC version 1 can be found in Appendix K of the NEP determination 2021-22.

NWAU Price weights for URG version 1.3 can be found in Appendix L of the NEP determination 2021-22.

Further details pertaining to the Emergency Department NWAU and NWAU adjustments can be found in the *Tasmanian Funding and Purchasing Model Guidelines 2021-22* for price weights for AECC 1 or UDG 1.3 can be found in the NEP determination 2021-22.

Teaching, Training and Research

The IHPA developed the Australian Teaching and Training Classification (ATTC) as a national classification for teaching and training activities which occur in public hospital service. IHPA has determined that for 2021–22, the efficient cost of Teaching, Training and Research (TT&R) will be determined in consultation with the state with reference to the efficient cost of in-scope expenditure identified as TT&R.

Educational and training resources on the topic of Teaching and Training are available on IHPA's website.

Supplementation Grants

In recognition that the THS has reported average cost greater than the NEP, a Supplementation Grant at the ABF stream level has been incorporated into the Funding Model for 2021-22. The Supplementation Grant is a mechanism for "keeping the system safe and operating" while the THS develops strategies to transition to the NEP.

The Supplementation Grants have been developed at the facility to recognise operational challenges faced by each ABF Facility.

2021-22 ABF Stream Supplementation Grants	Funding ($'000)
ABF Stream Supplementation - RHH	
Admitted Acute	34 724
Admitted Mental Health	2 745
Sub & Non-Acute	2 713
Emergency Department	12 021
Outpatients	10 346
ABF Stream Supplementation - LGH	
Admitted Acute	16 344
Admitted Mental Health	618
Sub & Non-Acute	732
Emergency Department	4 515
Outpatients	2 838
ABF Stream Supplementation - NWRH	
Admitted Acute	4 347

2021-22 ABF Stream Supplementation Grants	Funding ($'000)
Admitted Mental Health	396
Sub & Non-Acute	5
Emergency Department	0
Outpatients	35

The THS is encouraged to use the data available in the National Benchmarking Portal to identify the key cost drivers affecting their overall cost performance.

NHRA Public Hospital Funding

In line with the NHRA, a single National Health Funding Pool (NHFP) has been established, comprising a Reserve Bank of Australia account for each state and territory. The pool is operated by the NHFP Administrator (the Administrator), an independent statutory office holder.

All Australian Government funding for the NHRA is deposited into the State Pool Account along with the State's contribution to activity-based public hospital funding. NHR funding is paid to THS in accordance with the Service Plan.

The Administrator has responsibility for calculating the Australian Government contributions to states and ensuring Australian Government deposits into the NHFP are in line with the NHRA (ABF and NHRA Block models):

- Australian Government and State ABF Funding are deposited into the NHFP, then distributed directly to the State Pool Account; this is distributed directly to the THS. The ABF Funding is determined by the NWAU activity itemised in the Service Plan.
- Australian Government NHRA block funding is deposited into the NHFP, then distributed directly to the THS though the State Managed Fund (SMF). Similarly, State Block Funding is transferred directly to THS through the SMF, in accordance with the Service Plan.

During the annual ABF reconciliation process The Administrator may make a further adjustment to the price of an admitted activity to account for private insurance benefits paid for activity in public hospitals that has not been accounted for by the combined adjustments in the national efficient price (NEP) and state or territory funding models.

Further details pertaining to the Commonwealth National Health Reform funding to States and Territories can be found in the National Health Funding Bodies website.

Other State Health budget funds are paid though the SMF and do not form part of the NHR funding arrangements.

Adjustments to funding for any activity variance (increase/decrease) will be actioned via amendments to the Service Plan and as a result of the year activity/funding reconciliation process with the NHFB.