YOUR HEALTH AND HUMAN SERVICES

PROGRESS CHART

SEPTEMBER 2014

Department of Health and Human Services

Tasmanian Government

Your Health and Human Services Progress Chart provides a wide range of information about the performance of Tasmania's health and human services system.

The quarterly *Progress Chart* helps us evaluate our activities and determine our future directions.

The *Progress Chart* has been published continuously since 2006. We are currently reviewing how we can best improve the way we report information publicly on the performance of our services, including how we can improve the *Your Health and Human Services Progress Chart.*

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A note about the *MyHospitals* website

The *MyHospitals* Website, launched in 2010, is an Australian Government initiative to make it easier for people to access information about how hospitals are performing. The website provides information about bed numbers, patient admissions and hospital accreditation, as well as the types of specialised services each hospital provides. The website also provides comparisons national public hospital of performance statistics on waiting times for elective surgery, emergency department care and safety and quality data.

The website may present data on similar activity or performance indicators to those included in the *Your Health and Human Services (YHHS): Progress Chart.* Different figures for similar indicators may be observed between the two publications. This is because data provided by Tasmania for publication on the *MyHospitals* website must comply with agreed national data standards. On occasion, these standards may differ from those applied by the Department of Health and Human Services in the publication of the *YHHS: Progress Chart.*

What is the overall level of activity in our hospitals?

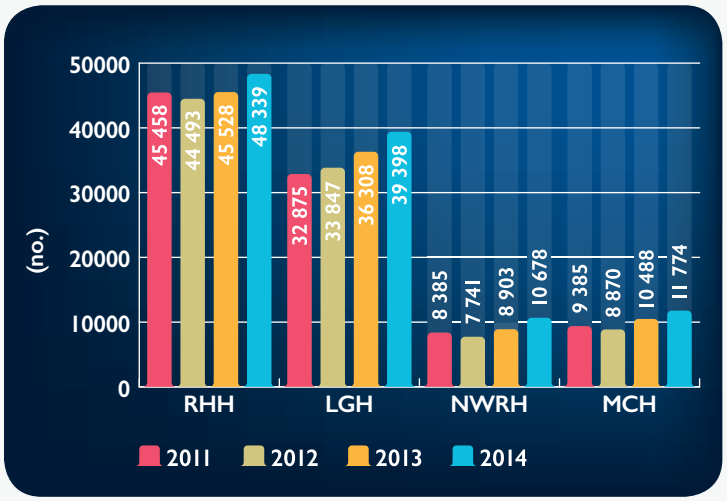
A separation is an episode of admitted patient care. Raw separations are not adjusted for the complexity of the episode of care and represent each individual episode of care in a given period (see explanatory note 1).

In the 12 months ending 30 June 2014 compared to the same period in the previous year, the number of raw separations increased:

- by 6.2 per cent at the RHH
- by 8.5 per cent at the LGH
- by 19.9 per cent at the NWRH
- by 12.3 per cent at the MCH.

Figure 1: Admitted patients – number of raw separations

(for the 12 months ending 30 June 2014)



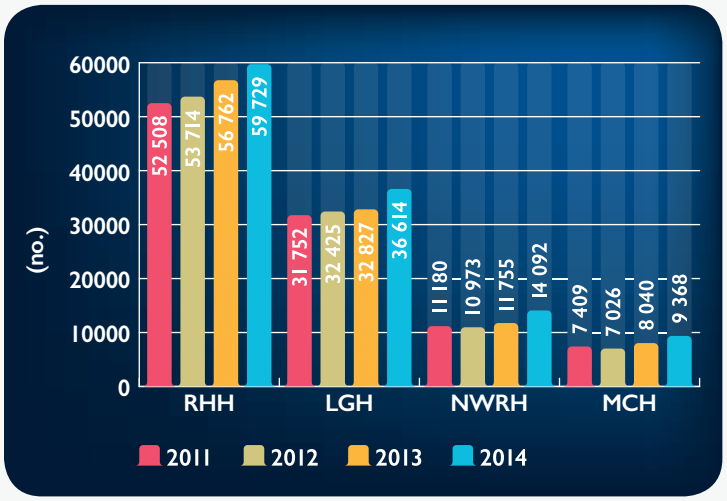
Weighted separations show the level and complexity of the work done in public hospitals by combining two measures: the number of times people come into hospital and how ill people are when they come into hospital (see explanatory note 1).

In the 12 months ending 30 June 2014 compared to the same period in the previous year, the number of weighted separations:

- increased by 5.2 per cent at the RHH
- increased by 11.5 per cent at the LGH
- increased by 19.9 per cent at the NWRH
- increased by 16.5 per cent at the MCH.

Figure 2: Admitted patients – number of weighted separations

(for the 12 months ending 30 June 2014)



How busy are our Emergency Departments?

Emergency department (ED) services are provided at each of the State's major public hospitals. EDs provide care for a range of illnesses and injuries, particularly those of a life-threatening nature. Figure 3 shows the number of people who presented to our EDs across the state.

In the 12 months ending 30 June 2014 compared to the same period in the previous year, ED presentations:

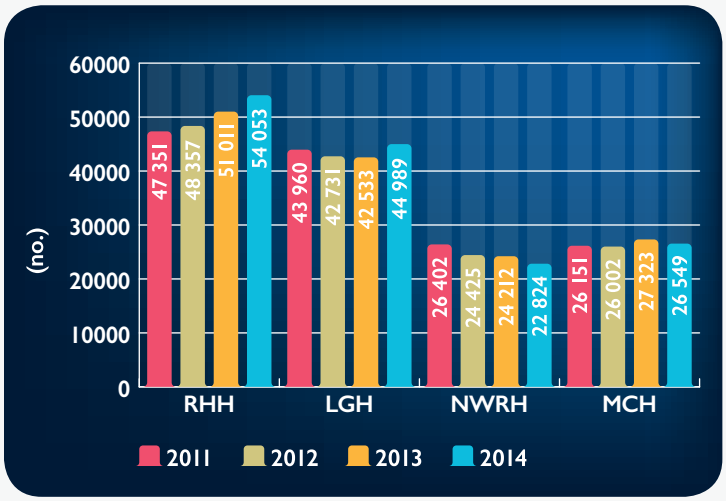
- increased by 6 per cent at the RHH
- increased by 1 per cent at the LGH
- decreased by 5.7 per cent at the NWRH
- decreased by 2.8 per cent at the MCH.

A range of initiatives continue to be implemented to address ED demand, performance issues and hospital patient flows. These initiatives are broadly aimed at:

- the diversion of patients who do not need ED care to more appropriate service providers
- using patient management protocols and procedures within EDs to maximise overall efficiency
- streaming patient care in the ED based on likely admission or discharge to improve efficiency
- improved efficiency and reduced waiting times for patients with non-life threatening minor injuries/illnesses through a fast-track model of care in the ED
- admission avoidance programs – managing patients in the community and reducing the demand on inpatient beds
- improving bed access and overcrowding procedures to maximise use of inpatient beds
- addressing staffing profiles within EDs.

Figure 3: Emergency Department presentations

(for the 12 months ending 30 June)



What percentage of patients were seen within recommended timeframes in EDs?

All patients presenting to an ED are triaged on arrival by a specifically trained and experienced registered nurse. The triage assessment and Australasian Triage Scale Categories are then allocated and recorded.

This indicator represents the percentage of patients assigned triage categories 1 through to 5 who commence medical assessment and treatment within the relevant waiting time from their time of arrival. The guidelines set by the Australasian College for Emergency Medicine (ACEM) are as follows:

- **Category 1 (resuscitation)** 100 per cent of patients should be seen immediately.
- **Category 2 (emergency)** 80 per cent of patients should be seen within 10 minutes.
- **Category 3 (urgent)** 75 per cent of patients should be seen within 30 minutes.
- **Category 4 (semi-urgent)** 70 per cent of patients should be seen within 1 hour.
- **Category 5 (non-urgent)** 70 per cent of patients should be seen within 2 hours.

In the 12 months ending 30 June 2014, the ACEM benchmarks were achieved for category 1, 2 and 5 patients at the RHH. ED workflow redesign and changes to admission processes for patients from ED to inpatient wards have been adopted to improve performance.

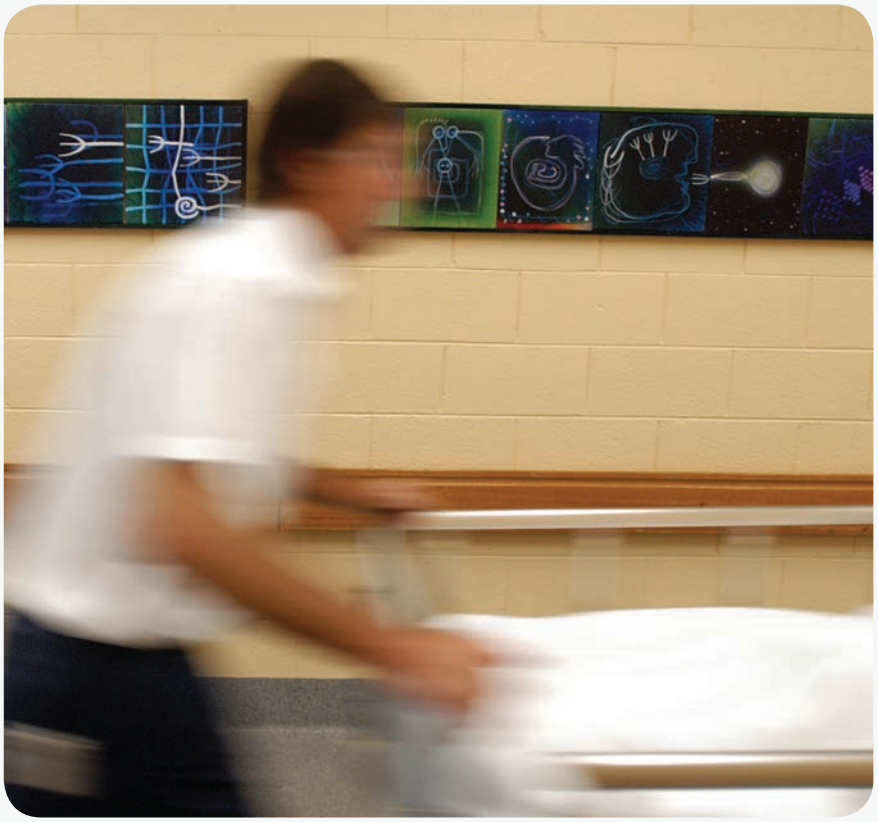
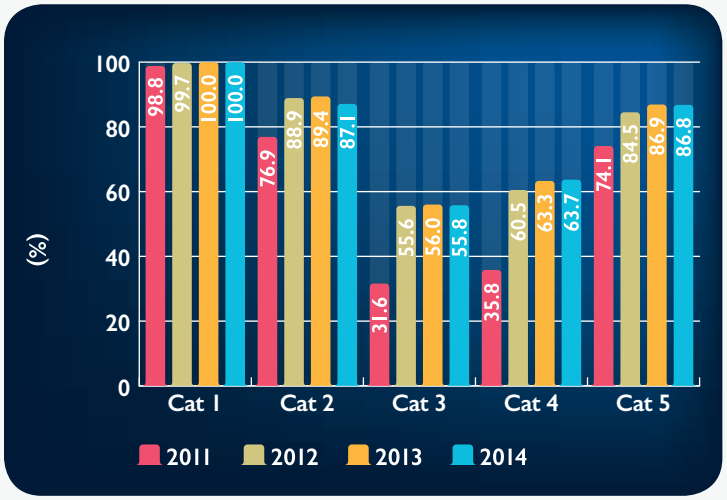


Figure 4: Patients who were seen within the recommended timeframe for Emergency Department Australasian Triage Scale Categories (RHH)

(for the 12 months ending 30 June)



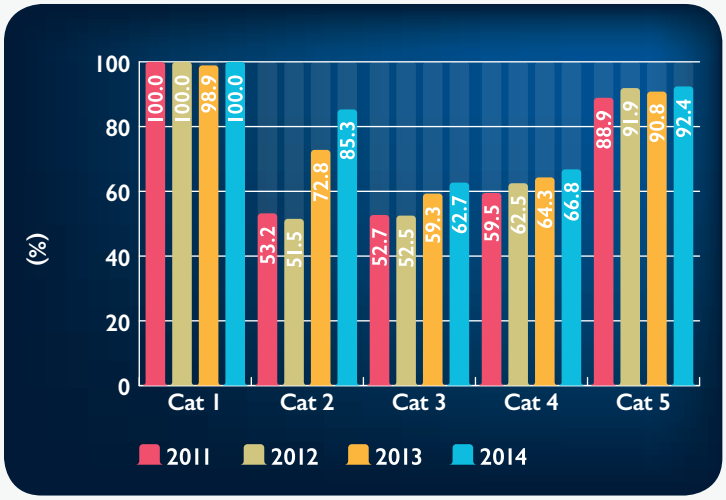
In the 12 months ending 30 June 2014 at the LGH, the ACEM benchmark was achieved for category, 1, 2 and 5 patients, with improvements shown in the other categories when compared to the previous year.

Over the period, a range of strategies have been implemented to improve category 2 performance, which resulted in significant improvement from 72.8 per cent to 85.3 per cent. Category 3 performance also improved.

Staffing recruitment and the new ED which opened in January 2012 have led to an improvement in the proportion of ED patients seen on time.

Figure 5: Patients who were seen within the recommended timeframe for Emergency Department Australasian Triage Scale Categories (LGH)

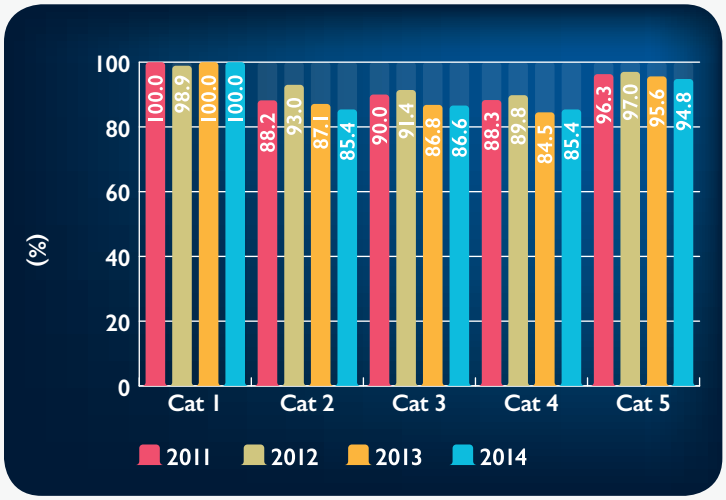
(for the 12 months ending 30 June)



In the 12 months ending 30 June 2014 at the NWRH, performance in all categories met the ACEM benchmarks, although performance for the percentage of categories 2, 3, and 5 seen in time is lower than the same time period last year.

Figure 6: Patients who were seen within the recommended timeframe for Emergency Department Australasian Triage Scale Categories (NWRH)

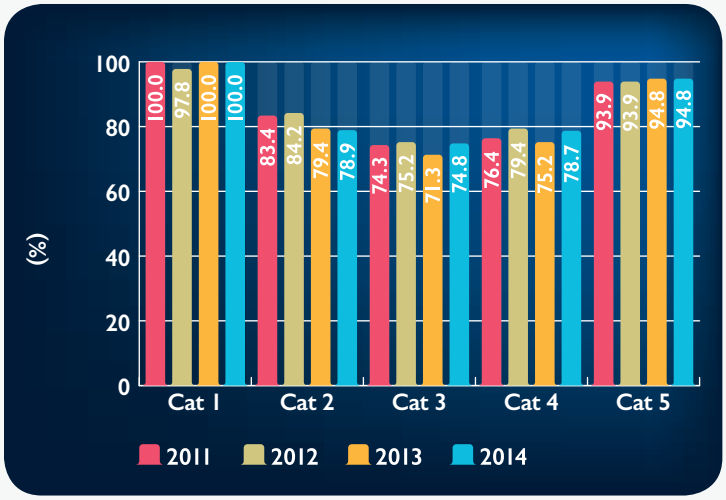
(for the 12 months ending 30 June)



In the 12 months ending 30 June 2014 at the MCH, ACEM benchmarks were achieved in all triage categories except triage categories 2 and 3.

Figure 7: Patients who were seen within the recommended timeframe for Emergency Department Australasian Triage Scale Categories (MCH)

(for the 12 months ending 30 June)



What percentage of patients leave the ED within 4 hours?

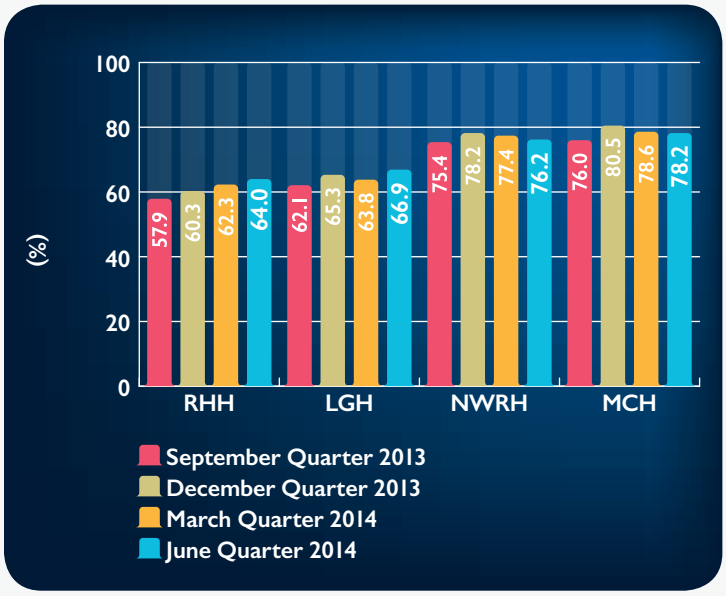
This emergency department indicator commenced in January 2012. Under the *National Partnership on Improving Public Hospital Services* the National Emergency Access Target (NEAT) has been introduced to improve Emergency Department length of stay. This measure reports the percentage of patients who physically leave the Emergency Department within four hours of presentation, regardless of whether they are admitted to hospital, referred to another hospital for treatment, or discharged.

This target is being phased in over four years, with annual interim targets set with the aim of achieving 90 per cent by 2015. The target for Tasmania for 2013 was 78 per cent and this increased to 84 per cent for 2014. More detailed performance data for this target is available in Appendix 1.

None of the hospitals met the target for the June Quarter, although there were improvements at the RHH and LGH.

Figure 8: Percentage of ED presentations who physically left within four hours of presentation

(July 2013- June 2014)



How many people were admitted from the elective surgery waiting list?

When compared to the same period in the previous year, admissions from the waiting list decreased

- by 4.8 per cent at the RHH
- by 0.6 per cent at the LGH

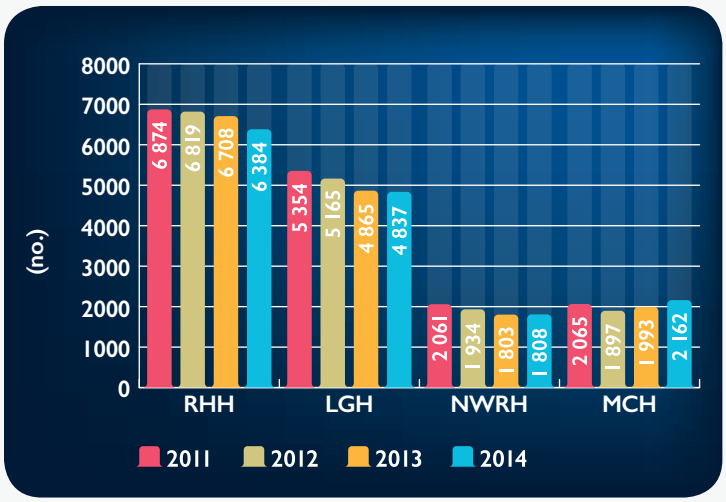
However, admissions increased:

- by 0.3 per cent at the NWRH
- by 8.5 per cent at the MCH.

This data includes patients treated through the funding provided by the Australian Government under the *National Agreement for Improving Public Hospital Services*.

Figure 9: Admissions from waiting list for elective surgery

(for the 12 months ending 30 June)



What is the waiting list for elective surgery?

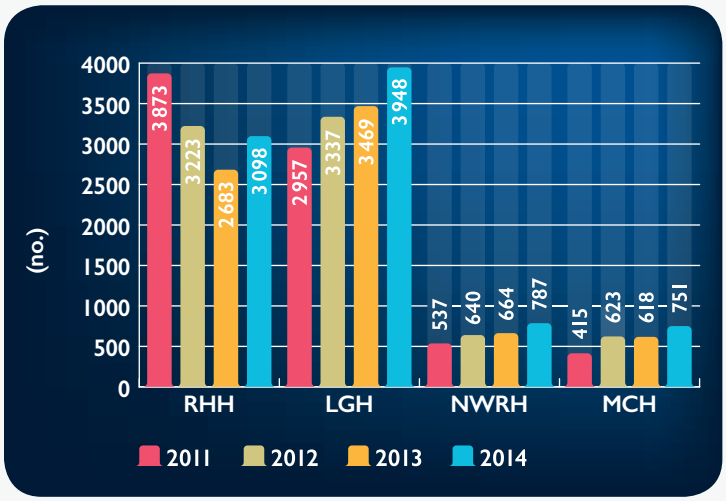
This information shows the number of patients waiting for elective surgery who are ready for care.

As at 30 June 2014 compared to the same time in the previous year, the number of patients waiting for elective surgery increased:

- by 15.5 per cent at the RHH
- by 13.8 per cent at the LGH
- by 18.5 per cent at the NWRH
- by 21.5 per cent at the MCH.

Figure 10: Waiting list for elective surgery

(as at 30 June 2014)



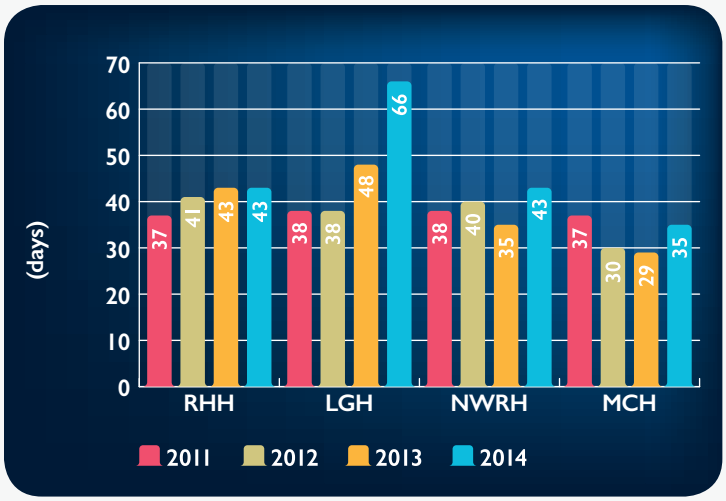
What is the usual time to wait for elective surgery?

Generally, the key question for patients requiring surgery is not how many patients are on lists but how long they are likely to wait for their surgery.

The median waiting at the RHH remained the same, but increased by 18 days at the LGH, by eight days at the NWRH and by six days at the MCH.

Figure 11: Median waiting times for elective surgery patients admitted from the waiting list

(for the 12 months ending 30 June)



What percentage of elective surgery patients were seen within recommended timeframes?

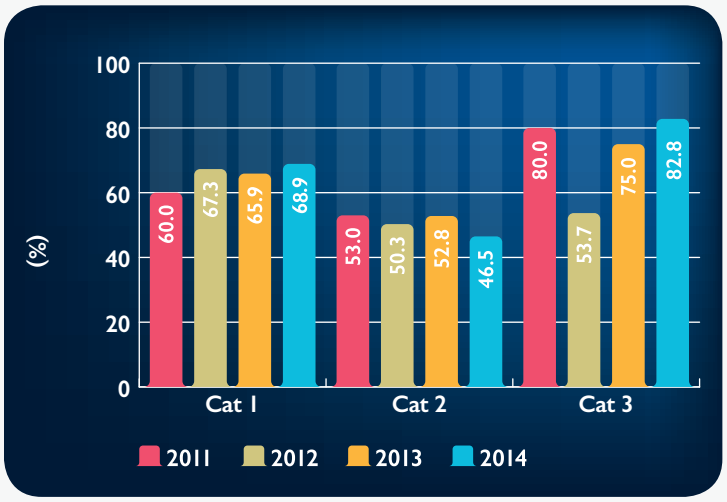
This indicator provides a measure of the percentage of patients admitted from the elective surgery list within the recommended timeframes. The current Tasmanian category timeframes are as follows:

- **Category 1 – Urgent:** Admission within 30 days is desirable for a condition that has the potential to deteriorate quickly to the point that it might become an emergency.
- **Category 2 – Semi-urgent:** Admission within 90 days is desirable for a condition which is likely to deteriorate significantly if left untreated beyond 90 days.
- **Category 3 – Non-urgent:** Admission beyond 90 days is acceptable for a condition which is unlikely to deteriorate quickly.

In the 12 months ending 30 June 2014 compared to the same time in the previous year the proportion of category 1 patients seen in time at the RHH increased from 65.9 per cent to 68.9 per cent, decreased in category 2 from 52.8 per cent to 46.5 per cent and increased in category 3 from 75.0 per cent to 82.8 per cent.

Figure 12: Patients seen within the recommended time for elective surgery at the RHH

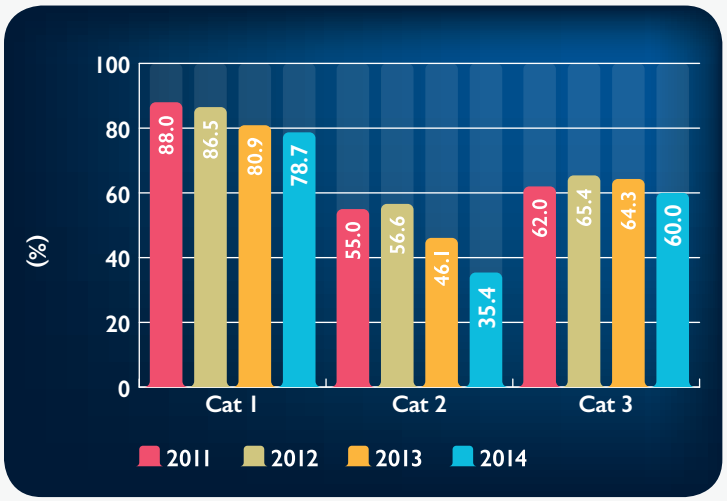
(for the 12 months ending 30 June)



At the LGH, the proportion of patients seen in time decreased in category 1 from 80.9 per cent to 78.7 per cent, decreased in category 2 from 46.1 per cent to 35.4 per cent and decreased in category 3 from 64.3 per cent to 60.0 per cent.

Figure 13: Patients seen within the recommended time for elective surgery at the LGH

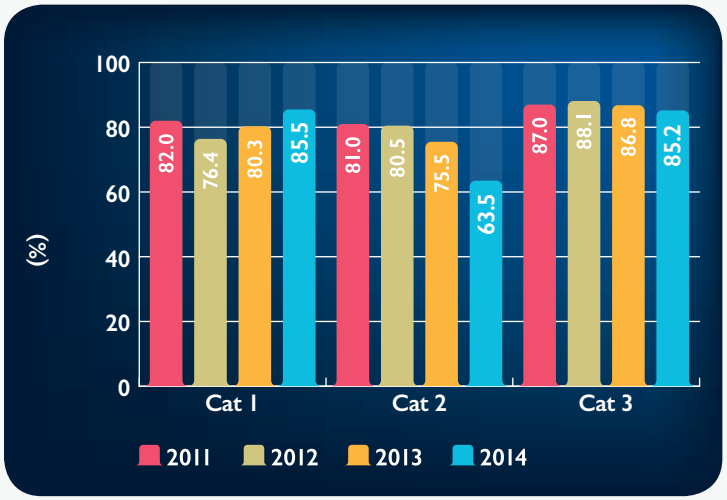
(for the nine months ending 30 June 2014)



At the NWRH, the proportion of patients seen in time increased in category 1 from 80.3 per cent to 85.5 per cent, decreased in category 2 from 75.5 per cent to 63.5 per cent and decreased from 86.8 per cent to 85.2 per cent in category 3.

Figure 14: Patients seen within the recommended time for elective surgery at the NWRH

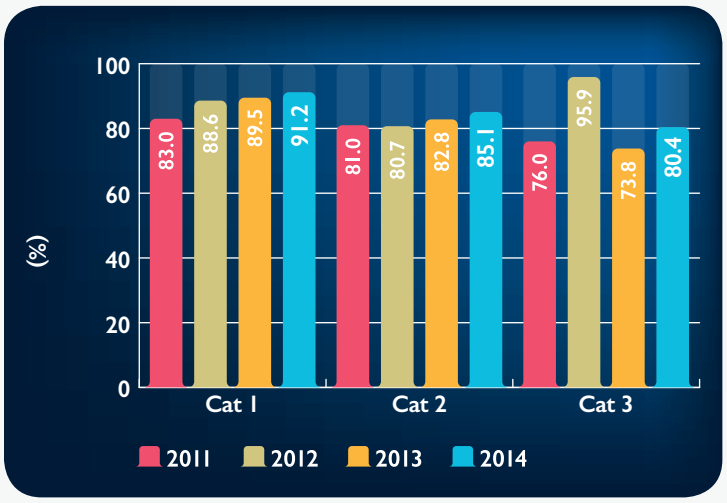
(for the 12 months ending 30 June)



At the MCH, the proportion of patients seen in time increased in category 1 from 89.5 per cent to 91.2 per cent, increased in category 2 from 82.8 per cent to 85.1 per cent, and increased in category 3 from 73.8 per cent to 80.4 per cent.

Figure 15: Patients seen within the recommended time for elective surgery at the MCH

(for the 12 months ending 30 June)



How is Tasmania progressing towards the National Elective Surgery Target?

Tasmania has agreed to report progress towards the *National Elective Surgery Access Target* (NEST) which is part of the *National Partnership Agreement on Improving Public Hospital Services.*

The NEST targets aim to improve the immediate and long term delivery and access to elective surgery through a range of system wide projects which are being co-ordinated through each of Tasmania's four major public hospitals.

The Agreement provides reward payments to be made in recognition of improved performance.

There are too many indicators in the NEST agreement to include in the main section of the *Progress Chart*. However, detailed performance data for the NEST targets is publicly available in Appendix 1.

What is the National Partnership Agreement on Improving Health Services in Tasmania?

The National Partnership Agreement on Improving Health Services in Tasmania (IHST) is part of the $325 million Tasmanian Health Assistance Package announced by the former Federal Health Minister Tanya Plibersek in June 2012. This agreement supports the delivery of a package of health service measures to address the future challenges of Tasmania's older population, high rates of chronic disease and Tasmanian health system constraints.

The IHST provides $30.5 million for the delivery of additional elective surgery procedures, between 2012 -2013 and 2015-2016. As part of this agreement Tasmania needs to perform at least 2 600 additional procedures for patients who have waited the longest beyond the clinically recommended period for their surgery. This means there will be a minimum of 500 additional procedures performed across the State each financial year until 30 June 2016.

IHST data for 1 January to 30 June 2014 showing the the number of procedures for targeted patients is included in this *Progress Chart* at Appendix 2.

How many call outs has our ambulance service responded to?

Ambulance Tasmania responds to calls for emergency medical assistance by dispatching sedans, ambulances, helicopters, fixed wing aircraft or in some cases marine responses.

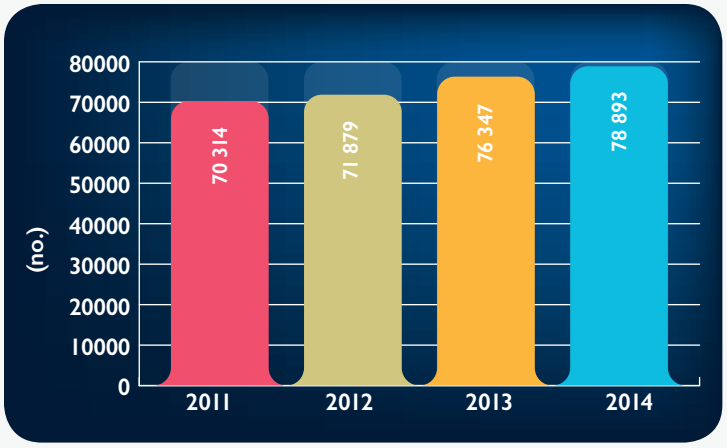
The number of vehicles dispatched (responses) is one measure of Ambulance Tasmania's workload and an indicator of the demand for ambulance services in Tasmania. This measure includes emergency, urgent and non-urgent responses, sometimes referred to as Domestic cases (Note: Cases managed by the Heath Transport Service – these include scheduled bookings for Non-Emergency Patient Transport Service patients – are excluded).

In 2012 Ambulance Tasmania refined its case load method to exclude vehicle movements that did not involve patients - such as the movement of a vehicle to a repairer or driving between stations when not on cases. Excluding these vehicle movements provides a more accurate reflection of actual patient related ambulance responses.
To enable comparison across years all figures reported in this chart have been calculated using the new method.

The long term trend is that ambulance responses are increasing largely due to the ageing population and an increase in the number of people with chronic conditions who are cared for at home but who require transport to hospital when their conditions become more serious.

Figure 16: Total ambulance responses

(for the 12 months ending 30 June)



How quickly does our ambulance service respond to calls?

The ambulance emergency response time is the difference in time between an emergency 000 call being received at the ambulance Communications Centre and the first vehicle arriving at the location to treat the sick or injured patient. The Median Emergency Response Time is the middle time value when all the response times are ordered from the shortest to the longest.

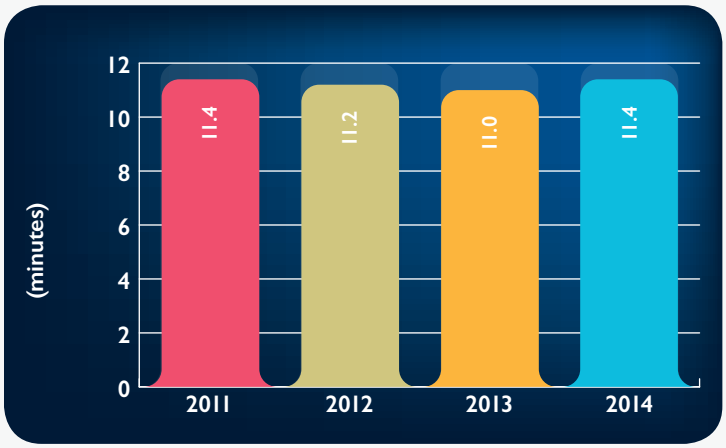
There is a direct correlation between increased calls for help and slower ambulance response times as the same number of vehicles become busier. Additional resourcing or achievement of efficiencies and innovation are used to minimise these effects. Increased time at hospitals due to ramping also increases ambulance response times.

There are a variety of factors which affect ambulance response times in Tasmania including:

- A relatively high proportion of the population living in rural and remote areas
- hilly terrain, ribbon urban development along the Derwent and Tamar rivers
- a high reliance on Volunteer Ambulance Officers.

Figure 17: Ambulance emergency response times

(for the 12 months ending 30 June)



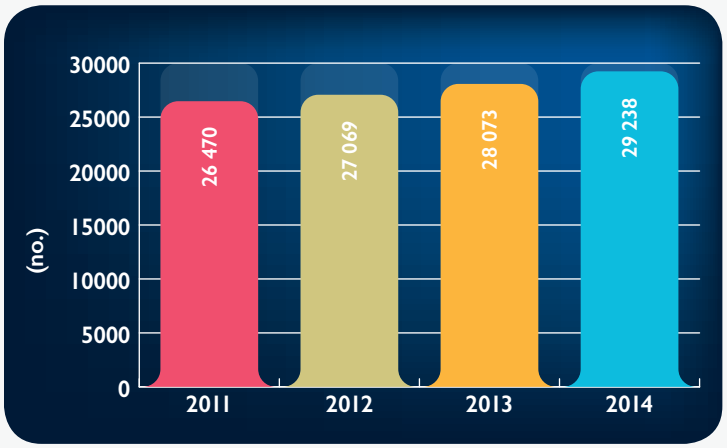
How many women are screened for breast cancer?

This is a measure of the number of eligible women screened for breast cancer. Screening for breast cancer amongst the eligible population occurs every two years for individual women. Service performance is therefore best measured by comparing the screening numbers for any given period with the equivalent period two years earlier.

Although the target population is all Tasmanian women aged between 50 and 69 years, all women aged over 40 years are eligible for screening services. Increasing the number of women screened for breast cancer is necessary to keep pace with growth in the eligible population.

Figure 18: Eligible women screened for breast cancer

(for the 12 months ending 30 June)



What proportion of BreastScreen clients were assessed within the recommended timeframe?

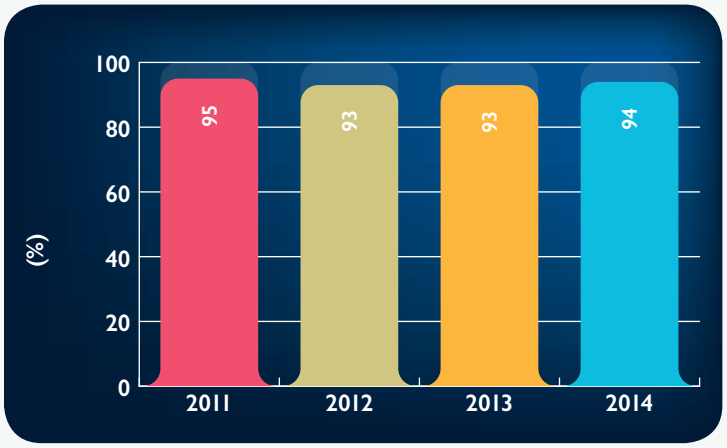
This indicator measures the percentage of those women called back for further assessment within 28 days of being screened out of all women who attend for further assessment within the reporting period.

In the 12 months ending 30 June 2014 94 per cent of clients were assessed within 28 days compared to 93 per cent for the comparable biennial screening cohort in 2012.

BreastScreen Tasmania continues to out-perform the BreastScreen Australia national target of 90 per cent for this measure.

Figure 19: Percentage of clients assessed within 28 days of mammogram

(for the 12 months ending 30 June)



How many dental appointments have adults accessed?

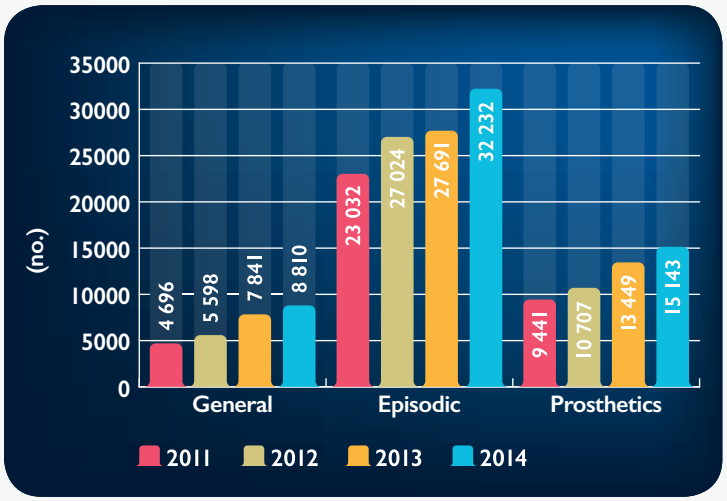
This indicator shows the number of occasions of service for all public dental services (episodic care, general care and prosthetics) provided around the State. It should be noted that outsourced general care provided by the private sector prior to 2012 under the General Care Tender is excluded from these figures. General care outsourced since 2012 is included.

In the 12 months ending 30 June 2014, compared to the same period in the previous year, there was:

- a 12.4 per cent increase in the number of general occasions of service.
- a 16.4 per cent increase in the number of episodic occasions of service.
- a 12.6 per cent increase in the number of prosthetics occasions of service.

Figure 20: Adults – occasions of service

(for the 12 months ending 30 June)



Additional funding by the Commonwealth was provided in 2013-14 under the National Partnership Agreement on Treating More Public Dental Patients. Services provided with this funding were the largest contributor to the increase in occasions of service.

How many dental appointments have children accessed?

In the 12 months ending 30 June 2014 compared to the same period in the previous year, there has been a 4.8 per cent decrease in the occasions of service for children receiving dental care.

Figure 21: Children – occasions of service

(for the 12 months ending 30 June)

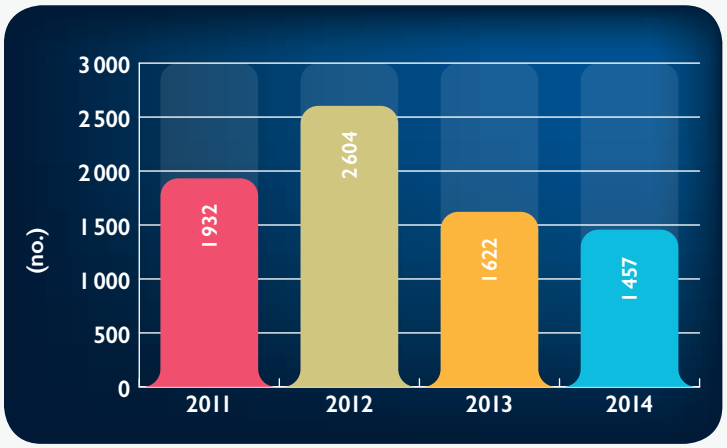
What are the waiting lists for oral health services?

The dentures waiting list indicator shows the number of people waiting for upper and/or lower dentures.

As at 30 June compared to the same time in the previous year, there was a 10.2 per cent decrease in the dentures waiting list.

Figure 22: Dentures – waiting list

(as at 30 June 2014)

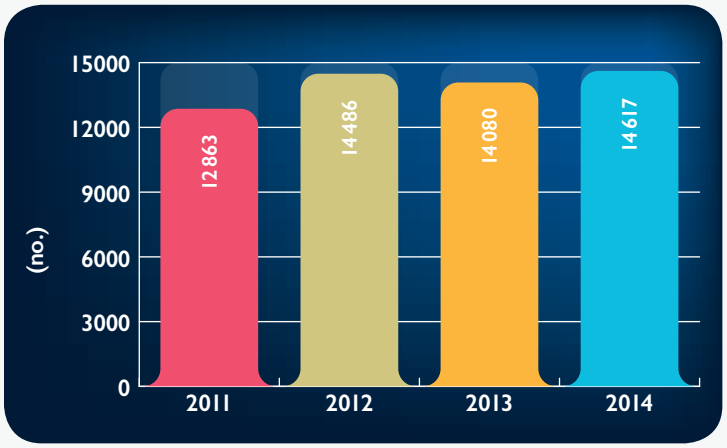


The general care (adults) waiting list indicator shows the number of adults waiting for general dental care.

As at 30 June 2014 the general care waiting list increased by 3.8 per cent compared to the same time in the previous year.

Figure 23: General care (adults) – waiting list

(as at 30 June 2014)



What is the activity rate in our mental health acute facilities?

This indicator reports the total number of mental health inpatient separations across the State. An inpatient separation refers to an episode of patient care in an acute mental health facility for a patient who has been admitted and who is now discharged. A separation therefore represents each individual episode of care in a given period.

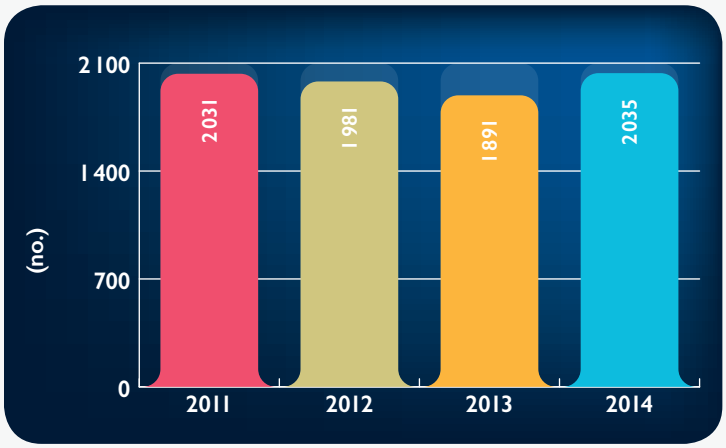
Activity rates are affected by the level of demand for services, the readmission rate, service capacity to admit clients with less severe mental illnesses and the effectiveness of the service system in managing clients in the community.

In the 12 months ending 30 June 2014 compared to the same period in the previous year, the number of people recorded as being treated in acute settings increased by 7.6 per cent.

The recording of inpatient separation data is much improved due to improved data collection and reporting procedures.

Figure 24: Mental Health Services – inpatient separations

(for the 12 months ending 30 June)



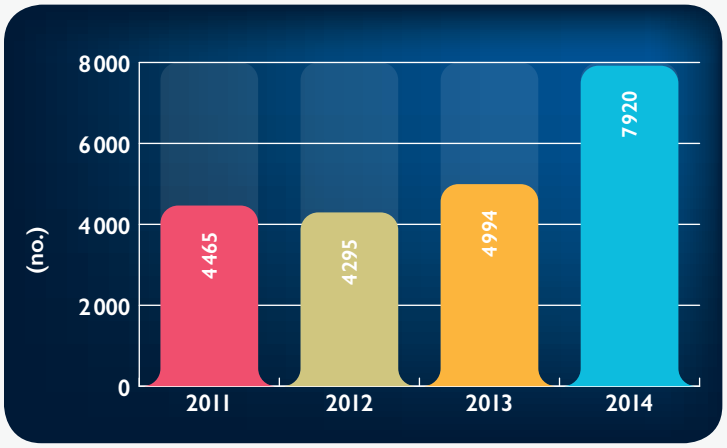
How many clients are accessing Mental Health Services?

This indicator measures the number of community and residential clients under the care of Mental Health Services. Active community clients are people who live in local communities who are actively accessing services provided by community-based Mental Health Services teams. Active residential clients are people residing in residential care provided by Mental Health Services and receiving clinical care from residential service teams.

The number of active community and residential clients is affected by a combination of demand for services and the accessibility of services. Increases in numbers of clients in community and residential care are desirable as it helps to keep clients out of hospital (acute psychiatric care settings) and assists in supporting the client with activities of day to day living.

Figure 25: Mental Health Services – community and residential – active clients

(for the 12 months ending 30 June)



In the 12 months ending 30 June 2014 compared to the same period in the previous year, the number of community and residential clients increased by 58.6 per cent.

The recording of client data is much improved due to implementation of new client administration system in July 2013.

What is the rate of readmissions to acute mental health facilities?

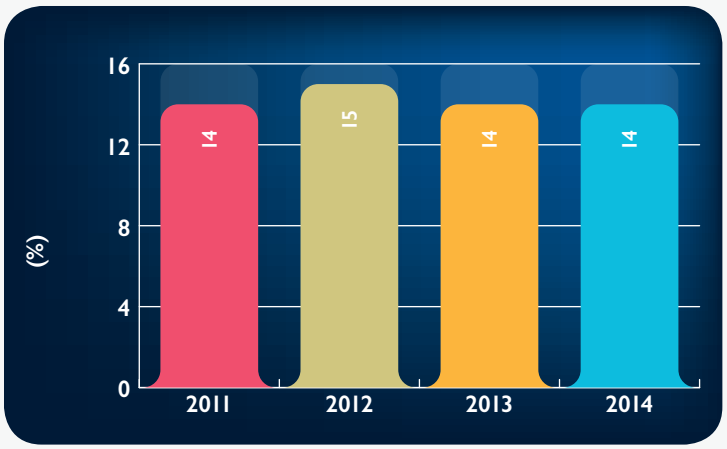
This shows the percentage of people whose readmission to an acute psychiatric inpatient unit within 28 days of discharge was unplanned or unexpected. This could be due to a relapse or a complication resulting from the illness for which the patient was initially admitted or from planned follow-up care.

For people who experience mental illness, and particularly those who require acute mental health care, the episodic nature of their condition can often mean that they are likely to require further treatment.

In the 12 months ending 30 June 2014 the 28 day readmission rate remained the same as in the same period in 2012-13 at 14 per cent.

Figure 26: 28 day readmission rate – all hospitals

(for the 12 months ending 30 June)



How many people have been housed?

This information shows the number of people who have been allocated public housing. This includes people who have been housed by community organisations from the public housing wait list.

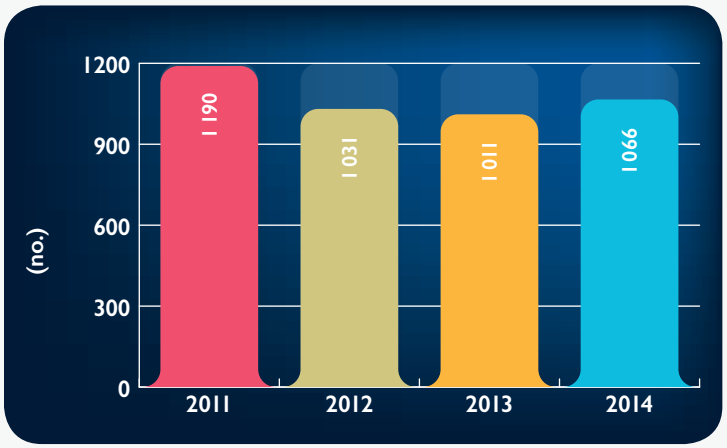
In the 12 months ending 30 June 2014, the number of people housed increased by 5.4 per cent compared to the same period in the previous year.

This does not reflect all people housed in affordable accommodation models, only those that are housed from the public housing wait list. More than 1 600 new affordable housing properties have been provided since 2009.

Occupancy rates and demand for public housing remain high.

Figure 27: Number of applicants housed

(for the 12 months ending 30 June)



How many people receive private rental assistance?

In the 12 months ending 30 June 2014, 4 100 households received financial assistance through Private Rental Assistance, a decrease of 0.7 per cent compared to the previous year.

Figure 28: Number of households assisted through the private rental support scheme

(for the 12 months ending 30 June)

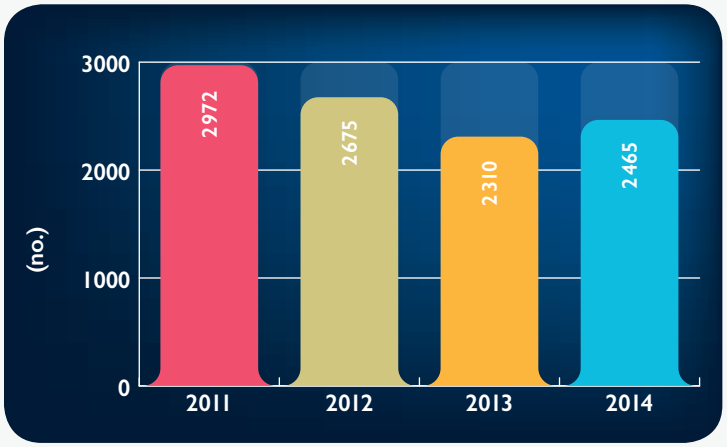
What are the waiting lists for public housing?

This indicator measures the total number of people who were waiting for public housing.

The public housing wait list has increased from last year. The wait list at 30 June 2014 was 2 465, an increase of 6.7 per cent compared to the previous year.

Figure 29: Number of applicants on waitlist for public housing

(as at 30 June 2014)



What is the usual wait for people with priority housing needs?

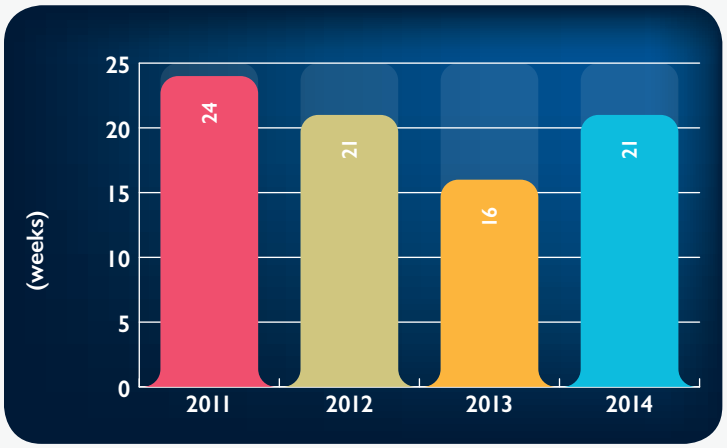
This indicates how many weeks it takes to house applicants who have been assessed to have the highest level of need, (Category 1 or exceptional needs). The assessment of need is based on adequacy, affordability and appropriateness of housing.

In the 12 months ending 30 June 2014, the average time to house category 1 or exceptional needs applicants was 21 weeks, an increase of five weeks from the previous year. This was an exceptional result for 2013 with usual wait times averaging from between 19 and 21 weeks.

The capacity to house priority applicants quickly is contingent upon the availability of homes that meet household amenity and locational needs.

Figure 30: Average time to house category 1 applicants

(for the 12 months ending 30 June)



How many child protection notifications are referred for investigation?

All notifications received are the subject of an initial assessment to determine if they meet the threshold for statutory intervention.

In the 12 months ending 30 June 2014, compared to the same period in the previous year, there has been a 27.4 per cent decrease in the number of notifications which met the threshold for statutory intervention referred for investigation across the State.

The numbers of notifications referred are quite volatile over time, as apparent from the figures over four years in Figure 31. The numbers of notifications and notifications referred for investigation are also variable across the different Children and Youth Services Areas due to the need to meet statutory obligations and respond to variable levels of demand.

Figure 31: Number of notifications referred to service centres for further investigation

(for the 12 months ending 30 June)

How many child protection notifications are not allocated within established timeframes?

The number of unallocated child protection notifications can vary from day to day, depending on a range of demand management requirements on any given day.

This refers to the number of notifications of child abuse and neglect received by DHHS that have been assessed as meeting the threshold for protective intervention that are then referred for investigation and not allocated within established time frames. Established timeframes, for allocation for investigation are according to priority:

- **Priority 1** – half a day.
- **Priority 2** – five days.
- **Priority 3** – ten days.

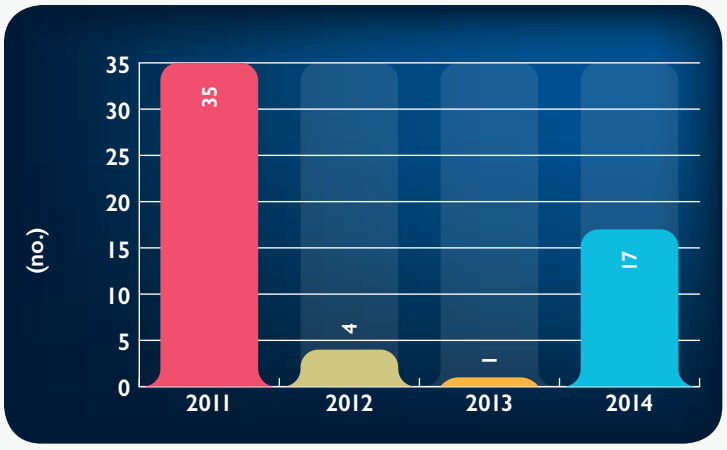
Every effort is made to ensure compliance with the standards, thus ensuring children are provided with a timely response proportionate to the assessed risk and need.

As at 30 June 2014, all Priority 1 notifications were allocated within the established timeframe. There were 17 notifications not allocated for investigation within the established time frames, 14 of which were Priority 2 and 3 of which were Priority 3.

A number of strategies have been implemented that have already produced a considerable reduction in investigations not allocated within the required timeframes since December 2013. DHHS remains committed to keeping this number low (see explanatory note 5).

Figure 32: Child abuse or neglect: number of unallocated cases

(as at 30 June 2014)



How many children are placed in Out-of-Home Care?

As at 30 June 2014 there were 1 054 children in Out-of-Home Care (OOHC), which represents a decrease of 1.2 per cent compared to the same time in the previous year. Since 2005, all states and territories have predominantly experienced an increase in the number of children in care.

The recent decrease in the number of children in out of home care in Tasmania has occurred in the context of a reduction in the number of notifications referred which met the threshold for protective intervention as well as a reduction in the number of children admitted to out of home care for the first time. Further investigation is required to definitively ascertain the reasons for the decline in flows of activity through Child Protection Services.

Children are likely to come in to care for a number of reasons, such as parental substance abuse, mental health issues and family violence, which place the child at risk of harm. Children remain in care until these issues are resolved, which often requires appropriate and sustained support.

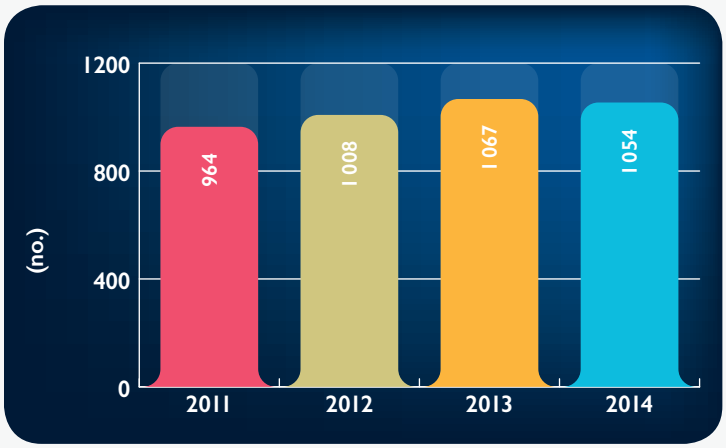
DHHS continues to develop appropriate family and specialist support services to enable parents to be reunified with their children in a timely and safe way. This includes strengthening opportunities to work with parents to support them to resolve safety issues.

The Department is also undertaking a significant reform of the whole OOHC system for children. This reform takes a whole of system approach so that the right services are provided for children and families when they need them.

A number of initiatives are also in place including the introduction of the Signs of Safety program, strengthening practice and leadership, improving communication and information exchange, and adopting a less adversarial child protection system.

Figure 33: Children in Out-of-Home Care

(as at 30 June 2014)



What are the waiting lists for people requiring supported accommodation?

This indicator shows the number of people with a disability urgently waiting for a supported accommodation placement. Supported accommodation services provide assistance for people with disability within a range of accommodation options, including group homes and other supported accommodation settings.

In addition to providing support for daily living these services promote access, participation and integration into the local community. Supported accommodation is provided by community-based organisations that are funded by the State Government.

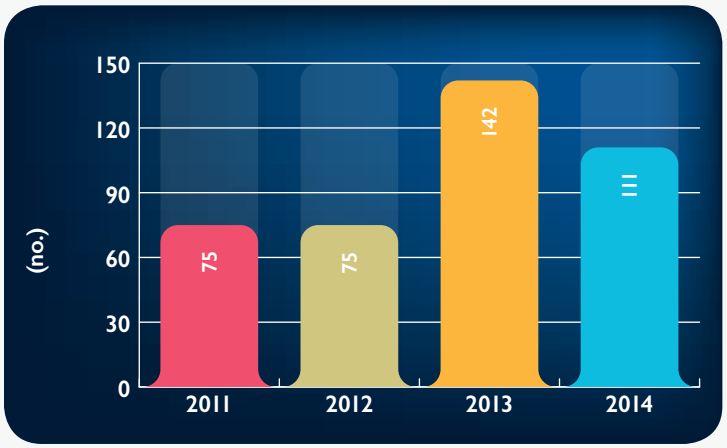
As at 30 June 2014 compared to the same time in the previous year, there has been a 21.8 per cent decrease in the number of people with a disability who are urgently waiting for a supported accommodation placement.

While no additional new funds have been allocated in 2013-14, clients from the waiting list access any vacancies that arise in the current system.

The National Disability Insurance Scheme (NDIS) is being trialled in Tasmania for eligible young people aged 15 to 24 years from 1 July 2013 to 30 June 2016. Introduction of the Scheme may explain some of the decrease in the waiting list, particularly as school leavers are able to directly enter the Scheme. It is estimated that 1000 young people will be eligible to benefit from the NDIS in the trial. As at 30 June 2014, 786 young people were participants of the Scheme including 85 people who were previously on the waiting list.

Figure 34: Disability services – supported accommodation – waiting list

(as at 30 June 2014)



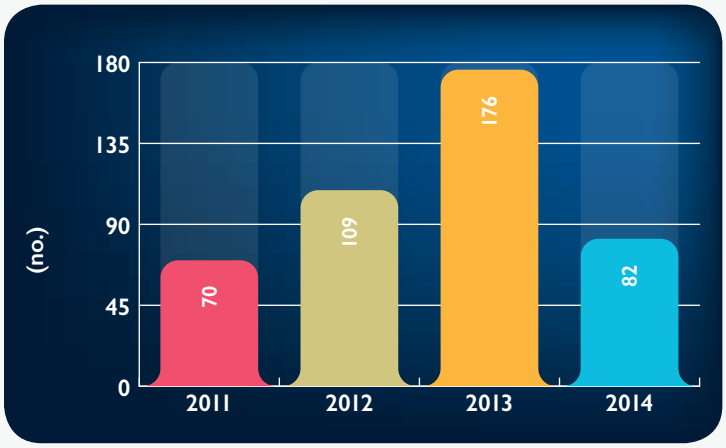
What is the waiting list for community access clients?

This indicator shows the number of people with disability who are waiting for a full-time or part-time community access placement. Community access services provide activities which promote learning and skill development and enable access, participation and integration in the local community. Community access services can also provide an important respite effect for carers of people with disability.

As at 30 June 2014 compared to the same time in the previous year, there has been a 53.4 per cent decrease in the number of people with a disability who are waiting for a full-time or part-time community access placement. This includes people who already have a placement and are seeking additional days.

Figure 35: Disability services – community access clients – waiting list

(as at 30 June 2014)



The National Disability Insurance Scheme (NDIS) is being trialled in Tasmania for eligible young people aged 15 to 24 years from 1 July 2013 to 30 June 2016. Introduction of the Scheme may explain the recent decrease in waiting lists, particularly as school leavers are able to directly enter the Scheme. It is estimated that 1000 young people will be eligible to benefit from the NDIS in the trial. As at 30 June 2014, 786 young people were participants of the Scheme including 58 people who were previously on the waiting list.

Explanatory notes

1. The figures for raw and weighted separations do not include outside referred patients or unqualified neonates.
2. The following acronyms are used in this report:

   a. ED Emergency Department
   b. LGH Launceston General Hospital
   c. NWRH North West Regional Hospital
   d. RHH Royal Hobart Hospital
   e. MCH Mersey Community Hospital

Appendix 1: Progress towards the National Emergency Access Target and the National Elective Surgery Target

As part of the *National Partnership Agreement on Improving Public Hospital Services,* Tasmania is required to report on progress towards the *National Emergency Access Target* (NEAT) and the *National Elective Surgery Target* (NEST). This statistical appendix provides an outline of the two agreements as well as detailed performance information in relation to the two targets. Tasmania is committed to reporting emergency care and elective surgery performance data.

NEAT

The objective of the NEAT is that by 2015, 90 per cent of all patients presenting to a public hospital ED will depart within four hours (either by admission to hospital, referral to another hospital for treatment, or discharge).

The 90 per cent target must be achieved by the end of December 2015 through a series of stepped intermediate targets. The target for Tasmania has increased to 84 per cent for 2014, from 78 per cent during 2013.

National Emergency Access Target (NEAT), by quarter, by hospital

Percentage of all patients who physically left the ED within four hours of presentation: 2013-2014	RHH	LGH	NWRH	MCH	Statewide
September 2013 Quarter	57.9%	62.1%	75.4%	76.0%	65.1%
December 2013 Quarter	60.3%	65.3%	78.2%	80.5%	68.0%
March 2014 Quarter	62.3%	63.8%	77.4%	78.6%	67.1%
June 2014 Quarter	64.0%	66.9%	76.2%	78.2%	69.3%

Note: The final NEAT data extracts for the June 2014 quarter have been approved by the Tasmanian Health Organisations as part of the DHHS quarterly *National Partnership Agreement on Improving Public Hospital Services* data submission to the Australian Institute of Health and Welfare (AIHW).

NEST

The objectives of the NEST are to increase the percentage of elective surgery patients seen so that 100 per cent of all Urgency Category patients waiting for surgery are seen within the clinically recommended time, and to reduce the number of patients who have waited longer than the clinically recommended time.

The two complementary strategies that make up the NEST are:

- **Part 1:** Stepped improvement in the number of patients treated within the clinically recommended time.
- **Part 2:** A progressive reduction in the number of patients who are overdue for surgery, particularly patients who have waited the longest beyond the clinically recommended time.

National Elective Surgery Target (NEST) indicators: 1 April – 30 June Quarter 2014					
Major Tasmanian Public Reportable Hospitals	**RHH**	**LGH**	**NWRH**	**MCH**	**Statewide**
NEST Part 1 – Number of patients receiving elective surgery from waiting lists					
Admitted as elective patient for awaited procedure in this hospital or another hospital	1 190	1 130	465	545	3 330
Admitted as emergency patient for awaited procedure in this hospital or another hospital	7	14	4	0	25
Total	**1 197**	**1 144**	**469**	**545**	**3 355**
Patients removed for reasons other than successful surgery					
Could not be contacted (includes patients who have died while waiting whether or not the cause of death was related to the condition requiring treatment)	15	25	3	8	51
Treated elsewhere for awaited procedure	34	40	8	1	83
Surgery not required or declined	88	71	24	6	189
Transferred to another hospital's waiting list	7	12	6	4	29
Not known	51	21	29	26	127
Total	**195**	**169**	**70**	**45**	**479**
NEST Part 1 – Number of patients treated within the clinically recommended time					
Category 1	470	258	105	100	933
Category 2	152	165	136	147	600
Category 3	56	139	95	228	518
Total	**678**	**562**	**336**	**475**	**2051**
NEST – Percentage of patients treated within the clinically recommended time					
Category 1	64.9%	67.9%	79.5%	91.7%	69.4%
Category 2	39.1%	31.0%	61.0%	84.5%	45.5%
Category 3	72.7%	63.8%	86.4%	87.0%	77.7%
Total	**57.0%**	**49.7%**	**72.3%**	**87.2%**	**61.6%**

Major Tasmanian Public Reportable Hospitals	RHH	LGH	NWRH	MCH	Statewide
Median waiting time for elective surgery admission (days)					
Cataract Extraction	91	485	NA	65	301
Cholecystectomy	37	294	44	50	47
Coronary Artery Bypass Graft	20	NA	NA	NA	20
Cystoscopy	27	34	NA	38	29
Haemorrhoidectomy	297	946	76	24	116
Hysterectomy	20	140	118	44	48
Inguinal Herniorraphy	84	290	57	142	89
Myringoplasty	275	438	36	43	46
Myringotomy	32	61	NA	NA	33
Prostatectomy	38	212	NA	NA	200
Septoplasty	113	336	27	NA	116
Tonsillectomy	45	132	343	56	107
Total Hip Replacement	598	341	297	NA	361
Total Knee Replacement	683	359	307	NA	528
Varicose Veins Stripping and Ligation	31	NA	419	NA	63
Other procedures not listed above	33	48	42	23	36
Total	**36**	**79**	**46**	**37**	**46**
Median waiting time by urgency category (days) Admissions					
Category 1	21	19	19	13	20
Category 2	128	203	69	33	111
Category 3	156	225	149	69	159
Total	**36**	**79**	**46**	**37**	**46**

Major Tasmanian Public Reportable Hospitals	RHH	LGH	NWRH	MCH	Statewide
Number of surgical episodes with one or more adverse event flags					
Number of adverse event flags	66	67	27	16	176
Number of unplanned readmissions within 28 days					
Number of 28 day readmissions	0	0	0	0	0
NEST Part 2 – Average overdue wait time in days for those patients still waiting and ready for care					
Category 1	30	27	39	13	30
Category 2	179	210	139	33	192
Category 3	1039	288	212	116	491

Note: NA (not available) indicates that the procedure is not provided at the hospital.

These final NEST indicator June 2014 data extracts have been approved by the Tasmanian Health Organisations as part of the DHHS quarterly *National Partnership Agreement on Improving Public Hospital Services* data submission to the Australian Institute of Health and Welfare (AIHW).

Appendix 2: Progress towards the Improving Health Services in Tasmania Action Plan

Under the *National Partnership Agreement on Improving Health Services in Tasmania* (NPA: IHST) a minimum of 2 600 additional elective surgery procedures must be performed between September 2012 and June 2016. The NPA: IHST is targeted at patients who have waited the longest beyond the clinically recommended period for their surgery.

In total, 745 elective surgery procedures were performed during 2012-13, the first year of the agreement. A further 655 procedures were performed during 2013-14.

Improving Health Services in Tasmania – Number of patients treated by THO and hospital				
Surgical Procedures	**THO – South, Royal Hobart Hospital**	**THO – North, Launceston General Hospital**	**THO – North West, North West Regional Hospital and Mersey Community Hospital**	**Total number of procedures**
Performed in September Quarter 2013	85	104	13	202
Performed in December Quarter 2013	63	135	14	212
Performed in March 2014 Quarter	24	70	5	99
Performed in June 2014 Quarter	72	64	6	142
Total number of procedures performed during 2013-14	**244**	**373**	**38**	**655**

Data confirming the performance of NPA: IHST procedures has been approved by the Tasmanian Health Organisations as part of the DHHS quarterly *National Partnership Agreement on Improving Public Hospital Services* data submission to the Australian Institute of Health and Welfare (AIHW).

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