Department of Health

Tasmanian Government

Tasmanian Health Service
2020-21 Service Plan
(May 2021 Amendment)

Amendments (May 2021)

Page/s	Sections
N/A	Removal of COVID19 specific preface included in original 2020-21 Service Plan.
N/A	Minor adjustments to language tense throughout Service Plan document to reflect progression since commencement of original 2020-21 Service Plan on 1 July 2020.
2	**Amendments to the Service Plan** Removal of specific mention of planned amendment dates following State Budget release.
8	**Project Agreement for the Community Health and Hospitals Program** Wording updated to reflect the rollover of all the unutilised Project Agreement funds into 2020-21 to address additional elective surgery requirements following COVID-19.
9	**National Partnership Agreement: Public Dental Services for Adults** Removal of sentence relating to unfinalised options for extending NPA, given NPA has been signed.
12	**New Health Executive Governance Structure** Paragraph moved to this page from original position as part of Preface. Wording updated to reflect the endorsed name of the performance sub-committee; the Strategic Performance and Forecasting Committee.
14	**Part B: Budget Initiatives** Pharmacy Charting information updated to reflect state-wide funding approval for 12 months at each major hospital.
17	**Part C: Supporting Information, Elective Surgery** Information updated as per the following: 1. Amendment of name of THS' elective surgery plan to the Statewide Surgical and Perioperative Services Plan 2020-21 (SSPSP). 2. Removal of reference to elective surgery KPI requiring finalisation.
17	**Part C: Supporting Information, Oral Health Services Tasmania (OHST) Outsourcing Recovery Program** Inclusion of information pertaining to the OHST Outsourcing Recovery Program and additional dental funding.
19-22	**Part D: Funding Allocation and Activity Schedule – Purchased Volumes and Grants** Funding Tables have been amended to reflect: 1. Update to the 2020-21 activity and funding schedule 2. Update to the 2020-21 Funding Source information 3. Variation to Total Activity target – 169 904 4. Allocation of $1.5 million to the Oral Health Services Outsourcing Recovery Program 5. Variation to THS own sourced revenue estimates to reflect current estimates for National Partnership Agreements (NPAs), Commonwealth Own Purpose Expenditures (COPEs), private funding agreements and operationally driven revenue from patient fees etc (excluding Pharmaceutical Benefits Scheme (PBS)).

	6. Addition of NEP information.
26-29	**Part F: 2020-21 Key Performance Indicators** Information updated as per the following: 1. Removal of reference to elective surgery KPIs requiring finalisation (page 26) Key Performance Indicator Schedule updated as follows: 2. Amendment to level at which KPIs 4.1, 4.2 and 7.1 are measured, from 'All specified facilities' to 'Statewide' 3. Inclusion of seven new KPIs as follows, reflecting targeted objectives attached to the additional funding provided under the *Project Agreement for the Community Health and Hospital Program,* the OHST Outsourcing Program funding, and the SSPSP: • 9.1 – Elective Surgery Category 1 - admit within recommended time. Target – 100 percent • 10.1 – Elective Surgery - Number of overboundary patients under 18 years old at 30 June 2021. Target – zero • 10.2 – Elective Surgery - Number of people waiting for surgery pre 2018 at 30 June 2021. Target – zero • 13.3.1 – Australian Government - Additional elective procedures and surgeries. Target – 2 813 • 13.3.2 – Australian Government - Additional Category 1 Colonoscopy procedures. Target – 2 186 • 13.5 – Dental - Additional Patient Appointments (July – Dec 2020). Target – 3 800 • 13.6 – Dental – Additional Dental Funding (April – June 2021). Target – 1 050 4. Variation to the annual target for KPI 13.1: • 13.1 National weighted activity units (NWAUs). Target – 169 904 5. Increase to the annual target for KPI 13.2 to reflect additional elective surgery procedures*:* • 13.2 Elective surgery admissions (baseline). Target – 16 289 6. Increase to the annual target for KPI 13.4 to reflect target revision following 2020-21 Service Plan commencement: • 13.4 Dental weighted activity units (DWAUs). Target – 38 155 **7.** Notes to Key Performance Indicator Schedule amended.
39	**Appendix 3. Tasmanian Funding Framework** Supplementation Grant table updated.
42	**Appendix 4: Australian Government – additional elective procedures and surgery funding**

	Inclusion of additional information and Tables (Tables 1.4 and 1.5) to detail funding allocations for the additional elective procedures and surgery operations under the *Project Agreement for the Community Health and Hospital Program*.

Contents

Approval

The Tasmanian Health Service (THS) 2020-21 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: 30 June 2020

Approved by:

The Honourable Sarah Courtney MP

Tasmanian Minister for Health

Date signed: 30 June 2020

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
(02 / 06 / 2021)

Tasmanian Health Service 2020-21 Service Plan

The Service Plan applies from 1 July 2020 to 30 June 2021. 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**: Budget Initiatives
- **Part C:** Supporting Information
- **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:

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

To ensure compliance, the THS should:

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

Safety and Quality

The Australian Commission on Safety and Quality in Health Care

The National Safety and Quality Health Service (NSQHS) Standards, and associated accreditation scheme, were developed by the Australian Commission on Safety and Quality in Health Care (ACSQHC), 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 (second addition) (2017) 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 quality standards and accreditation framework provides assurance to recipients of aged care services. Relevant law requires Australian Government-funded aged care providers to meet quality standards. From 1 July 2019 the new Aged Care Quality Standards came into effect in response to the Aged Care Legislation Amendment (Single Quality Framework) Principles 2018.

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

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

Professional Training Accreditation

Accreditation requires an onsite review by the appropriate professional 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 2020-21 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 2020-21 there are six ABF patient service categories which are being used nationally and have their own classification system. These are:

- Admitted acute care
- Sub-acute and non-acute care
- Non-admitted care
- Mental health care
- Emergency care and

- Teaching, training and research.

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

Data reporting to national bodies and performance reporting against the 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), Urgency Related Groups (URG), 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.dhhs.tas.gov.au/intranet/system/activity_based_funding_abf/activity_based_funding_abf_resources2

www.ihpa.gov.au/sites/default/files/minisite/static/8601/pricing-framework-2020-21/index.html

www.ihpa.gov.au/sites/default/files/publications/national_efficient_price_determination_2020-21.pdf

www.ihpa.gov.au/sites/default/files/Documents/national_efficient_cost_determination_2020-21.pdf

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

National and Other Agreements

The 2020-21 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 growth and total Australian Government funding is capped at 6.5 per cent per year. 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

In recognition of the impact of the response to the COVID-19 pandemic on hospital activity, the Australian Government is providing a multilateral minimum funding guarantee to all states for 2019-20 and 2020-21. Under these arrangements, Tasmania is guaranteed a minimum level of NHR funding in 2019-20 and 2020-21. Entitlement to this guarantee is based on NHR funding plus the Hospital Services Payment component of the NPCR being less than the guaranteed amount in those years. This guarantee provides Tasmania with an improved level of funding certainty for the two financial years where public hospital activity is most likely to be impacted by the response to COVID-19.

The Australian Government has also 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 Consumer Price Index growth and national population growth.

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 Therapies

High cost 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 provides for the cost of these therapies to be equally shared between the Australian Government and state governments. They will also be exempt from the annual 6.5 per cent funding cap for two years from the commencement of service delivery of the new treatment.

In addition to the equitable sharing of costs, it is important states have a role in deciding which high cost therapies should be delivered in public hospitals. The 2020-25 NHRA provides for joint decision making by Chairs of the Medical Services Advisory Committee, the Pharmaceutical Benefits Advisory Committee and a nominated representative of the COAG Health Council, on the referral of applications for a new high cost therapy likely to be offered within public hospitals. It also provides for state involvement throughout the assessment process. This process provides an adequate level of state involvement in the assessment of those high cost therapies intended to be delivered in public hospitals

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.

Importantly, the 2020-25 NHRA provides that these changes will be backcast, meaning the effect of significant changes to the national health funding model are also reflected in the model for the year prior to the change taking place. The requirement for any private patient adjustments to be backcast removes the majority of the financial risk to the states from those adjustments.

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 (2019-2023) to provide for additional elective surgery and endoscopy procedures in Tasmania, with $5 million originally allocated to additional endoscopy procedures in 2019-20.

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

COVID-19 had a significant impact on the THS' ability to undertake elective surgery in 2019-20 and deliver the estimated number of procedures, due to the national restrictions on non-urgent elective surgery that were in place from 25 March to 26 April 2020 and the temporary closure of the North West Regional Hospital (NWRH) and North West Private Hospital (NWPH). These restrictions had flow on effects for the State's elective surgery profile.

As such, the decision was made to preserve the full quantum of the elective surgery funding for use in 2020-21 and beyond to help manage elective surgery demand following the impact of COVID-19, and as a result only a small number of procedures were funded from the available elective surgery funding in 2019-20. Therefore, the remaining $19.972 million of the original $20 million is available in 2020-21 to assist the THS to undertake elective surgery activity delayed due to the response to COVID-19. The activity profile has been informed by the THS' Statewide Surgical and Perioperative Services Plan 2020-21 (SSPSP). Refer to Part C: Supporting Information, Part D: Funding Allocation and Activity Schedule, and Appendix 4 for further information.

National Partnership on 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.

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 Australian Government have offered Tasmania a one year extension of the 2017-20 NPA to 30 June 2021.

Other Agreements

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

NPAs

- Improving Health Services in Tasmania – Schedule G – Subacute and acute projects

COPEs

- Aged Care Assessment Program
- Commonwealth Home Support Program
- Home and Community Care
- 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 2020-21.

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.

New 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 will be 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 particular relevance to the Service Plan is the establishment of the Strategic Performance and Forecasting Committee (SPFC), a sub-committee of Health Executive, which will be responsible for informing performance related decisions based on the THS' performance against the KPI specified in the Service Plan.

Part B: Budget Initiatives

The 2020-21 State Budget was released in November 2020. Funding announcements made in the 2020-21 State Budget are included as follows:

Health Demand funding

The RER 2019-20 provided funding of $150 million to support the delivery of health services in 2020-21 and across the Forward Estimates period. Major initiatives that will be funded out of this allocation include:

Royal Hobart Hospital - K Block Beds

On 2 September 2019, the Minister announced the opening of 44 beds at the RHH in the second half of 2019-20. This commitment expanded the number of beds to be open at the RHH to 50 as of 1 July 2020. The total funding allocated to the operation of these beds in 2020-21 is comprised of Health Demand funding plus funding already identified in the 2019-20 State Budget and Forward Estimates for use in 2020-21.

Royal Hobart Hospital - K Block Commissioning

The Service Plan provides funding for ongoing annual costs associated with the commencement of services from the newly opened RHH K-Block building.

Hospital in the Home (South)

The *RHH Access Solutions Action Plan* identified the development of a HiTH trial, as an action to improve patient flow at the RHH. Accordingly, a 12-bed, 12-month HiTH trial providing acute hospital substitution care has been developed.

Pharmacy Charting

A medication charting trial, aimed at reducing length of stay and medication errors (referred to as Partners Pharmacist Medication Charting – PPMC trial), was identified as a medium-term action of the *RHH Access Solution Action Plan*. A state-wide PPMC model has been developed and funding is provided in the Service Plan to run a 12-month trial at each major hospital.

Medtasker

On 28 June 2019 the then Minister for Health announced practical outcomes emanating from the Access Solutions Meeting earlier in June 2019. The Medtasker system was announced as a way of improving access to data to drive quality of care, communication and service efficiency through its implementation at the RHH. MedTasker allows staff to very clearly understand where a patient is and what that patient's next requirement is to complete their journey through the Tasmanian inpatient system. The Service Plan provides ongoing funding for this important patient management system.

Ongoing Initiatives

180 more Nursing Graduates across Tasmania

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

Eight Bed Acute Medical Unit at the NWRH

Commencing in 2018-19, funding of $28.3 million was provided over six years to open eight new acute medical beds at the NWRH, including four Emergency Department (ED) short stay beds and four surgical beds for elective surgery patients who need to stay overnight.

Eight Beds on Ward 4K at the Launceston General Hospital (LGH)

The 2019-20 Budget continues the provision of funding announced in the 2018-19 Budget of $19.1 million over five years to fully staff and open eight new beds on Ward 4K at the LGH, on completion of the redevelopment.

Community Rapid Response

Commencing in 2018-19, funding of $6.9 million was provided over six years to extend the Community Rapid Response Service pilot program in the North into a permanent part of the health system. This program supports people who need short-term intermediate care that can be safely delivered in the community or in the home. Funding was also provided to roll out a three-year pilot program to the Greater Hobart Area ($5.6 million) and the North West Coast ($5.6 million). Evaluation of the new pilot programs will occur after two years.

27 Mental Health Beds in Southern Tasmania

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

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

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

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

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

Mental Health Service Hospital Avoidance Program

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

Specific 2020-21 funding details for this commitment are available in the funding schedule under the THS Operational Grants.

Part C: Supporting Information

Elective Surgery

The national and state responses to the COVID-19 pandemic significantly impacted the delivery of elective surgery to the Tasmanian community in the latter part of 2019-20. Most notably, the national elective surgery restrictions that were enforced from 25 March to 26 April 2020 reduced the level of elective surgery activity delivered during this time, with the closure of the NWRH further contributing to the reduction in activity.

Subsequent flow on effects to the THS' elective surgery profile occurred, with the wait list and number of overboundary patients and long wait patients all increasing. In addition, the number of presentations to general practitioners and public outpatient clinics reduced significantly during this time, resulting in fewer additions to the elective surgery wait list. It is anticipated that a sharp rise in additions to the elective surgery wait list will occur in future months as social distancing restrictions are relaxed and people seek to have their conditions addressed.

The aforementioned impacts on Tasmania's elective surgery profile continued to be felt in 2020-21, requiring ongoing, proactive management in order to ensure access to surgical services is restored and maintained. As such, the THS developed the SSPSP which outlines, amongst other things:

- The planned approach to restoring access to elective surgery, in accordance with national principles;
- Ongoing COVID-19 response measures;
- Priority areas for surgery at a regional and state-wide basis;
- Approach to ensuring equity of access for all Tasmanians regardless of where they live;
- Issues and constraints facing surgical services;
- Innovative models of care and alternative care pathways to ensure patient are receiving the most appropriate care for their needs as close to home as possible;
- Primary prevention and management;
- Telehealth options for surgical services.

The SSPSP has both a short- and long-term focus. In the short-term, the plan includes strategies and activities to immediately address and improve elective surgery access in Tasmania and manage the expected influx of new elective surgery referrals. The SSPSP also details how the remaining $19.972 million Project Agreement for the Community Health and Hospitals Program funding will be allocated and utilised in 2020-21. In the longer term, the SSPSP considers reform strategies and diversional initiatives that look to promote the sustainability of the elective surgery program, and ensure that alternative care pathways are available to redirect patients from surgical to non-surgical pathways where clinically appropriate, and elective surgery is only performed when it is the most appropriate treatment. This long-term focussed work relies heavily on collaboration with other health care organisations, such as Primary Health Tasmania (PHT) and General Practice.

Oral Health Services Tasmania (OHST) Outsourcing Recovery Program

As part of OHST's response to the COVID-19 pandemic, OHST suspended the delivery of all non-essential dental treatment in April and May 2020. This treatment suspension resulted in the cancellation of a

significant number of adult and child patient appointments. Services recommenced at the end of May 2020, at reduced throughput levels.

OHST's COVID-19 Recovery Plan is focused on transitioning to normal services over time by offering dental care to patients cancelled during the pandemic whilst continuing to provide and manage emergency dental care; followed by expanding service delivery to non-essential patients requiring treatment. OHST's Recovery Plan identified a shortfall in projected appointment availability for adult dental services compared to the number of appointments required. This translated to a significant risk that OHST may not be able to meet the dual demands of recovery – concurrently managing cancelled patients and the demand from new patients; which in turn would impact on patients through extensive waiting time for care to be delivered and an increase to waiting lists which will take many years to recover from.

To mitigate this risk and meet patient demand during the recovery from COVID-19, an additional $1.5 million has been provided to OHST:

- An initial $1 million to outsource a portion of dental care to the private sector between 1 July and 31 December 2020; and
- An additional $500 000 to support extra dental appointments for Tasmanians, including across emergency dental, general dental care and denture clinics. This $500 000 forms part of a larger $5 million funding investment to support more Tasmanians to get the dental care they need sooner. This funding investment was announced in March 2021, for use between April 2021 and December 2022; with the remaining $4.5 million to be allocated in 2021/22 and 2022/23.

The expenditure of the $1.5 million for 2020/21 is monitored through two separate KPI in the Service Plan *(See Part F: Key Performance Indicators, KPI 13.5 and 13.6)*. Funding details for these commitments are available in the funding schedule under the THS Operational Grants.

Mersey Community Hospital Reset Plan

One of the major impacts of the COVID-19 outbreak at the NWRH and NWPH, and the subsequent decision to close these hospitals, was that the MCH was used to accommodate a large number of decanted North West patients, with a small number transferring to the LGH, and where necessary, the RHH.

In May 2020, with the full recommissioning of the NWRH and NWPH completed, the Minister announced a plan for resetting the MCH, to open it more generally for suitable admissions and allow a rebalancing of patient load across all four major acute hospitals. Key actions include a staged re-opening of services, including the ED, which re-opened on 31 May 2020 with restricted operating hours from 8am to 10pm.

A rebalancing of patient load across all four major acute hospitals will impact on the projected 2020-21 hospital-based activity volumes that underpin the funding allocation in this Service Plan. At the time of this Service Plan's issue, the impact of this rebalancing of patient load was unknown. Future amendments to this Service Plan may be required as actions are fully implemented.

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

2020-21 Activity and Funding Schedule

Table 1.1 Tasmanian Health Service	Measure	Activity	Funding ($'000)
Activity Funding			
Admitted			
Acute Patients (Excluding Elective Surgery)	NWAU	84 910	451 720
Acute Elective Surgery	NWAU	25 284	134 510
Acute - Scopes	NWAU	3 292	17 514
Acute Facilities Mental Health	NWAU	7 540	40 116
Sub-Acute and Non-Acute	NWAU	8 037	42 757
Non-admitted			
Outpatients - Non-Admitted Patients	NWAU	19 680	104 698
Emergency Department	NWAU	21 161	112 577
Total Activity Funding		**169 904**	**903 892**
Block Grants for Activity Based Funded Hospitals			
RHH K-Block Commissioning	Block Funded		18 452
Partnered Pharmacist Medication Charting - Statewide	Block Funded		1 176
Medical Cannabis	Grant		920
Blood	Block Funded		7 530
Boarders	Block Funded		97
Home and Community Care (HACC)	Block Funded		208
Home Ventilation - ABF Block payment model	Block Funded		2 703
Non-ABF Activity	Block Funded		49 490
Organ Procurement	Block Funded		280
Patient Travel Assistance Scheme (PTAS)	Block Funded		8 775
Admitted Acute Patients Supplementation	Block Funded		40 421
Admitted Mental Health Patients Supplementation	Block Funded		6 046
Sub & Non-Acute Inpatients Supplementation	Block Funded		16 174
Emergency Department Supplementation	Block Funded		16 537

Table 1.1 Tasmanian Health Service (continued)	Measure	Activity	Funding ($'000)
Outpatients Supplementation	Block Funded		3 722
Transition Care Program	Block Funded		3 370
Teaching, training and research	Block Funded		46 229
Non-Admitted - Community Rapid Response[1]	Block Funded		312
Total Block grants for Activity Based Funded Hospitals			**222 442**
THS Operational Grants			
Health Demand Funding (incl. Budget Commitment: Demand + Beds)	Grant		93 068
Allocation of Prior Year Commitments	Grant		3 731
Mersey Community Hospital Funding[2]	Grant		23 231
Primary Health	Grant		43 704
Primary Health - NEC Hospitals	Grant		63 918
Stand Alone Mental Health Facilities	Grant		36 607
Mental Health Hospital Avoidance Strategies	Grant		4 342
Child and Adolescent Mental Health Service	Grant		12 635
Mental Health Services	Grant		48 997
Alcohol and Drug Services	Grant		9 086
Alcohol and Drug Services Detoxification Unit (SMHS)	Grant		4 555
Correctional Mental Health Services	Grant		2 746
Oral Health	Grant		21 413
Oral Health Services Outsourcing Recovery Program	Grant		1 500
CHAPS	Grant		13 299
Cancer Screening	Grant		6 280
Forensic Medical Services	Grant		1 593
Private Patient Scheme Subsidy	Grant		26 000
Statewide Ops Command Centre	Grant		1 500
Nurse Graduates Program	Grant		2 893
8 Beds on Ward 4K	Grant		3 018
Palliative Care Clinical Nurse Educators	Grant		400
Donate Life	Grant		171
Interstate Charging	Grant		38 400
Enhancing Retrieval and Referral Services	Grant		144

Table 1.1 Tasmanian Health Service (continued)	Measure	Activity	Funding ($'000)
MedTasker Annual Costs	Grant		303
Capital Expenditure	Grant		7 500
Total Operational Grants			**471 033**
TOTAL Tasmanian Health Service			**1,597,367**

Notes:

1 The balance of the $5.1 million available for Non-Admitted - Community Rapid Response is included in the NWAU funding for Outpatients - Non Admitted Patients.

2 $86.6 million is provided in Mersey Community Hospital Funding. The balance of $63.4 million is incorporated into the THS NWAU activity target of 169 904.

2020-21 Funding Source

Table 1.2 Funding Source	Funding ($'000)
State Funding[1]	1 132 309
Australian Government Funding[2]	465 058
Sub Total	**1 597 367**
THS Retained Revenue[3]	134 897
Pharmaceutical Benefits Scheme	90 110
Sub Total	**225 007**
Total	**1 822 374**

Notes:

1 State Funding includes State ABF, State Block and $86.6 million provided for Mersey Community Hospital.

2 Commonwealth Funding includes Commonwealth ABF and Block.

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	113 485	7 540	8 037	21 161	19 680	169 904

The NEP is $5 320 per national weighted activity unit 2020–21 (NWAU (20)).

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 provides a high level of transparency and accountability across the THS and the Department and will be used to drive better outcomes for Tasmanians.

Performance management and the *Tasmanian Health Service Act 2018*

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

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

Roles and responsibilities of the Secretary and the Executive

The Secretary

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

The Executive

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

Ministerial Charter

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

Overall expectations

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

Specific expectations of the Secretary

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

Specific expectations of the Tasmanian Health Service

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

The Performance Framework

Performance Objectives

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

The Performance Framework 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
- descriptions of the underlying performance risks
- clear identification of KPI

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

The Performance Framework will focus on:

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

Part F: Key Performance Indicators

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

KPI have been grouped under 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.

2020-21 Key Performance Indicator Schedule

KPI No.	Key Performance Indicator	Target	Measured Statewide or Facility Level
Effectiveness			
1	**Breast cancer detection**		
1.1	Eligible women screened for breast cancer	34 377	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

KPI No.	Key Performance Indicator	Target	Measured Statewide or Facility Level
Continuity of care			
6	**Mental health transition from inpatient to community care**		
6.1	Re-admissions within 28 days	Not more than 14 per cent	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	Elective Surgery Category 1 – admit within recommended time	100 per cent	Statewide
10	**Elective Surgery waiting list reduction**		
10.1	Elective Surgery – Number of overboundary patients under 18 years old at 30 June 2021	Zero	Statewide
10.2	Elective Surgery – Number of people waiting for surgery pre 2018 at 30 June 2021	Zero	Statewide
11	**Patient flow from Emergency Departments**		
11.1	Patients with an emergency department (ED) length of stay of less than four hours	Not less than 90 per cent	All specified facilities
11.2	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
11.3	Patients with an ED length of stay of less than 24 hours	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)	169 904	Statewide
13.2	Elective surgery admissions (baseline)	16 289	Statewide
13.3	13.3.1 Australian Government – Additional elective procedures and surgeries	2 813[1]	Statewide
	13.3.2 Australian Government - Additional Category 1 Colonoscopy procedures	2 186[1]	Statewide
13.4	Dental Weighted Activity Units (DWAUs)	38 155	Statewide
13.5	Dental - Additional Patient Appointments (July - Dec 2020)	3 800	Statewide
13.6	Dental – Additional Dental Funding (April – June 2021)	1050	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[2]	Statewide
15.2	Clinical coding errors corrected within 30 days	100 per cent	Statewide

Notes:

1 Refer to Appendix 4 for further details and funding amounts.

2 This KPI is currently under joint review by the Department and the THS. The outcome of this review may inform future changes to the KPI.

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 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.

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 2.0 of the HAC list will be used for pricing in 2020–21. 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 funding adjustments for hospital acquired complications

		Complexity Group		
Hospital Acquired Complication		Low	Moderate	High
		%	%	%
1.	Pressure injury	11.0	3.10	1.70
2.	Falls resulting in fracture or other intracranial injury	3.80	2.60	0.80
3.	Healthcare associated infection	8.10	2.90	1.40
4.	Surgical complications requiring unplanned return to theatre	13.10	9.60	7.0
5.	Unplanned intensive care unit admission [1]	Nil	Nil	Nil
6.	Respiratory complications	13.60	8.70	5.30
7.	Venous thromboembolism	10.30	7.70	5.90
8.	Renal failure	19.50	7.20	3.20
9.	Gastrointestinal bleeding	8.60	7.40	5.80
10.	Medication complications	8.50	8.20	2.70
11.	Delirium	8.70	7.00	5.00
12	Persistent incontinence	3.50	3.00	2.10
13.	Malnutrition	7.50	6.00	4.50
14.	Cardiac complications	10.7	8.10	5.70

[1] No funding adjustment for 'Unplanned intensive care unit admission' (5) will be applied in 2020-21 as it cannot be identified in current data sets

Hospital Acquired Complication		Complexity Group		
		Low	Moderate	High
15.1	Third degree perineal laceration during delivery [2]	Nil	Nil	Nil
15.2	Fourth degree perineal laceration during delivery	31.9	21.2	21.2
16	Neonatal birth trauma	Nil	Nil	Nil

[2] No funding adjustment for 'Third degree perineal laceration during delivery' (15.1) and 'Neonatal birth trauma' (16) will be applied in 2020-21 due to small patient cohorts or other issues which have prevented development of a robust risk adjustment approach at this time.

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:

- 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 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, five specialist public psychiatric hospitals, eligible community psychiatric programs, teaching, research and other services provided.
- 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,
- The NHRA block funding for regional and rural hospitals is informed by the efficient cost of small rural hospitals and is based on the NWAU produced and the reported in scope costs. Other block-funded hospitals or facilities are treated separately from the efficient cost of small rural hospitals.

Tasmanian funding model

The NHRA requires a National Efficient Price (NEP) and the National Efficient Cost (NEC) determinations for Australian public hospital services for the specific financial year. The 2020-21 Tasmanian ABF Model is based on the national NHRA determinations and model developed by the IHPA to fund public hospital services.

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 $5 320 per national weighted activity unit 2020–21 (NWAU (20)).

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.

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:
        - $2.040 million for hospitals with an annual NWAU (19) less than or equal to 176.
        - $2.040 million less 0.029 per cent per-NWAU (19) for hospitals with an annual NWAU (19) greater than 176. There is an additional loading of 39.1 per cent for 'very remote' hospitals.
        - The variable component of the efficient cost is determined as $5,687 per-NWAU (19) for hospitals with an annual NWAU (19) greater than 176.
- 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.

- The IHPA has determined that for 2020–21, 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 2017−18 and where required In-scope activity.

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

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 2020-21 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 20 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 2020-21* or the NEP determination 2020-21.

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 2020-21* or the NEP determination 2020-21.

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 mental health services for 2020–21 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 2020-21 or* the NEP determination 2020-21.

Non-Admitted - Outpatients

Non-admitted outpatient care will be classified using Tier 2 Version 5.0 for 2020-21. Tasmania has adopted the IHPA classification.

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

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

Further details pertaining to the price weights for Tier 2 Non-Admitted Care classification version 5.0 can be found in Appendix K of the NEP determination 2020-21.

Emergency Care

The ED Classification Systems of Urgency Related Groups (URG) version 1.4 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 2020-21 National ABF model. Tasmania has adopted the National ABF model ED and ES services.

NWAU Price weights for URG version 1.4 can be found in Appendix L of the NEP determination 2020-21.

NWAU Price weights for URG version 1.3 can be found in Appendix M of the NEP determination 2020-21.

Further details pertaining to the Emergency Department NWAU and NWAU adjustments can be found in the *Tasmanian Funding and Purchasing Model Guidelines 2020-21* for price weights for URG 1.4 or UDG 1.3 can be found in the NEP determination 2020-21.

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 2020–21, 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.

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 2020-21. 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 Facilities.

2020-21 ABF Stream Supplementation Grants	Funding ($'000)
ABF Stream Supplementation - RHH	
Acute Admitted	32 399
Admitted Mental Health	3 836
Admitted Sub & Non-Acute	12 902
Emergency Department	9 029
Outpatients	2 811
ABF Stream Supplementation - LGH	
Acute Admitted	5 508
Admitted Mental Health	1 226
Admitted Sub & Non-Acute	2 401
Emergency Department	4 788
Outpatients	673
ABF Stream Supplementation - NWRH	
Acute Admitted	2 514
Admitted Mental Health	984
Admitted Sub & Non-Acute	871
Emergency Department	2 720
Outpatients	237

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) 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.

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.

Appendix 4. Australian Government – additional elective procedures and surgery funding

The Australian Government, under the *Project Agreement for the Community Health and Hospital program Tasmania 2018-19 Initiatives,* provided $20 million for additional elective procedures and surgery operations to reduce the number of Tasmanians waiting on waiting lists and the time they have waited. The funding was originally allocated for distribution over a four-year period (2019-2023), with $5 million apportioned in 2019-20 to deliver additional endoscopy procedures (approximately 2248). In November 2019 the Australian Government announced the remaining $15 million for this commitment would be payable in 2019-20, with the flexibility for activity purchased with this funding to be performed in 2020-21 (and future years if required).

In the latter part of 2019-20, COVID-19 had a significant impact on the THS' ability to undertake elective surgery and deliver the estimated number of procedures, due to the national restrictions on non-urgent elective surgery that were in place from 25 March to 26 April 2020 and the temporary closure of the NWRH and NWPH. These restrictions had flow on effects for the State's elective surgery profile. As such, the decision was made to preserve the full quantum of the elective surgery funding for use in 2020-21 to help manage elective surgery demand following the impact of COVID-19, and as a result only a small number of procedures were funded from the available elective surgery funding in 2019-20 (to the value of approximately $27 800). Therefore, the remaining $19.972 million of the original $20 million has been allocated in 2020-21 to assist the THS to undertake elective surgery activity delayed due to the response to COVID-19. The activity profile has been informed by the THS' SSPSP.

The available funding has been distributed as detailed in Tables 1.4 and 1.5 below, with the funding prioritised to support the following patient cohorts/priority areas in 2020-21:

- Patients waiting pre-2018
- Overboundary children (and the preventing of new overboundary children occurring)
- Overboundary Category 2 and 3 patients (and ongoing demand during the period)
- Additional Category 1 Colonoscopy procedures

Monitoring of the expenditure of funds and progress of THS in delivering the estimated number of admissions for the aforementioned patient cohorts/priority areas will be done through two separate KPI within the Service Plan which specifically relate to this Project Agreement funding:

- 13.3.1 Australian Government – Additional elective procedures and surgeries
- 13.3.2 Australian Government – Additional Category 1 Colonoscopy procedures

See Part F: Key Performance Indicators for further information.

Table 1.4 KPI 13.3.1 Australian Government – Additional elective procedures and surgeries

	RHH	LGH	NWRH	MCH	Totals
Share of $19.97 million NPA funding					
Patients waiting pre-2018	$72 906	$54 468	-	-	$127 375
Overboundary patients under 18 years	$4 713 734	$1 192 985	$368 802	-	$6 275 521
Cat 2 and 3 overboundaries	$4 999 653	$3 008 091	$562 352	-	$8 570 097
Totals	$9 786 293	$4 255 545	$931 154	-	**$14 972 993**
Estimated no. of admissions					
Patients waiting pre-2018	10	7	-	-	17
Overboundary patients under 18 years	1 027	298	95	-	1 420
Cat 2 and 3 overboundaries	798	494	84	-	1 376
Totals	1 835	799	179	-	**2 813**

Table 1.5 KPI 13.3.2 Australian Government – Additional Category 1 Colonoscopy procedures

	RHH	LGH	NWRH	MCH	Total
Share of $19.97 million NPA funding	$1 780 568	$2 451 626	$61 754	$706 052	**$5 000 000**
Estimated no. of additional Cat 1 overboundary colonoscopies	778	1 072	27	309	**2 186**

Funds will be reimbursed to the THS upon evidence of completion for the recognised procedure and funds will be provided to the THS monthly in arrears.