Your Health and Human Services

Progress Chart

September 2012

Department of Health and Human Services

Tasmanian Government

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A note about the *MyHospitals* website

The *MyHospitals* Website, launched on 10 March 2010, is an Australian Government initiative to inform the community about hospitals by making it easier for people to access information about how individual 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 to national public hospital 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?

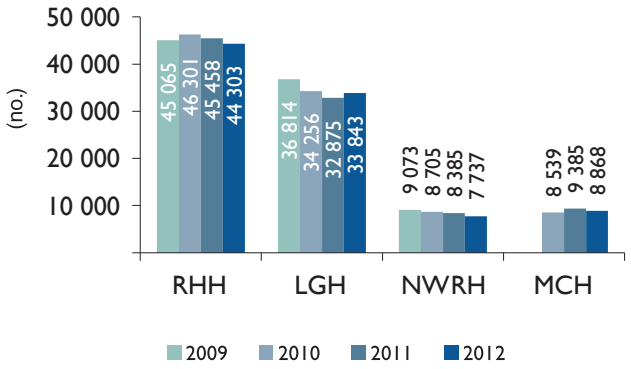
A separation is an episode of admitted patient care. Raw separations are not adjusted for the complexity of the episode of care and represent each individual episode of care in a given period (see explanatory note 1).

In the 12 months ending 30 June 2012 compared to the same period in the previous year, the number of raw separations:

- decreased by 2.5 per cent at the RHH
- increased by 2.9 per cent at the LGH
- decreased by 7.7 per cent at the NWRH
- decreased by 5.5 per cent at the MCH (for the MCH, data prior to September 1 2008 is unavailable – see explanatory note 2).

Figure 1: Admitted patients – number of raw separations

(for the 12 months ending 30 June)



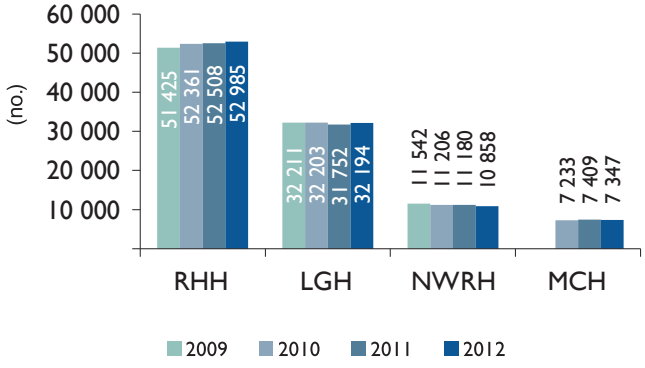
Weighted separations show the level and complexity of the work done in public hospitals by combining two measures: the number of times people come into hospital and how ill people are when they come into hospital (see explanatory note 1).

In the 12 months ending 30 June 2012 compared to the same period in the previous year, the number of weighted separations:

- increased by 0.9 per cent at the RHH
- increased by 1.4 per cent at the LGH
- decreased by 2.9 per cent at the NWRH
- decreased by 0.8 per cent at the MCH.

Figure 2: Admitted patients – number of weighted separations

(for the 12 months ending 30 June)



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 times that people presented at our EDs across the state.

In the 12 months ending 30 June 2012 compared to the same period in the previous year, ED presentations increased by 2.1 per cent at the RHH. At the other hospitals presentations decreased:

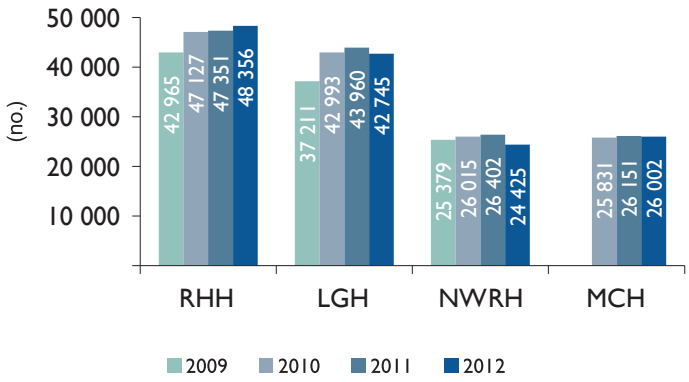
- by 2.8 per cent at the LGH
- by 7.5 per cent at the NWRH
- by 0.6 per cent at the MCH.

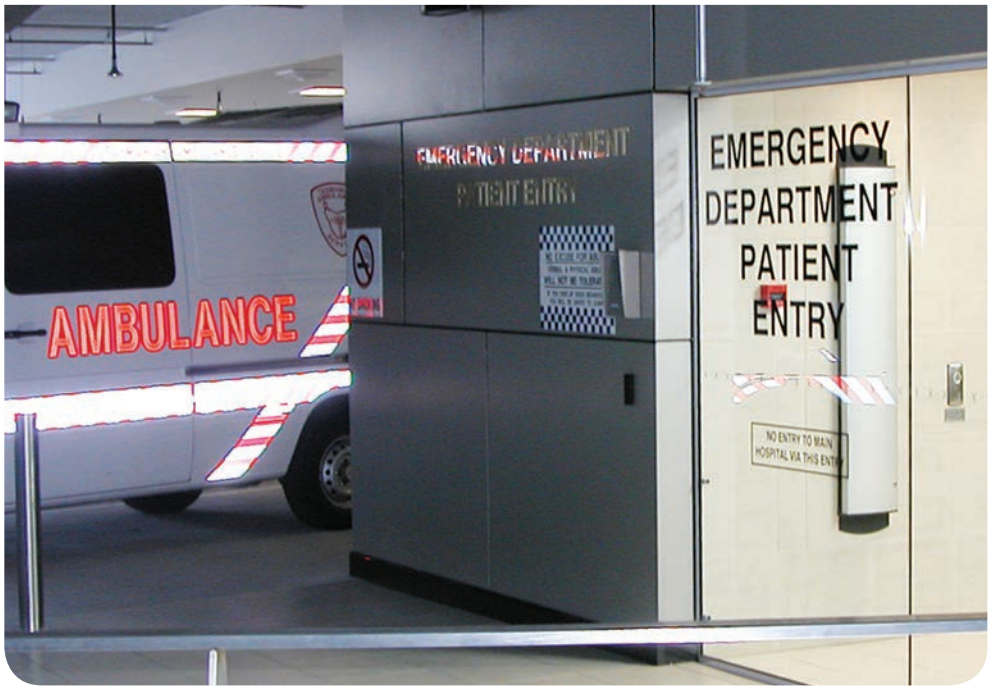
A range of initiatives have been introduced to address ED demand and performance issues and hospital patient flows. These initiatives are broadly aimed at:

- the diversion of patients who do not need ED care to more appropriate service providers
- addressing physical facilities and staffing within EDs
- 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
- improving bed access and overcrowding procedures to maximise use of inpatient beds.

Figure 3: Emergency Department presentations

(for the 12 months ending 30 June)





What percentage of patients were seen within recommended time frames 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.

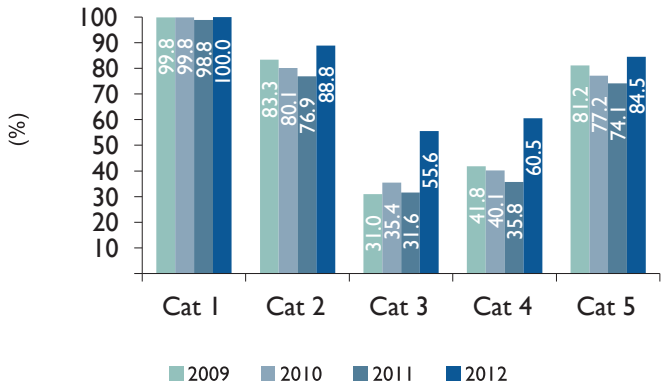
This indicator represents the percentage of patients assigned triage categories 1 through to 5 who commence medical assessment and treatment within the relevant waiting time from their time of arrival. The guidelines set by the Australasian College for Emergency Medicine (ACEM) are as follows:

- **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 2012, the ACEM benchmarks were achieved for category 1, 2 and 5 patients at the RHH. Improved performance was seen in all categories. Changes to admission processes for patients from ED to inpatient wards are being progressed and it is anticipated this will lead to a more responsive service for these patients.

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)



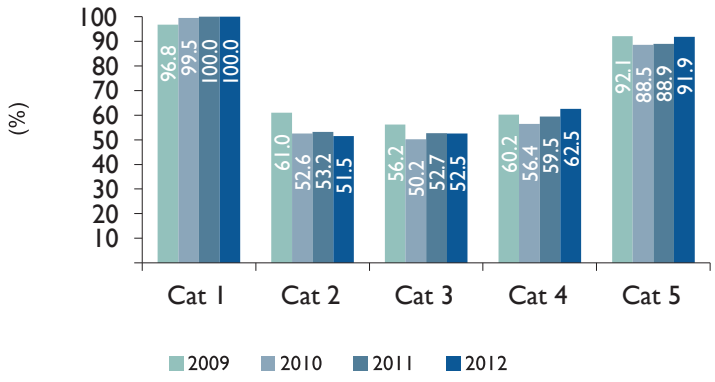
In the 12 months ending 30 June 2012 at the LGH, the ACEM benchmark was achieved for category 1 and 5 patients, with improvements shown in category 4 and 5 compared to the same time period last year.

Over the period, performance in category 2 decreased from 53.2 per cent to 51.5 per cent and category 3 from 52.7 per cent to 52.5 per cent.

The new ED which opened in January 2012 and the establishment of the interim Acute Medical Unit is expected to further improve the proportion of ED patients seen on time.

Figure 5: Patients who were seen within the recommended time frame for Emergency Department Australian Triage Scale Categories (LGH)

(for the 12 months ending 30 June)

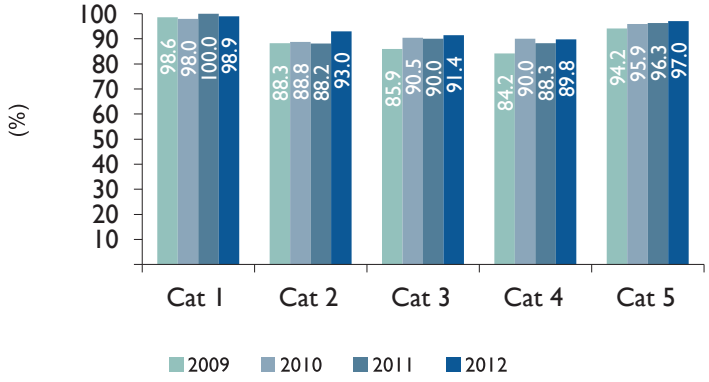


In the 12 months ending 30 June 2012 at the NWRH, performance in category 1 decreased from 100 per cent to 98.9 per cent. Categories 2, 3, 4 and 5 achieved ACEM benchmarks with improvements in all four categories compared to the same time period last year.

Note: Category 1 – in nearly all cases any drop below 100 per cent is due to incorrect triage allocation or clerical error.

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

(for the 12 months ending 30 June)

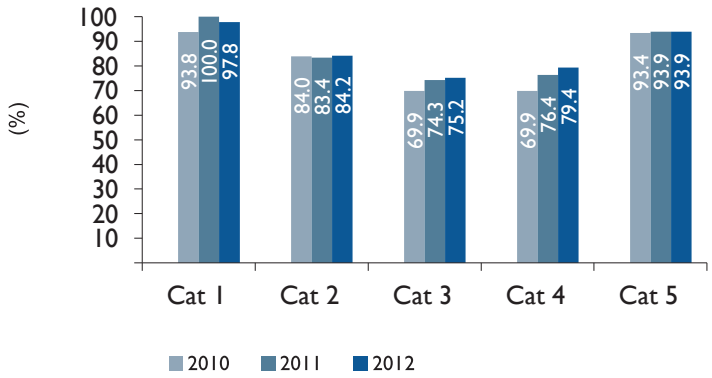


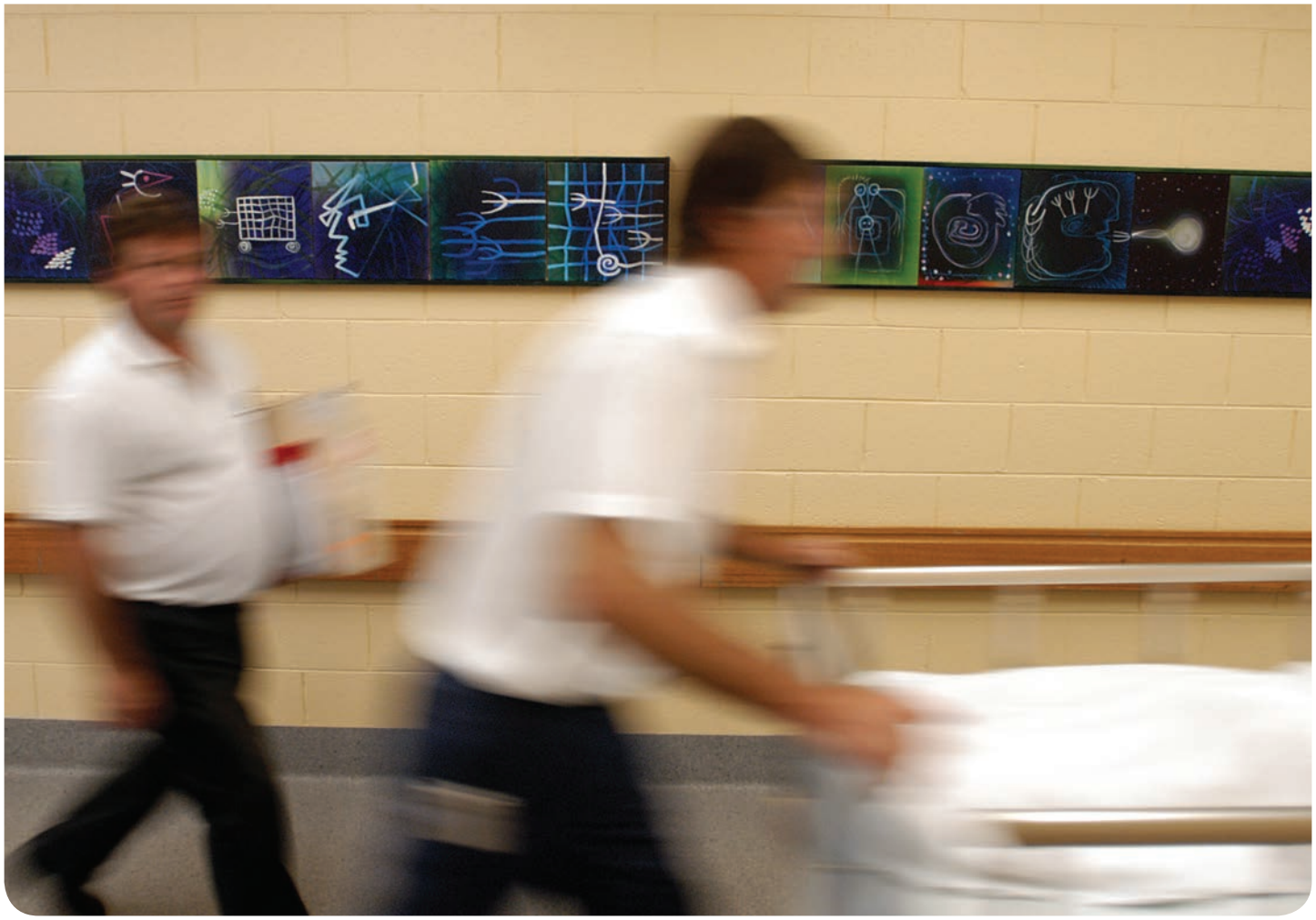
In the 12 months ending 30 June 2012 at the MCH, ACEM benchmarks were achieved in categories 2, 3, 4 and 5 (data prior to 1 September 2008 is unavailable – see explanatory note 2).

Note: Category 1 – in nearly all cases any drop below 100 per cent is due to incorrect triage allocation or clerical error.

Figure 7: Patients who were seen within the recommended time frame 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 is a new Emergency Department care indicator, with data provided for the first two quarters of 2012. Under the National Partnership on Improving Public Hospital Services the National Emergency Access Target (NEAT) has been introduced to measure 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.

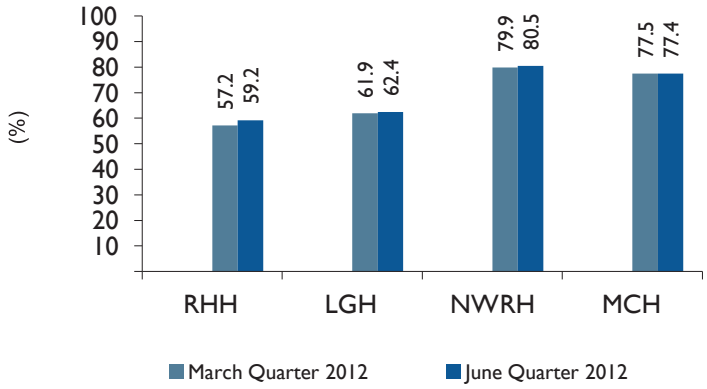
Commencing 1 January 2012, this target will be phased in over four years, with annual interim targets set with the aim of achieving 90 per cent by 2015. The target for Tasmania for 2012 is 72 per cent. More detailed performance data for this target is available in Appendix 1.

The proportion leaving the ED within four hours at the RHH increased from 57.2 per cent in the March quarter to 59.2 per cent in the June Quarter. The proportion leaving within four hours at the LGH also increased from 61.9 per cent to 62.4 per cent.

The proportions leaving within four hours at the NWRH and the MCH exceeded the target for both quarters.

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

(for the 6 months ending 30 June)



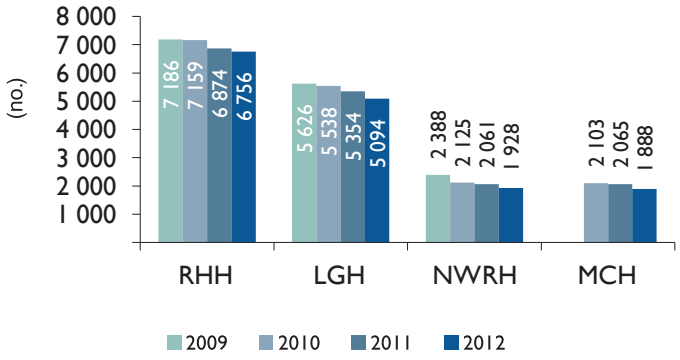
How many people were admitted from the elective surgery waiting list?

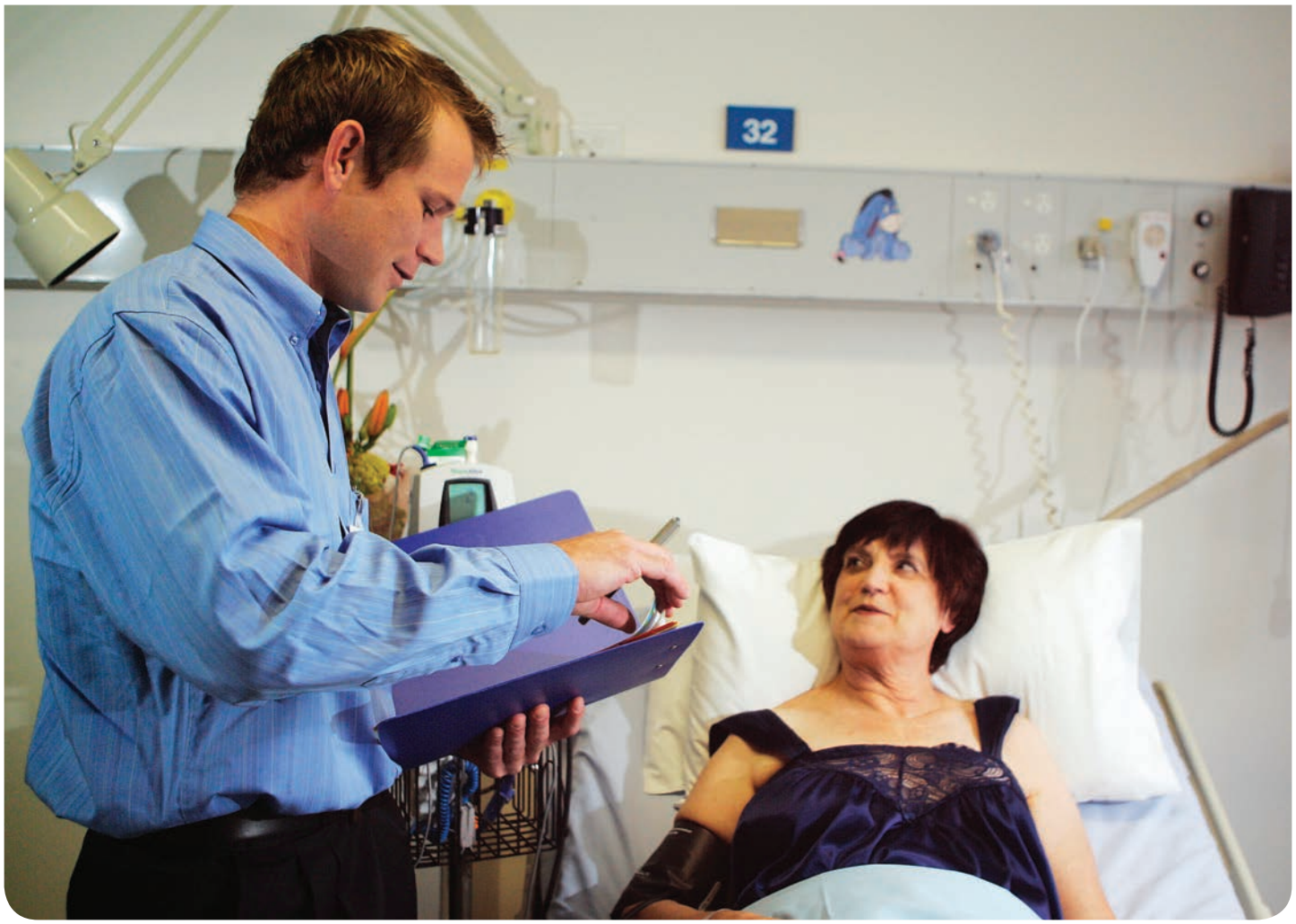
Admissions from the waiting list decreased at all four hospitals:

- by 1.7 per cent at the RHH
- by 4.9 per cent at the LGH
- by 6.4 per cent at the NWRH
- by 8.6 per cent at the MCH.

Figure 9: Admissions from waiting list

(for the 12 months ending 30 June)





What is the waiting list for elective surgery?

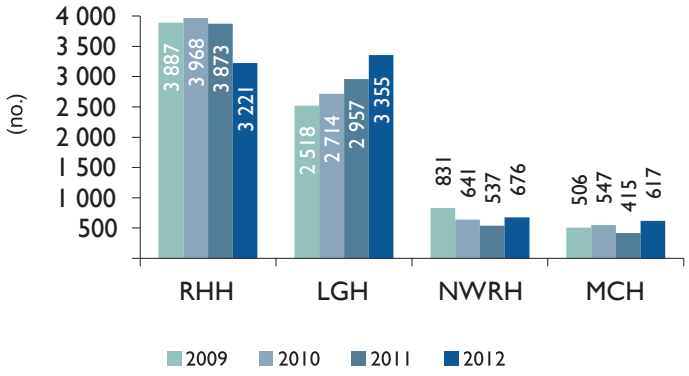
This information shows the number of patients waiting for elective surgery who are ready for care.

As at 30 June 2012 compared to the same time in the previous year, the number of patients waiting for elective surgery:

- decreased by 16.8 per cent at the RHH
- increased by 13.5 per cent at the LGH
- increased by 25.9 per cent at the NWRH
- increased by 48.7 per cent at the MCH.

Figure 10: Waiting list

(as at 30 June)



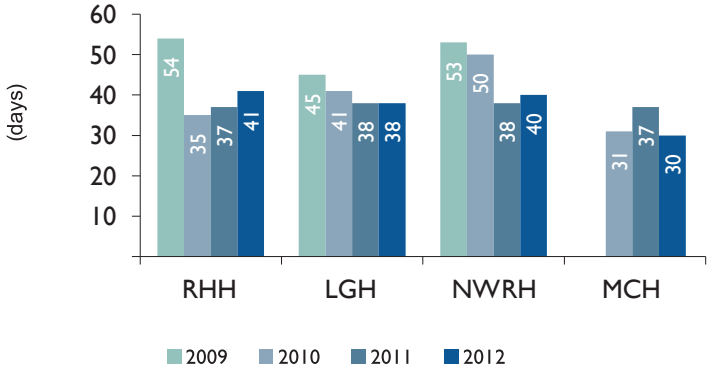
What is the usual time to wait for elective surgery?

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 time increased by four days at the RHH, by two days at the NWRH, remained steady at the LGH and decreased by 7 days at the MCH.

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

(for the 12 months ending 30 June)



What percentage of elective surgery patients were seen within recommended time frames?

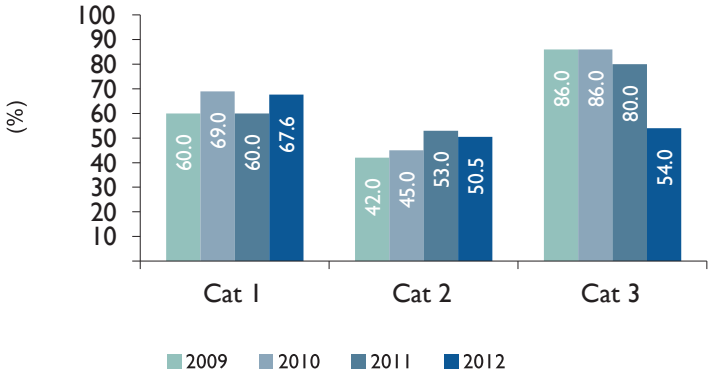
This indicator provides a measure of the percentage of patients admitted from the elective surgery list within the recommended timeframes. The current Tasmanian category timeframes are as follows:

- **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 2012 compared to the same time in the previous year the proportion of category 1 patients seen on time at the RHH increased from 60 per cent to 67.6 per cent, decreased in category 2 from 53 per cent to 50.5 per cent and decreased in category 3 from 80 per cent to 54 per cent.

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

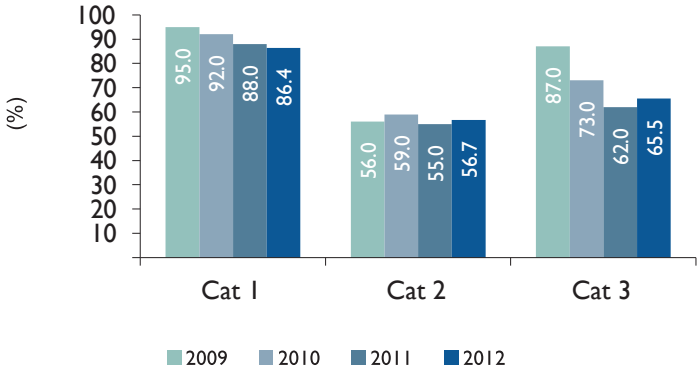
(for the 12 months ending 30 June)



At the LGH, the proportion seen on time decreased in category 1 from 88 per cent to 86.4 per cent. The proportion seen on time in category 2 increased from 55 per cent to 56.7 per cent and in category 3 from 62 per cent to 65.5 per cent.

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

(for the 12 months ending 30 June)



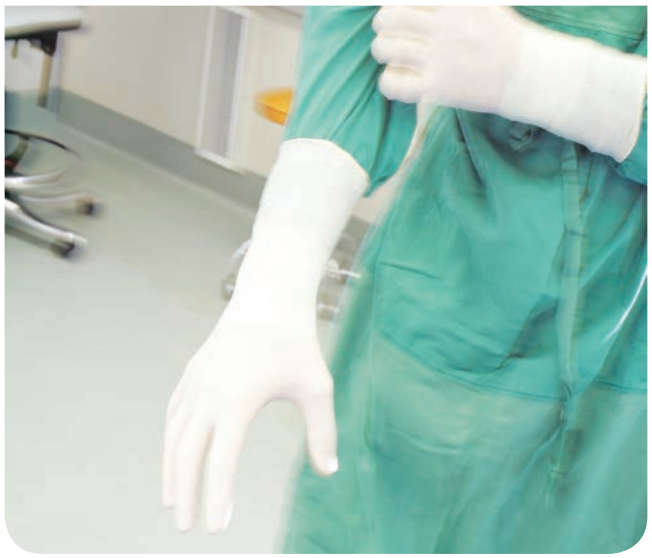
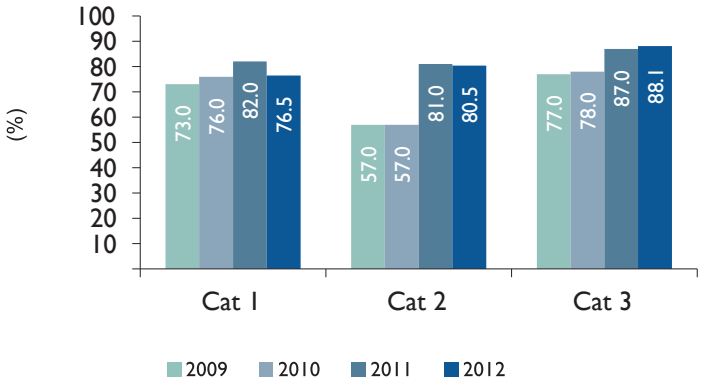


Figure 14: Patients seen within the recommended time for elective surgery at the NWRH

(for the 12 months ending 30 June)

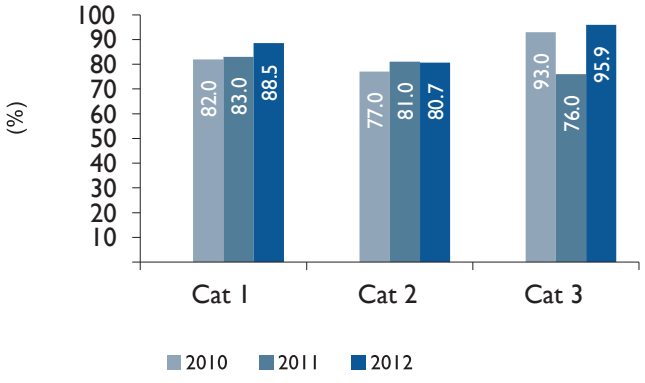


At the NWRH, the proportion of patients seen on time decreased in category 1 from 82 per cent to 76.5 per cent, decreased in category 2 from 81 per cent to 80.5 per cent and increased from 87 per cent to 88.1 per cent in category 3.

At the MCH, the proportion of patients seen on time increased in category 1 from 83 per cent to 88.5 per cent, decreased in category 2 from 81 per cent to 80.7 per cent, and increased in category 3 from 76 per cent to 95.9 per cent.

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

(for the 12 months ending 30 June)



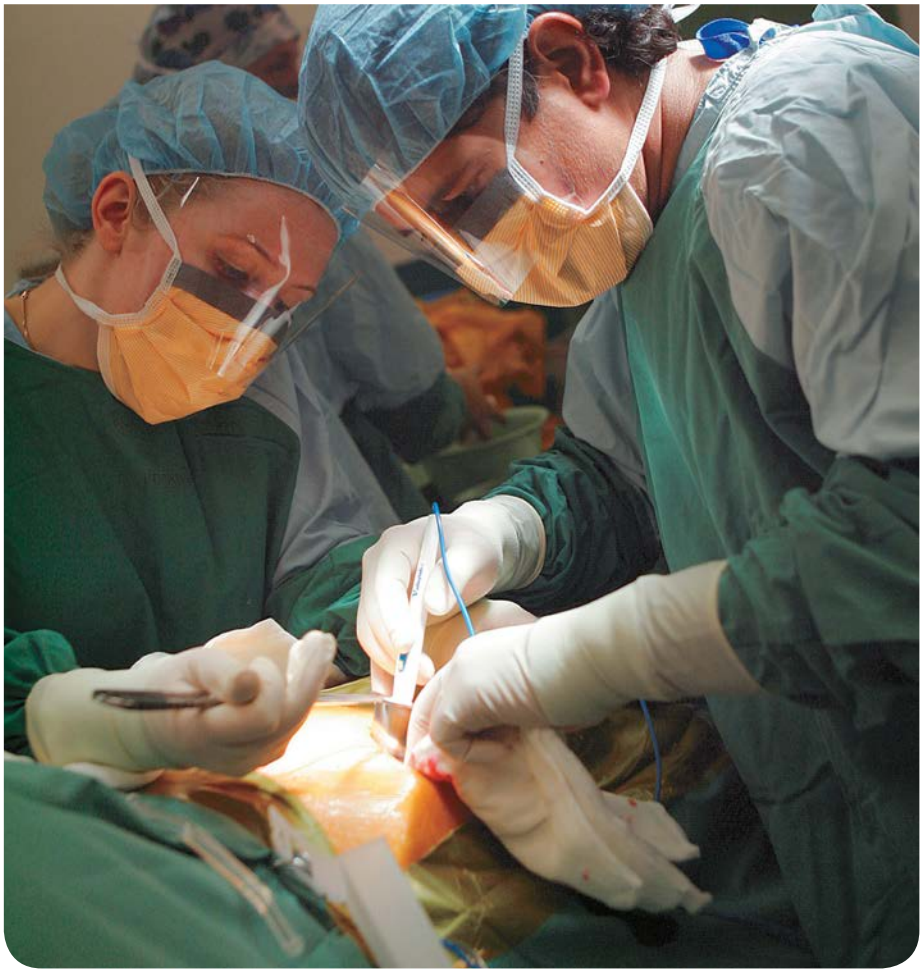
How is Tasmania progressing towards the National Elective Surgery Target?

Continuing on from the *National Partnership Agreement on the Elective Surgery Waiting List Reduction Plan, The National Partnership Agreement on Improving Public Hospital Services* (1 July 2011 – 30 June 2017) is a complementary agreement between the Commonwealth and State & Territory Governments to improve the number of Australians receiving their surgery within the clinically recommended time and to reduce the number of long waiting patients.

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

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

There are too many NEST performance indicators to include in the main section of the *Progress Chart.* However, detailed performance data for the NEST is publicly available for the first time in Appendix One. It is anticipated that in future *Progress Charts* NEST performance indicators will gradually replace the current elective surgery indicators provided in this edition.



How many call outs has our ambulance service responded to?

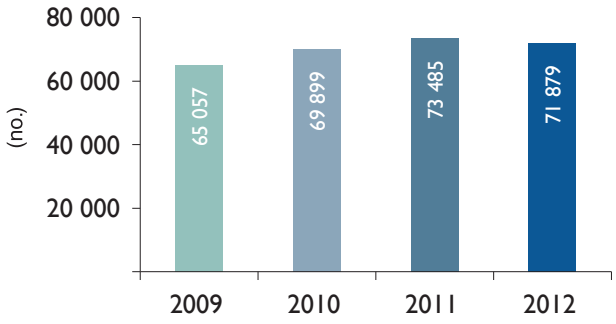
An ambulance response occurs when a vehicle or vehicles are sent to a pre-hospital incident or accident. This measure for the total ambulance responses includes emergency, urgent and non-urgent responses.

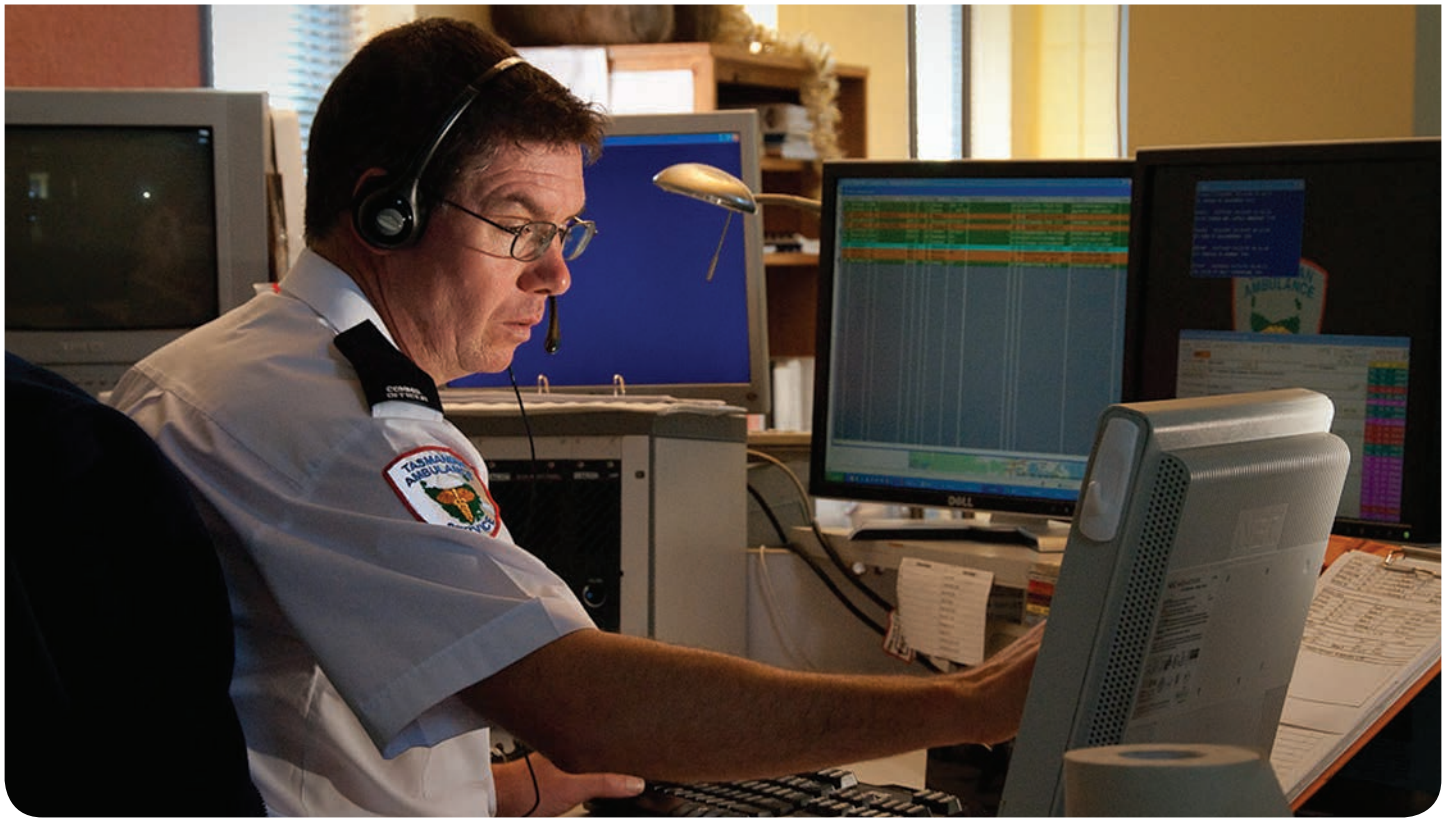
2012 figures are sourced from the new reporting system developed by Ambulance Tasmania that excludes vehicle movements between locations that do not involve actually responding to a patient. As data for the previous years was calculated using different methodology it is not possible to directly compare published 2012 caseload figures with previous years.

However, 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 time difference between the time when an emergency 000 call is received at the ambulance Communications Centre and when the ambulance arrives at the location to treat the sick or injured patient. The median response time is the time within which 50 per cent of emergency cases are responded to.

Ambulance Tasmania now includes all patient related responses in the state including all prolonged remote responses and has still achieved a modest improvement to response performance during 2012.

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 and ribbon urban development along the Derwent and Tamar rivers
- a high reliance on volunteers.

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)

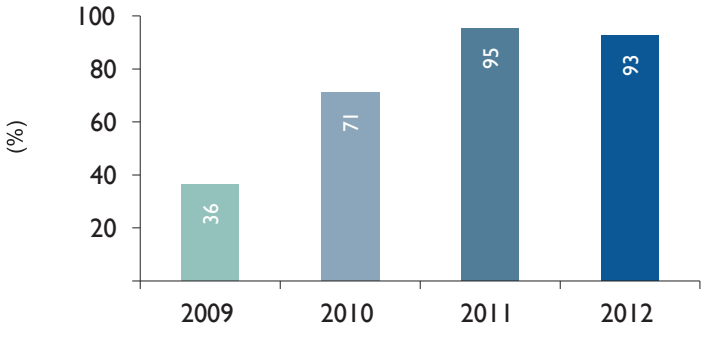
What proportion of BreastScreen clients were assessed within the recommended timeframe?

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 2012 compared to the same period in the previous year the proportion decreased from 95 per cent to 93 per cent. BreastScreen Tasmania continues to out-perform the BreastScreen Australia national target of 90 per cent for this measure.

Figure 19: Clients assessed within 28 days of mammogram

(for the 12 months ending 30 June)



How many dental appointments have adults accessed?

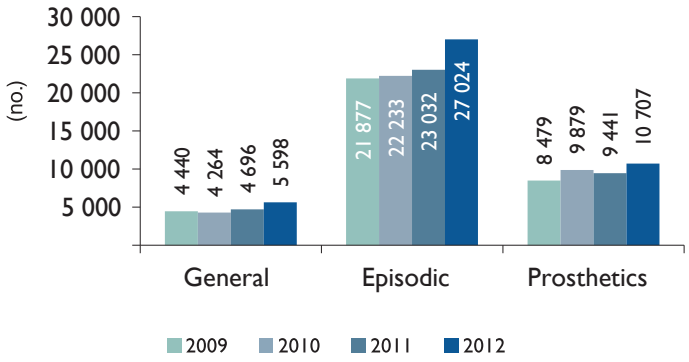
This indicator shows the number of occasions of service for all dental services (episodic care, general care and prosthetics) provided around the State. It should be noted that outsourced general care provided by the private sector is excluded from these figures.

In the 12 months ending 30 June 2012, compared to the same period in the previous year, there was:

- a 19.2 per cent increase in the number of general occasions of service.
- a 17.3 per cent increase in the number of episodic occasions of service.
- a 13.4 per cent increase in the number of prosthetics occasions of service.

Figure 20: Adults – occasions of service

(for the 12 months ending 30 June)



Prosthetics activity has increased following infrastructure upgrades of statewide laboratory facilities. Services were temporarily interrupted in 2010-2011 while this work was undertaken.

Variations in levels of activity reflect fluctuating numbers within the public sector dental workforce. A range of recruitment and retention strategies are in place to increase and sustain clinician numbers.

How many dental appointments have children accessed?

In the 12 months ending 30 June 2012 compared to the same period in the previous year, there has been a 6.2 per cent increase in the occasions of service for children receiving dental care.

Dental care for children is provided by dental therapists.

An ageing workforce and a growing national shortage of dental therapists are likely to continue to affect oral health services into the future. To counter this Oral Health Services Tasmania has increased recruitment of graduates of a new qualification, the Bachelor of Oral Health (BoH). BoH graduates are able to provide services to both children and adults and will, in the long term, replace the dental therapy workforce.

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 provides a measure of the number of people waiting for upper and/or lower dentures.

As at 30 June 2012 compared to the same time in the previous year, there was a significant 34.8 per cent increase in the dentures waiting list.

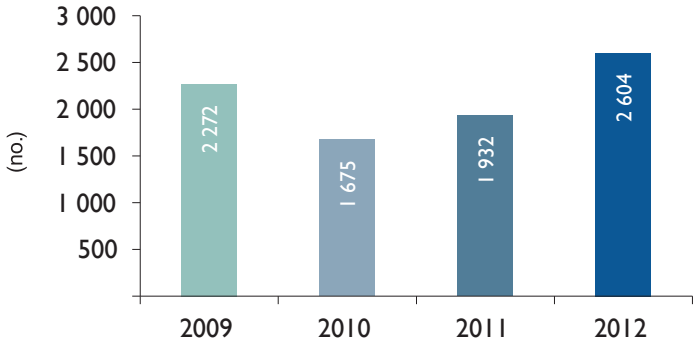
Non-recurrent additional funding for prosthetic services in 2010 enabled additional services to be purchased from the private sector, as well as investment in additional prosthetics staff and improved laboratory facilities.

This additional funding saw a reduction in the waiting list in 2010, but there was a short term interruption to internal service delivery while laboratory facilities were upgraded in 2011.

Increased general care in 2011-2012 has added to the demand for dentures.

Figure 22: Dentures – waiting list

(as at 30 June)



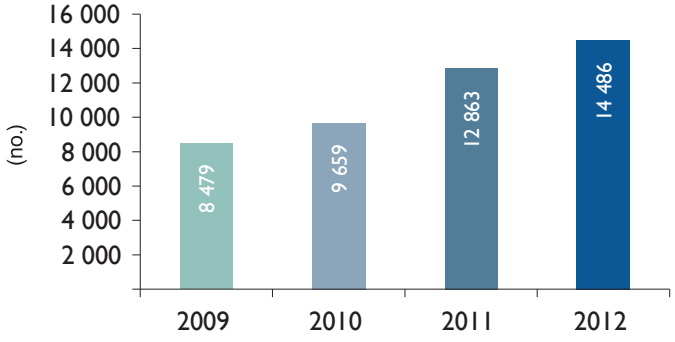
The general care (adults) waiting list indicator shows the number of adults waiting for general care oral health services.

As at 30 June 2012 compared to the same time in the previous year, there has been a 12.6 per cent increase in the general care waiting list.

Despite more general care in 2011-2012, the extra demand for episodic care saw the waiting list increase. Demand for episodic care directly impacts on the capacity to provide general care.

Figure 23: General care (adults) – waiting list

(as at 30 June)



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.

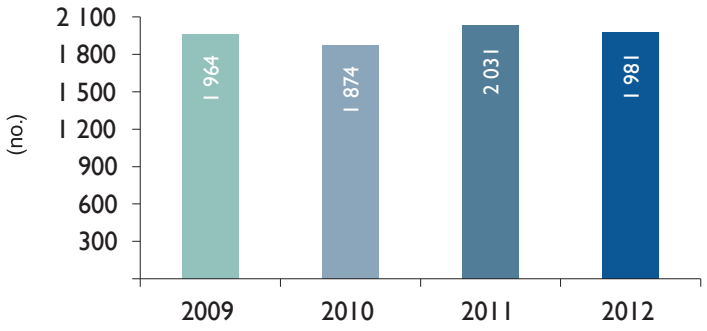
Activity rates are affected by the level of demand for services, the readmission rate, service capacity to admit clients with less severe mental illnesses and the effectiveness of the service system in managing clients in the community.

In the 12 months ending 30 June 2012 compared to the same period in the previous year, the number of people recorded as being treated in acute settings decreased by 2.5 per cent (see explanatory note 5).

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?

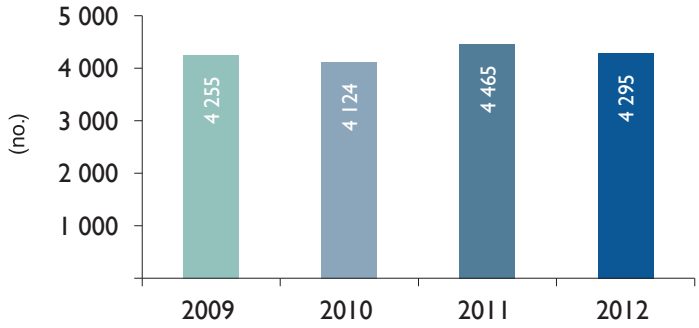
This indicator measures the number of community and residential clients under the care of Mental Health Services. Active community clients are people who live in local communities who are actively accessing services provided by community-based Mental Health Services teams. Active residential clients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

In the 12 months ending 30 June 2011 compared to the same period in the previous year, the number of community and residential clients decreased by 3.8 per cent.

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

(for the 12 months ending 30 June)



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.

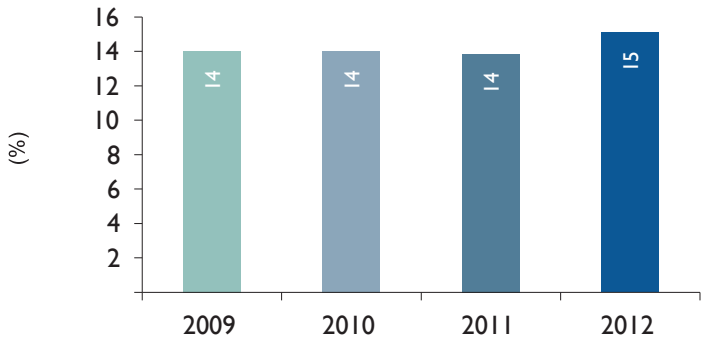
For people who experience mental illness, and particularly those who require acute mental health care, the episodic nature of their condition can often mean that they are likely to require further treatment.

This indicator is a percentage calculated on relatively small numbers and as such, is susceptible to large fluctuations.

In the 12 months ending 30 June 2012 the 28-day readmission rate increased to 15 per cent compared to the 14 per cent recorded in the corresponding period in 2010-11.

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.

Despite property values in Tasmania beginning to plateau, the cost of private rental remains comparatively high, particularly for people on low to moderate incomes. With limited affordable rental options in the market generally, public housing tenants are reluctant to leave secure, affordable tenure. As a result, occupancy rates in public housing remain high.

Even with these challenges, in the 12 months ending 30 June 2012 the number of people housed increased by 2.4 per cent compared to the same period in the previous year.

Figure 27: Number of applicants housed

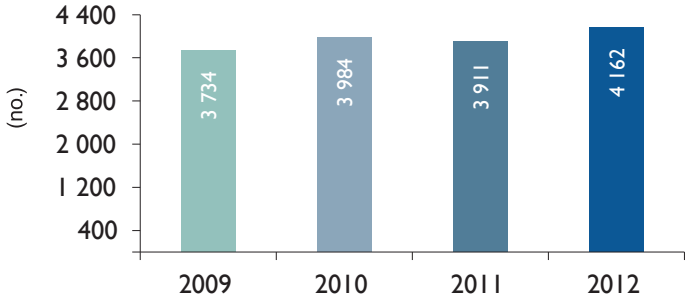
(for the 12 months ending 30 June)

How many people receive private rental assistance?

In the 12 months ending 30 June 2012, 4 162 households received financial assistance through the Private Rental Support Scheme (PRSS), an increase of 6.4 per cent compared to the same period in 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?

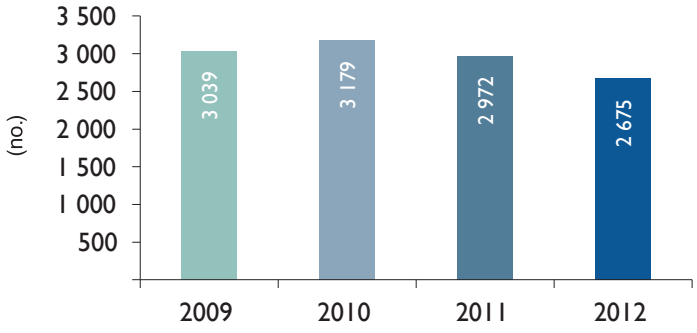
This indicator measures the total number of people who were waiting for public housing.

The public housing waitlist at 30 June 2012 decreased by 10 per cent compared to the previous year.

This is partly due to the additional 1 400 new affordable housing properties delivered under a variety of Government programs between 2010 and 2012.

Figure 29: Number of applicants on waitlist

(for the 12 months ending 30 June)



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

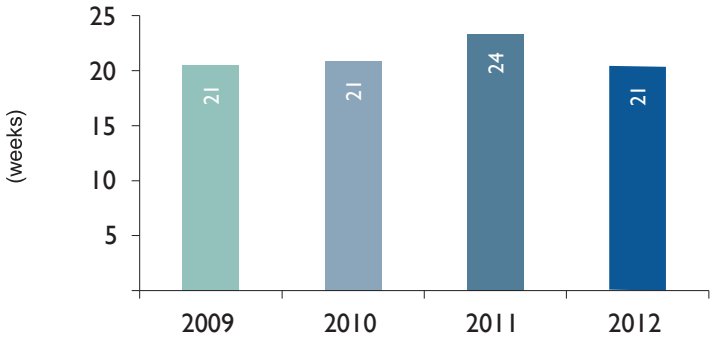
This indicates how long it takes to house applicants who have been assessed to have the highest level of need, category 1. The assessment of need is based on adequacy, affordability and appropriateness of housing.

In the 12 months ending 30 June 2012, the average time to house category 1 applicants was 21 weeks, a decrease of three weeks compared to the same time in the previous year.

The capacity to house priority applicants quickly is contingent upon the availability of homes that meet household amenity and locational needs. In an environment where private rental properties are becoming increasingly unaffordable for low income earners, fewer public housing tenants are leaving for private rentals resulting in very high occupancy rates. The shortage of vacancies also makes it difficult to match the increasingly complex needs of applicant households to available homes.

Figure 30: Average time to house category 1 applicants

(for the 12 months ending 30 June)



How many child protection cases are referred for investigation?

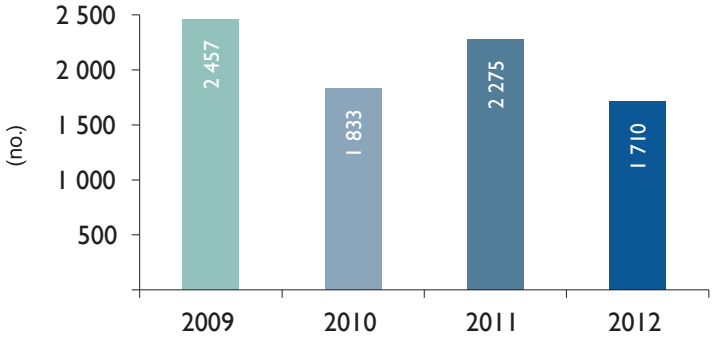
The Gateway, Integrated Family Support Services and other reform initiatives have directed a greater focus on intervening earlier with family services and better integrating the delivery of child protection and family support services.

In the 12 months ending 30 June 2012 compared to the same period in the previous year, there has been a 24.8 per cent decrease in the number of notifications referred for investigation across the State. This is consistent with adoption of a preventive approach.

However, fluctuations in cases referred are likely to be observed over time 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 time frames?

TThis refers to the number of notifications of child abuse and neglect received by DHHS that are not allocated for investigation within established time frames.

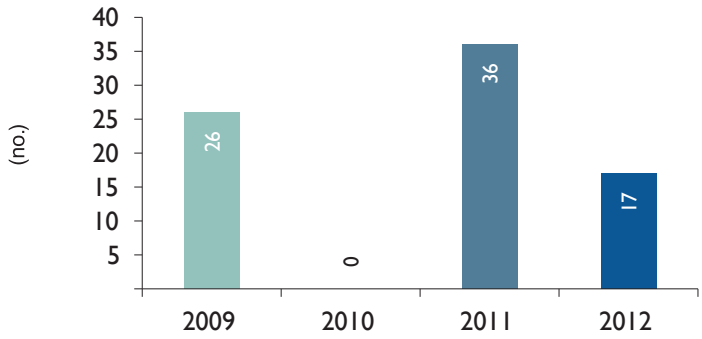
The number of unallocated cases as at 30 June 2012 was 17, compared with 36 at the same time last year. DHHS remains committed to keeping this number low.

The overall reduction in unallocated cases has been achieved as a result of several improvements including the introduction of a new operating model in February 2008.

The introduction of a comprehensive Child Protection Information System (CPIS 2) in 2010 has further improved responsiveness to demand.

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

(as at 30 June)



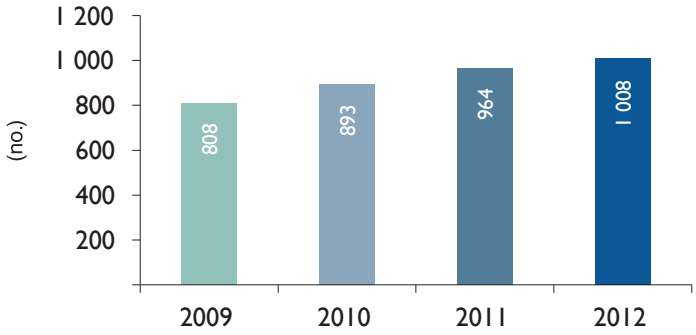
How many children are placed in out-of-home care?

As at 30 June 2012 compared to the same time in the previous year there was a 4.6 per cent increase in the number of children in out-of-home care.

All states and territories have experienced an upward trend in the number of children in care since 2005. The rise can be partly explained by the tendency for children to remain in care once admitted due to the complexity of issues such as low family income, parental substance abuse, mental health issues and family violence, which are only addressed with appropriate and sustained support over time.

Figure 33: Children in out-of-home care

(as at 30 June)



As part of the overall commitment of DHHS to the health and wellbeing of all children in Tasmania, a project to redesign the Tasmanian family support service system is expected to improve early intervention and, in doing so, assist in reducing the rate at which children enter out of home care. In addition, an increased focus on permanency planning for children in longer term care is likely to improve the stability of care arrangements.

Due to external factors and the need to meet statutory obligations for children at risk, periodic increases in the number of children in out-of-home care may still be observed. DHHS remains committed to providing safe placements for children who are unable to stay safely at home.

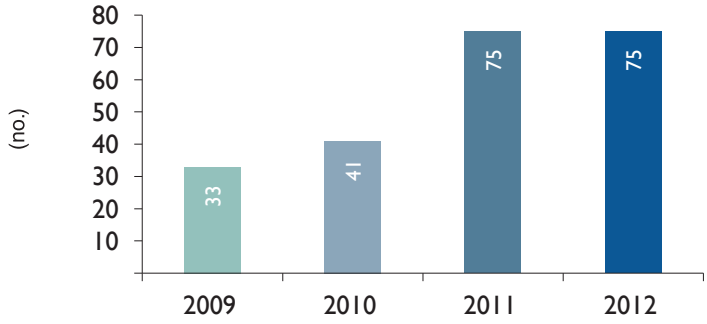
What are the waiting lists for people requiring supported accommodation?

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 a disability within a range of accommodation options, including group homes and other residential care 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.

Figure 34: Disability services – supported accommodation – waiting list

(as at 30 June)



Since July 2010, waiting list figures for supported accommodation have been compiled by *Gateway Services*. Comparisons with previously reported figures should therefore be undertaken with caution. These figures are also a 'snapshot' of a single point in time and are not necessarily representative of waiting list figures at other periods within the year.

In the 12 months ending 30 June 2012 compared to the same period in the previous year, there were the same number of people with a disability who were urgently waiting for a supported accommodation placement.

What is the waiting list for community access clients?

This shows the number of people with a 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.

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

(as at 30 June)

Since July 2010, waiting list figures for community access services have been compiled by *Gateway Services*. Comparisons with previously reported figures should therefore be undertaken with caution. These figures are also a 'snapshot' of a single point in time and are not necessarily representative of waiting list figures at other periods within the year.

In the 12 months ending 30 June 2011 compared to the same period in the previous year, there has been a 55.7 per cent increase in the number of people with a disability who are waiting for a full-time or part time community access placement.

Explanatory notes

1. The figures for raw and weighted separations do not include outside referred patients or unqualified neonates.
2. For the Mersey Community Hospital (with the exception of elective surgery waiting lists), comparable data for years prior to 2010 are unavailable. This is because the Tasmanian Government only resumed management of the hospital from the Australian Government on 1 September 2008.
3. Please note that end of year figures have been updated to reflect more accurate data being made available. Quarterly data is not available for 2008 as during this period the indicator was only reported on an annual basis.
4. Due to more accurate data becoming available, data reported from previous *Progress Charts* may differ.
5. The 2010 Mental Health Services Inpatient Separation figure has been adjusted to reflect improved source data reporting systems.
6. 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.

NEAT

The objective of the NEAT is that 90 per cent of all patients presenting to a public hospital ED to either physically:

a) leave the ED for admission to hospital

b) be referred to another hospital for treatment, or

c) be discharged within four hours.

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 for the first assessment period (2012) is 72 per cent. Tasmania's 2009-2010 baseline performance for the NEAT was 66 per cent.

National Emergency Access Target (NEAT), by quarter, by hospital					
	RHH	**LGH**	**NWRH**	**MCH**	**Statewide**
March 2012 Quarter: Percentage of all patients who physically left the ED within four hours of presentation.	57.2%	61.9%	79.9%	77.5%	69.1%
June 2012 Quarter: Percentage of all patients who physically left the ED within four hours of presentation.	59.2%	62.4%	80.5%	77.5%	69.9%

Note: These final 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).

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 by the end of the agreement.

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.

Please note that the NEST Part 1 targets (the volume or number of patients who received elective surgery and the percentage of patients treated within the clinically recommended times) have not yet been agreed with the Commonwealth. It is anticipated that the targets will be finalised with the Commonwealth in late September 2012.

National Elective Surgery Target (NEST) indicators: January 1 – March 31 Quarter 2012					
Major Tasmanian Public Reportable Hospitals	**RHH**	**LGH**	**NWRH**	**MCH**	**Statewide**
NEST – Number of patients receiving elective surgery from waiting lists					
Admitted as elective patient for awaited procedure in this hospital or another hospital	1 532	1 040	415	448	3 435
Patients removed for reasons other than successful surgery					
Admitted as emergency patient for awaited procedure in this hospital or another hospital	13	10	1	4	28
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)	21	15	2	2	40
Treated elsewhere for awaited procedure	39	31	6	3	79
Surgery not required or declined	107	56	27	12	202
Transferred to another hospital's waiting list	12	9	3	5	29
Not known	41	13	7	12	73
Total	**233**	**134**	**46**	**38**	**451**
Patients treated within the clinically recommended time					
Category 1	505	314	111	95	1 025
Category 2	324	241	155	158	878
Category 3	90	163	53	121	427
Total	**919**	**718**	**319**	**374**	**2 330**
NEST – Percentage of patients treated within the clinically recommended time					
Category 1	70%	79%	77%	83%	74%
Category 2	50%	58%	73%	76%	59%
Category 3	53%	73%	91%	96%	74%
Total	**60%**	**69%**	**77%**	**83%**	**68%**

Major Tasmanian Public Reportable Hospitals	RHH	LGH	NWRH	MCH	Statewide
Median waiting time for elective surgery admission (days)					
Cataract Extraction	520	43	NA	94	242.5
Cholecystectomy	286	108	46	50	101
Coronary Artery Bypass Graft	22	NA	NA	NA	22
Cystoscopy	36	30	NA	55	33
Haemorrhoidectomy	122	724	103	65	144.5
Hysterectomy	25	60	125	76	73.5
Inguinal Herniorraphy	57	164	47	56	56
Myringoplasty	29	406	55	16	55
Myringotomy	57	99	NA	NA	90
Prostatectomy	44	70	NA	NA	65.5
Septoplasty	136	227	63	39	133
Tonsillectomy	157	62	NA	22	105
Total Hip Replacement	611	259	81	NA	256
Total Knee Replacement	657	277	55	NA	591
Varicose Veins Stripping and Ligation	64	62	40	NA	62
Other procedures not listed above	31	31	40	29	32
Total	**42**	**36**	**45**	**35**	**40**
Median waiting time by urgency category (days) admissions					
Category 1	15	13	16	16	14
Category 2	90	67	63	57	70
Category 3	266	189	137	93	171
Total	**42**	**36**	**45**	**35**	**40**

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

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	99	81	27	9	216
Number of unplanned readmissions within 28 days					
Number of 28 day readmissions	13	4	1	0	18
NEST – Average overdue wait time in days for those still waiting and ready for care					
Category 1	76	29	14	6	63
Category 2	285	224	88	55	248
Category 3	682	261	88	193	493

NEST – Treatment and removal of 10% longest wait patients for 2012	Target	Removed in March 2012 Quarter	Remaining at 31 March 2012
All hospitals	**372**	**83**	**289**

Note: These final 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).

National Elective Surgery Target (NEST) indicators: April 1 – June 30 Quarter 2012					
Major Tasmanian Public Reportable Hospitals	**RHH**	**LGH**	**NWRH**	**MCH**	**Statewide**
NEST – Number of patients receiving elective surgery from waiting lists					
Admitted as elective patient for awaited procedure in this hospital or another hospital	1 713	1 140	467	498	3 818
Patients removed for reasons other than successful surgery					
Admitted as emergency patient for awaited procedure in this hospital or another hospital	6	14	2	1	23
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)	35	12	4	4	55
Treated elsewhere for awaited procedure	45	40	3	5	93
Surgery not required or declined	164	97	21	6	288
Transferred to another hospital's waiting list	19	11	3	3	36
Not known	44	21	7	27	99
Total	**313**	**195**	**40**	**46**	**594**
Patients treated within the clinically recommended time					
Category 1	515	368	112	143	1 138
Category 2	347	253	191	152	943
Category 3	138	175	66	151	530
Total	**1 000**	**792**	**369**	**446**	**2 607**
NEST – Percentage of patients treated within the clinically recommended time					
Category 1	69%	82%	74%	92%	76%
Category 2	50%	55%	80%	83%	60%
Category 3	50%	76%	87%	95%	71%
Total	**58%**	**70%**	**79%**	**90%**	**68%**

Major Tasmanian Public Reportable Hospitals	RHH	LGH	NWRH	MCH	Statewide
Median waiting time for elective surgery admission (days)					
Cataract Extraction	403	623	NA	111	313
Cholecystectomy	266	91	46	28	88.5
Coronary Artery Bypass Graft	25	NA	NA	NA	25
Cystoscopy	42	20	NA	19	24.5
Haemorrhoidectomy	197	NA	45	162	102
Hysterectomy	54	104	90	53	65
Inguinal Herniorraphy	106	66	64	33	56
Myringoplasty	422	46	53	14	55
Myringotomy	81	44	NA	NA	47.5
Prostatectomy	71	46	NA	NA	71
Septoplasty	330	236	NA	NA	244
Tonsillectomy	177	64	186	103	93.5
Total Hip Replacement	295	238	110	NA	206
Total Knee Replacement	679	312	151	NA	520.5
Varicose Veins Stripping and Ligation	41	NA	80	NA	69
Other procedures not listed above	31	36	34	22	32
Total	**44**	**42**	**41**	**27**	**40**
Median waiting time by urgency category (days) admissions					
Category 1	17	14	20	12	15
Category 2	89	79	49	36	65
Category 3	379	184	117	74	199
Total	**44**	**42**	**41**	**27**	**40**

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

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	104	62	20	7	193
Number of unplanned readmissions within 28 days					
Number of 28 day readmissions	7	5	0	0	12
NEST – Average overdue wait time in days for those still waiting and RFC					
Category 1	51	33	22	14	44
Category 2	305	261	120	40	273
Category 3	759	289	140	136	519

NEST – Treatment and removal of 10% longest wait patients for 2012	Target	Removed in June 2012 Quarter	Remaining at 31 June 2012
All hospitals	**372**	**61**	**228**

Note: These final 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).

Tasmania

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