

# YOUR HEALTH PROGRESS CHART



**MARCH 2015**

## About Your Health Progress Chart

*Your Health Progress Chart* provides a wide range of information about the performance of Tasmania's health system services. The quarterly *Progress Chart* helps us evaluate our activities and determine our future directions.

The *Your Health and Human Services Progress Chart* has been published continuously since 2006. From the March 2015 edition onwards Health and Human Services will be reported separately to enable a clearer focus on each of these two important service areas.

We are currently reviewing the way we report publicly on the performance of our services, including how we can improve on the *Your Health Progress Chart*.

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## A note about the *MyHospitals* website

The *MyHospitals* website, launched in 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 (YH): 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 *YH: 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 six months ending December 2014 compared to the same period in the previous year, the number of raw separations increased:

- by 2 per cent at the RHH
- by 10.5 per cent at the LGH
- by 14.2 per cent at the NWRH.

However, at the MCH raw separations decreased by 6.2 per cent.

Weighted separations show the level and complexity of the work done in 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 six months ending 31 December 2014 compared to the same period in the previous year, the number of weighted separations increased:

- by 2.4 per cent at the RHH
- by 7.6 per cent at the LGH
- by 11.9 per cent at the NWRH.

However, weighted separations decreased by 3.5 per cent at the MCH.

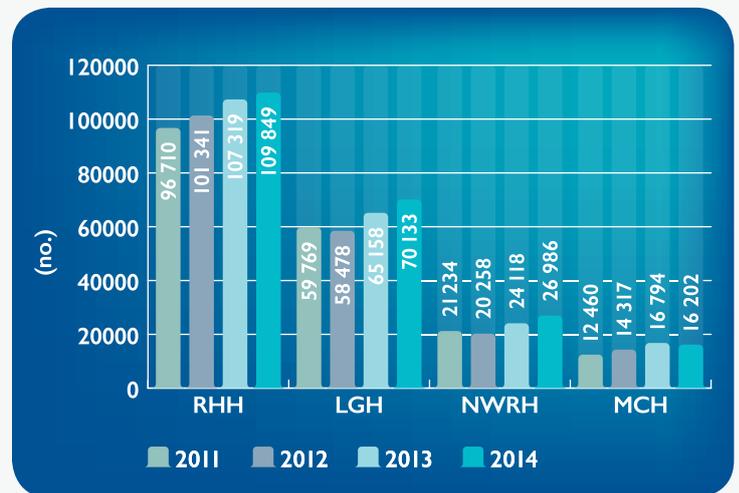
**Figure 1: Admitted patients – number of raw separations**

(for the six months ending 31 December 2014)



**Figure 2: Admitted patients – number of weighted separations**

(for the six months ending 31 December 2014)



## How busy are our Emergency Departments?

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

In the six months ending 31 December 2014 compared to the same period in the previous year, ED presentations:

- increased by 4.8 per cent at the RHH
- decreased by 0.4 per cent at the LGH
- increased by 3.1 per cent at the NWRH
- decreased by 1.5 per cent at the MCH.

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

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

**Figure 3: Emergency Department presentations**

(for the six months ending 31 December 2014)



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

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

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

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

In the six months ending 31 December 2014, the ACEM benchmarks were achieved for category 1, 2 and 5 patients at the RHH. ED workflow redesign and changes to admission processes for patients from ED to inpatient wards have been adopted to improve performance.



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

(for the six months ending 31 December 2014)



In the six months ending 31 December 2014 at the LGH, the ACEM benchmark was achieved for category, 1, 2 and 5 patients, with improvements shown in the other categories when compared to the previous year.

Over the period, a range of strategies have been implemented to improve category 3 performance, which resulted in significant improvement from 57.0 per cent to 63.0 per cent.

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

In the six months ending 31 December 2014 at the NWRH, performance in all categories met the ACEM benchmarks, and there were improvements in the percentage of categories 2, 3, 4 and 5 patients seen in time compared to the same time period last year.

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

(for the six months ending 31 December 2014)



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

(for the six months ending 31 December 2014)



In the six months ending 31 December 2014 at the MCH, ACEM benchmarks were achieved in all triage categories except triage categories 2 and 3.

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

(for the six months ending 31 December 2014)



## What percentage of patients leave the ED within 4 hours?

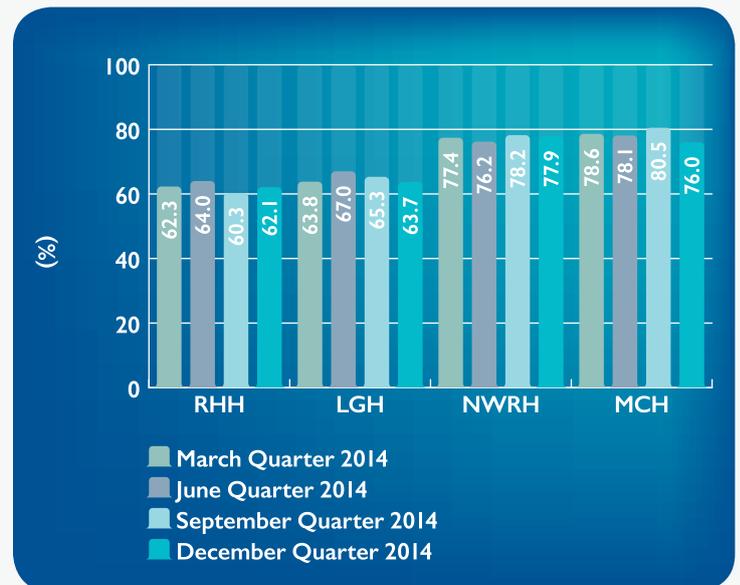
This emergency department indicator commenced in January 2012. Under the *National Partnership on Improving Public Hospital Services* the National Emergency Access Target (NEAT) has been introduced to improve emergency department length of stay. This measure reports the percentage of patients who physically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

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

The proportions leaving within four hours were below the target for all four hospitals for every quarter.

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

(January 2014 – December 2014)



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

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

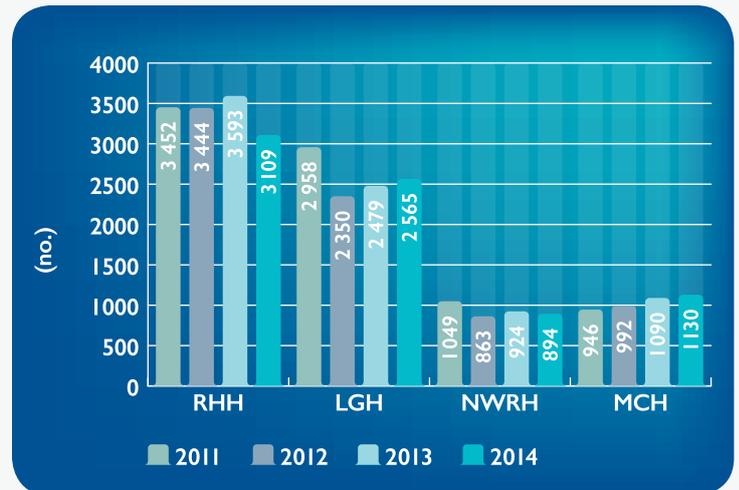
- by 13.5 per cent at the RHH
- by 3.2 per cent at the NWRH.

However, admissions increased:

- by 3.5 per cent at the LGH
- by 3.7 per cent at the MCH.

The noticeable drop in admissions at the Royal Hobart Hospital appears to be due to the interaction of increasing emergency demand and medical admissions at RHH, and seasonal and staffing factors.

**Figure 9: Admissions from waiting list for elective surgery**  
(for the six months ending 31 December 2014)



## 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 31 December 2014 compared to the same time in the previous year, the number of patients waiting for elective surgery increased:

- by 41.9 per cent at the RHH
- by 2.8 per cent at the LGH
- by 5.8 per cent at the NWRH
- by 13.8 per cent at the MCH.

**Figure 10: Waiting list for elective surgery**

(as at 31 December 2014)



## What is the usual time to wait for elective surgery?

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

The median waiting time increased by two days at the RHH, by 19 days at the LGH, by 5 days at the NWRH and by 6 days at the MCH.

The noticeable increase in the median waiting time of patients admitted for elective surgery at Launceston General Hospital reflects the increasing focus on treating very long-waiting patients at that hospital.

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

(for the six months ending 31 December 2014)



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

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

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

In the six months ending 31 December 2014 compared to the same time in the previous year the proportion of category 1 patients seen in time at the RHH increased from 58.0 per cent to 60.6 per cent, decreased in category 2 from 73.1 per cent to 37.2 per cent and decreased in category 3 from 83.6 per cent to 82.7 per cent.

At the LGH, the proportion of patients seen in time increased in category 1 from 58.0 per cent to 83.5 per cent, decreased in category 2 from 65.9 per cent to 33.9 per cent and increased in category 3 from 56.8 per cent to 57.9 per cent.

The decrease in the percentage of category 2 patients seen within the recommended time at RHH and LGH reflect efforts at both hospitals to maintain focus on the most urgent category 1 cases.

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

(for the six months ending 31 December 2014)



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

(for the six months ending 31 December 2014)



At the NWRH, the proportion of patients seen in time decreased in category 1 from 91.1 per cent to 84.9 per cent, decreased in category 2 from 65.6 per cent to 63.4 per cent and increased from 84.3 per cent to 84.8 per cent in category 3.



At the MCH, the proportion of patients seen in time increased in category 1 from 90.6 per cent to 90.9 per cent, decreased in category 2 from 87.1 per cent to 77.7 per cent, and increased in category 3 from 73.3 per cent to 89.5 per cent.

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

(for the six months ending 31 December 2014)



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

(for the six months ending 31 December 2014)



# How long do patients wait for outpatient appointments?

As part of the Government’s commitment to publish transparent and honest data, the *Progress Chart* now includes data on outpatient waiting times drawn from the waiting list module in the statewide patient administration system. The data presented here reflects the full range of outpatient clinics – including medical, surgical and allied health – covering a much broader group of patients than just those waiting for elective surgery.

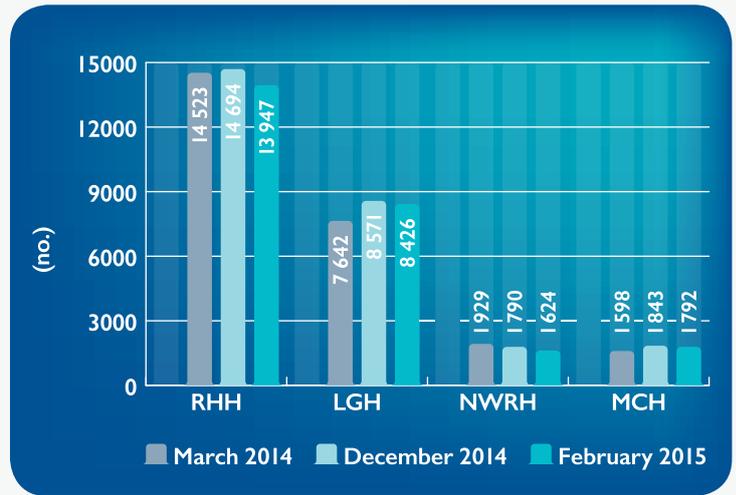
The majority of outpatient activity is not captured by the waiting list module. For example in 2014 there were approximately 495 000 occasions of service recorded as outpatient activity, yet there were only around 26 900 patients reported as being on outpatient waiting lists as of January 2015. This pattern of activity suggests that most outpatient activity does not involve being placed on a waiting list.

It also highlights that some clinics are booking patients directly or using different systems to manage their waiting lists. Furthermore the waiting list module is used in different ways by different clinics and hospitals.

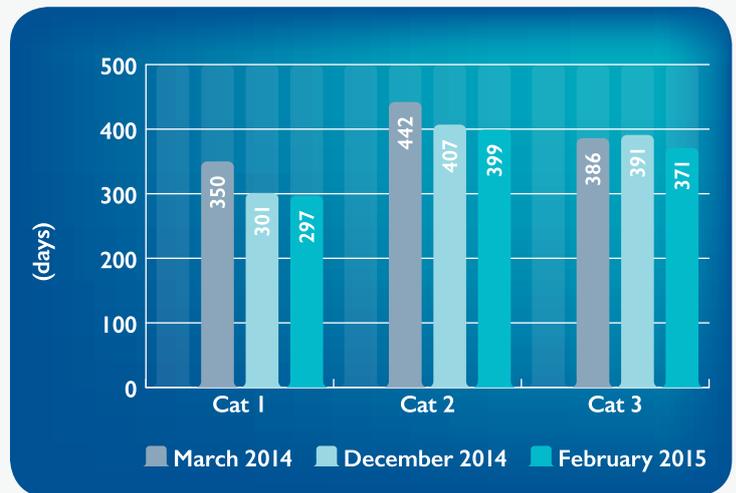
These differences have not been documented but it is clear that some areas use the module to actively manage their wait lists, while others use it simply to keep track of their patients and not as a waiting list management tool.

The data does not discriminate between a patient’s actual waiting time and elapsed waiting time. A patient who requires a post-surgical review for example, may not require an appointment for six months following their surgery. Although though they may appear to ‘wait’ six months for an appointment, this period is actually elapsed time that the patient should wait until it is clinically appropriate for them to be reviewed, and does not represent them having to ‘wait’ due to any delay.

**Figure 16: Outpatient waiting list (ready for care patients)**  
(March 2014 – February 2015)



**Figure 17: Average outpatient waiting time (ready for care patients) at the RHH**  
(March 2014 – February 2015)



There are a number of other issues with the collection and reporting of outpatient data including:

- the use of outpatient waiting lists is not consistent across hospitals or the state and there is no statewide mandated policy or protocols on the management of waiting lists for outpatient activity
- the recording of some data items is not consistent or mandatory across clinics, hospitals or the state
- not all patients waiting for a surgical outpatient appointment will require elective surgery and so are not on a 'hidden waiting list' for elective surgery.

Combined, these issues make it difficult to get an accurate view of outpatient activity and waiting list numbers and difficult to compare activity between THOs, hospitals and outpatient clinics. This means that this data should be interpreted with caution. However, the Government is committed to transparency and openness, and we are confident that the benefits of publishing these data outweigh their limitations.

**Figure 18: Average outpatient waiting time (ready for care patients) at the LGH**

(March 2014 – February 2015)



The Department and the THOs acknowledge the limitations of the outpatient data and are working to improve data quality and accuracy into the future. Significant statistical development work is also being undertaken at a national level (in which Tasmania is an active participant) to develop valid, meaningful and comparable “measures of access time to elective surgery”, and to better inform how long patients wait for their entire care journey. As improved data and measures become available they will be published by DHHS.

Notwithstanding their limitations, these data show a statewide trend of reductions in the size of the outpatient waiting list and of stable or falling outpatient waiting times over the period since the Government has published these statistics.

The graphs show the changes to the outpatient waiting times and waiting lists over the 11 months to February 2015.

The outpatient waiting lists decreased:

- by 5.1 per cent at the RHH
- by 1.7 per cent at the LGH
- by 9.3 per cent at the NWRH
- by 2.8 per cent at the MCH.

The average outpatient waiting time:

- at the RHH decreased by four days for category 1, by eight days for category 2 and decreased by 20 days for category 3
- at the LGH increased by six days for category 1, increased by 28 days for category 2 and increased by 27 days for category 3
- at the NWRH decreased by two days in category 1, decreased by 22 days in category 2 and decreased by 25 days in category 3
- at the MCH decreased by 11 days in category 1, increased by 14 days in category 2 and increased 21 days in category 3.

**Figure 19: Average outpatient waiting time (ready for care patients) at the NWRH**

(March 2014 – February 2015)



**Figure 20: Average outpatient waiting time (ready for care patients) at the MCH**

(March 2014 – February 2015)



## How is Tasmania progressing towards the National Elective Surgery Target?

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

The agreement provides reward payments in recognition of improved performance.

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



# How many call outs has our ambulance service responded to?

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

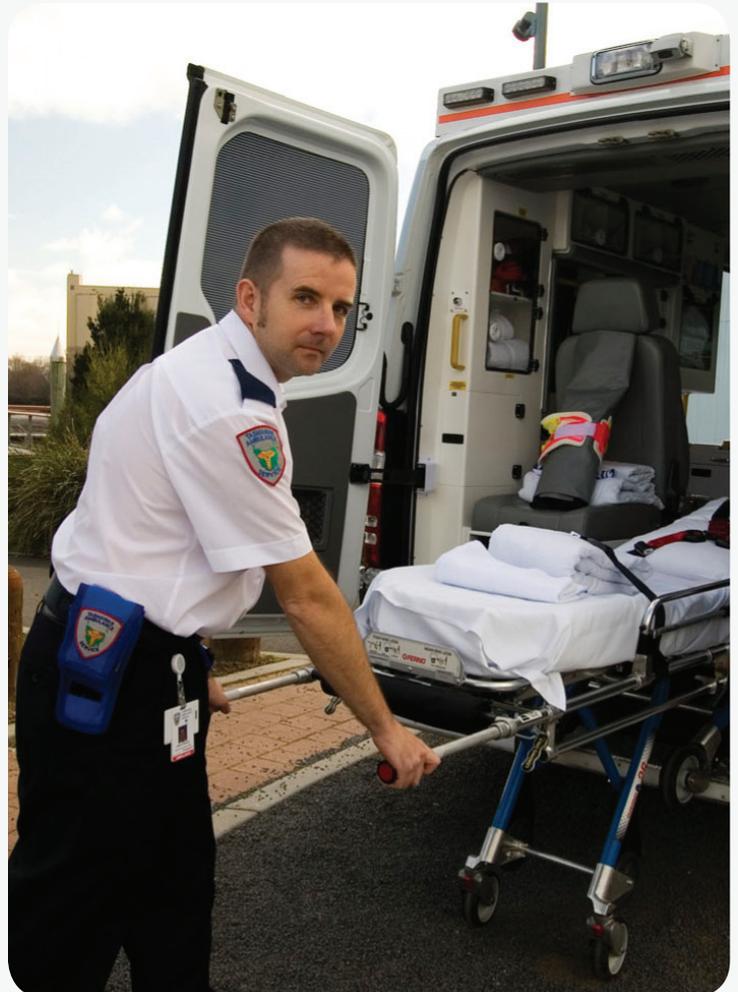
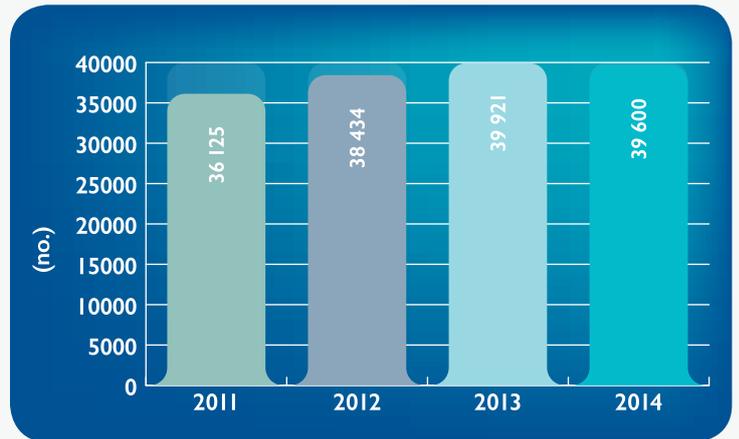
The number of vehicles dispatched (responses) is one measure of Ambulance Tasmania's workload and an indicator of the demand for ambulance services in Tasmania. This measure includes emergency, urgent and non-urgent responses, sometimes referred to as Domestic cases (Note: Cases managed by the Heath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

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

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

**Figure 21: Total ambulance responses**

(for the six months ending 31 December 2014)



## How quickly does our ambulance service respond to calls?

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

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

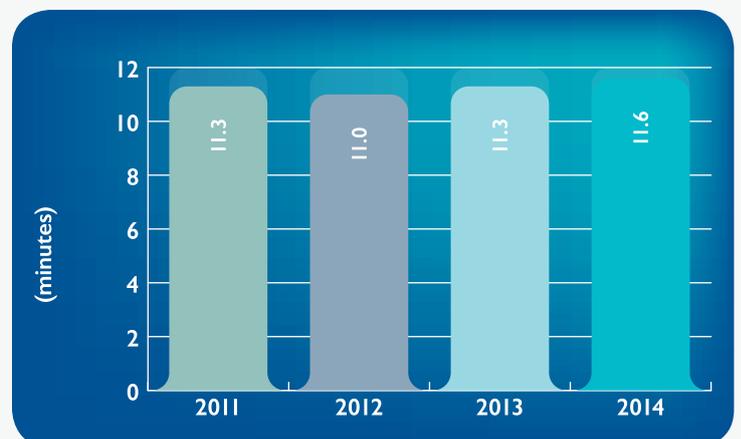
There are a variety of factors which affect ambulance response times in Tasmania including:

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



**Figure 22: Ambulance emergency response times**

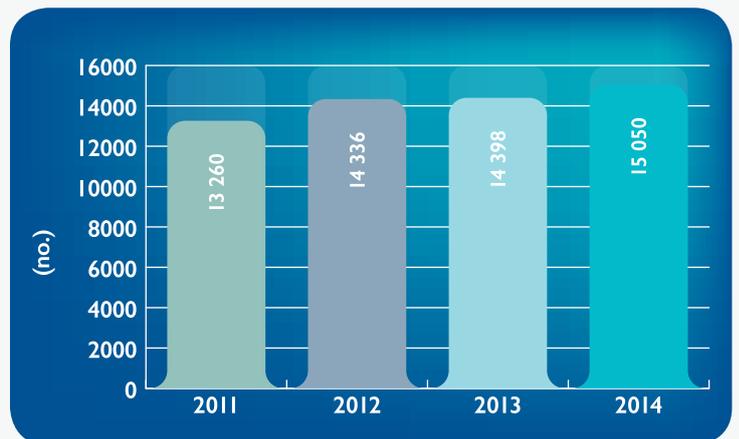
(for the six months ending 31 December 2014)



## 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.

**Figure 23: Eligible women screened for breast cancer**  
(for the six months ending 31 December 2014)



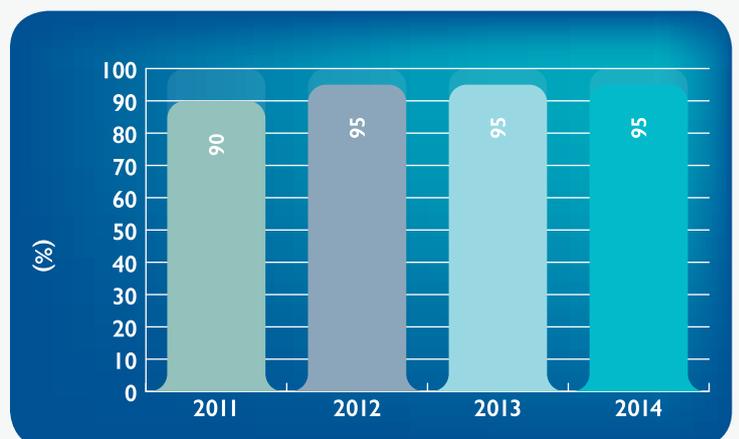
## What proportion of BreastScreen clients were assessed within the recommended timeframe?

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 six months ending 31 December 2014 95 per cent of clients were assessed within 28 days, the same as in the comparable biennial screening cohort in 2012.

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

**Figure 24: Percentage of clients assessed within 28 days of mammogram**  
(for the six months ending 31 December 2014)



## How many dental appointments have adults accessed?

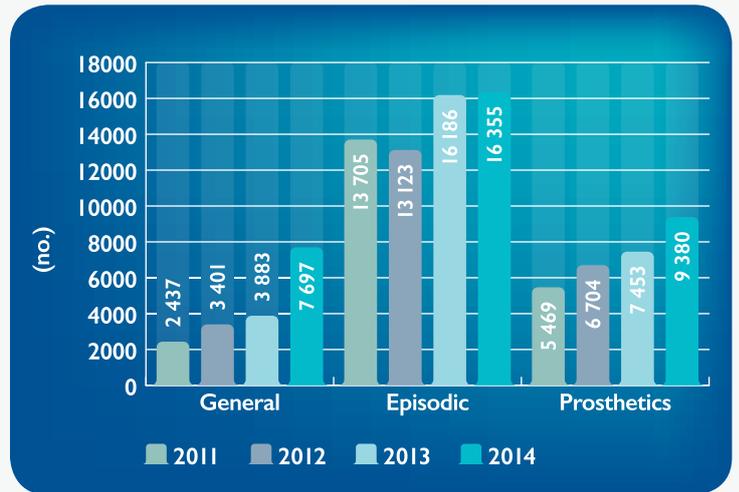
This indicator shows the number of occasions of service for all public dental services provided around the State. It should be noted that outsourced general care provided by the private sector prior to 2012 under the General Care Tender is excluded from these figures, which may have reduced the 2011 figure. General care outsourced since 2012 is included.

In the six months ending 31 December 2014, compared to the same period in the previous year, there was:

- a 98.2 per cent increase in the number of general occasions of service.
- a 1.0 per cent increase in the number of episodic occasions of service.
- a 25.9 per cent increase in the number of prosthetics occasions of service.

**Figure 25: Adults – occasions of service**

(for the six months ending 31 December 2014)

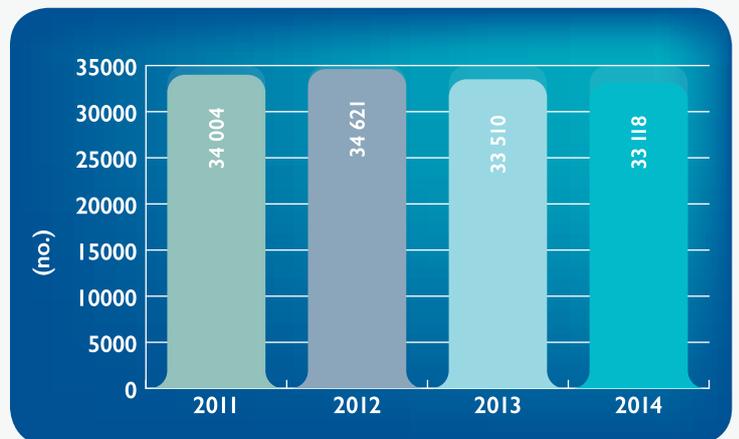


## How many dental appointments have children accessed?

In the six months ending 31 December 2014 compared to the same period in the previous year, there has been a 1.2 per cent decrease in the occasions of service for children receiving dental care.

**Figure 26: Children – occasions of service**

(for the six months ending 31 December 2014)



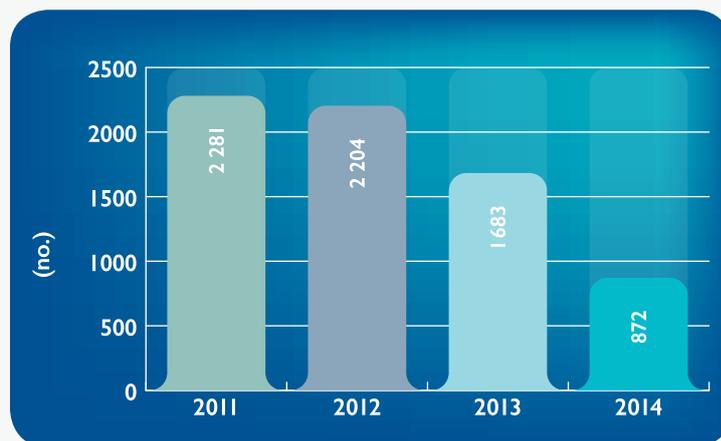
## What are the waiting lists for oral health services?

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

As at 31 December 2014 compared to the same time in the previous year, there was a 48.2 per cent decrease in the dentures waiting list.

**Figure 27: Dentures – waiting list**

(as at 31 December 2014)

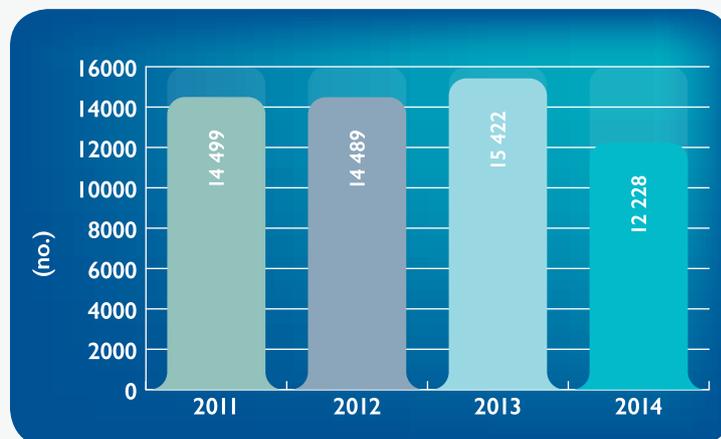


The general care (adults) waiting list indicator shows the number of adults waiting for general dental care.

As at 31 December 2014 the general care waiting list was 20.7 per cent lower compared to the same time in the previous year.

**Figure 28: General care (adults) – waiting list**

(as at 31 December 2014)



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

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

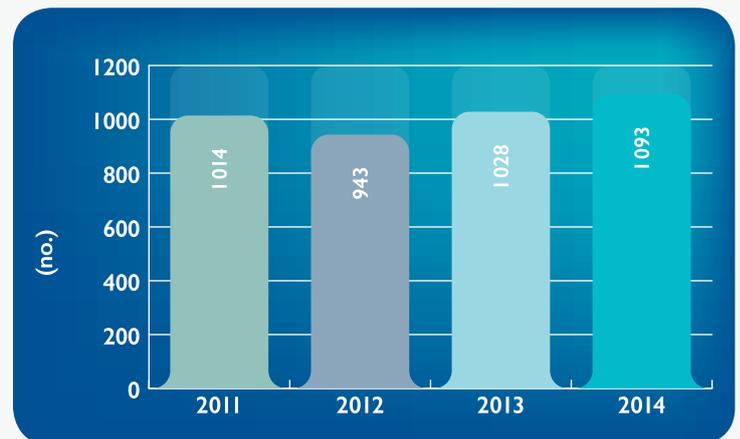
Activity rates are affected by the level of demand for services, the readmission rate, service capacity to admit clients with less severe mental illnesses and the effectiveness of the service system in managing clients in the community.

In the six months ending 31 December 2014 compared to the same period in the previous year, the number of people recorded as being treated in acute settings increased by 6.3 per cent (see explanatory note 4).

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

**Figure 29: Mental Health Services – inpatient separations**

(for the six months ending 31 December 2014)



## 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.

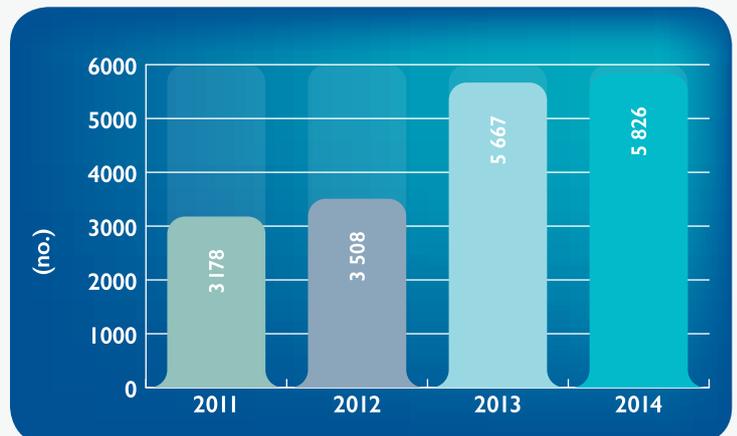
In the six months ending 31 December 2014 compared to the same period in the previous year, the number of community and residential clients increased by 2.8 per cent.

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



**Figure 30: Mental Health Services – community and residential – active clients**

(for the six months ending 31 December 2014)



## 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.

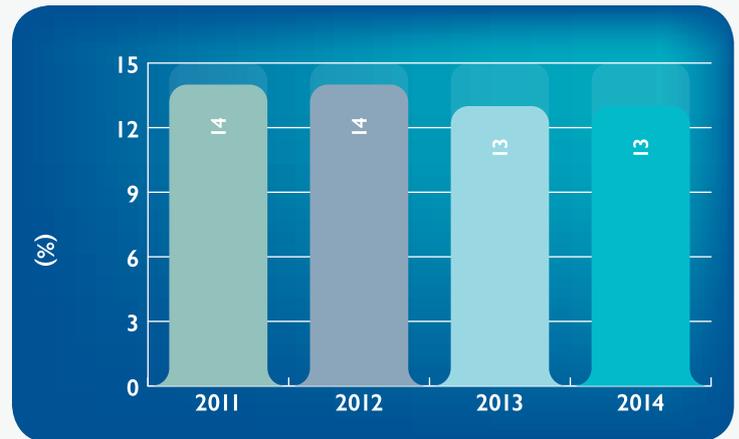
For people who experience mental illness, and particularly those who require acute mental health care, the episodic nature of their condition can often mean that they are likely to require further treatment.

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

In the six months ending 31 December 2014 the 28 day readmission rate was the same as in the same period in 2013-14.

**Figure 31: 28 day readmission rate – all hospitals**

(for the six months ending 31 December 2014)



## Explanatory notes

- 1** The figures for raw and weighted separations do not include outside referred patients or unqualified neonates.
- 2** Due to more accurate data becoming available, data reported from previous *Progress Charts* may differ.
- 3** The 2010 Mental Health Services Inpatient Separation figure has been adjusted to reflect improved source data reporting systems.
- 4** Figures for previous years have been updated to address a data quality issue and to more accurately reflect the actual number of allocated cases.
- 5** 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 I: Progress towards the National Emergency Access Target and the National Elective Surgery Target

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

### NEAT

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

The 90 per cent target must be achieved by the end of December 2015 through a series of stepped intermediate targets. The target for Tasmania in 2013 was 78 per cent and this increased to 84 per cent in 2014. Tasmania's 2009-10 baseline performance for the NEAT was 66 per cent.

National Emergency Access Target (NEAT), by quarter, by hospital					
Percentage of all patients who physically left the ED within four hours of presentation: 2013-14	RHH	LGH	NWRH	MCH	Statewide
March 2014 Quarter	62.3%	63.8%	77.4%	78.6%	67.1%
June 2014 Quarter	64.0%	67.0%	76.2%	78.1%	69.3%
September 2014 Quarter	60.3%	65.3%	78.2%	80.5%	68.2%
December 2014 Quarter	62.1%	63.7%	77.9%	76.0%	67.5%

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

### NEST

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

The two complementary strategies that make up the NEST are:

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

**National Elective Surgery Target (NEST) indicators:  
1 October – 31 December Quarter 2014**

Major Tasmanian Public Reportable Hospitals	RHH	LGH	NWRH	MCH	Statewide
<b>NEST Part I – Number of patients receiving elective surgery from waiting lists</b>					
Admitted as elective patient for awaited procedure in this hospital or another hospital	1 471	1 235	423	516	3 645
Admitted as emergency patient for awaited procedure in this hospital or another hospital	18	6	4	2	30
<b>Total</b>	<b>1 489</b>	<b>1 241</b>	<b>427</b>	<b>518</b>	<b>3 675</b>
<b>Patients removed for reasons other than successful surgery</b>					
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)	18	153	3	14	188
Treated elsewhere for awaited procedure	43	94	10	5	152
Surgery not required or declined	101	130	40	3	274
Transferred to another hospital's waiting list	28	14	3	4	49
Not known	56	19	17	34	126
<b>Total</b>	<b>264</b>	<b>416</b>	<b>77</b>	<b>62</b>	<b>819</b>
<b>NEST Part I – Number of patients treated within the clinically recommended time</b>					
Category 1	499	326	104	96	1 025
Category 2	236	217	119	140	712
Category 3	95	138	108	211	522
<b>Total</b>	<b>830</b>	<b>681</b>	<b>331</b>	<b>447</b>	<b>2 289</b>
<b>NEST – Percentage of patients treated within the clinically recommended time</b>					
Category 1	65%	86%	90%	95%	75%
Category 2	40%	35%	67%	79%	46%
Category 3	79%	59%	83%	89%	76%
<b>Total</b>	<b>56%</b>	<b>55%</b>	<b>78%</b>	<b>87%</b>	<b>63%</b>

Major Tasmanian Public Reportable Hospitals	RHH	LGH	NWRH	MCH	Statewide
<b>Median waiting time for elective surgery admission (days)</b>					
Cataract Extraction	163	499	NA	57	216
Cholecystectomy	42	208	38	71	55
Coronary Artery Bypass Graft	12	NA	NA	NA	12
Cystoscopy	37	27	NA	23	68
Haemorrhoidectomy	77	204	45	220	68
Hysterectomy	53	142	152	41	91
Inguinal Herniorraphy	61	281	68	46	105
Myringoplasty	116	236	47	NA	190
Myringotomy	34	122	NA	NA	87
Prostatectomy	74	309	NA	NA	82
Septoplasty	414	285	NA	NA	287
Tonsillectomy	119	153	336	72	134
Total Hip Replacement	181	343	137	NA	231
Total Knee Replacement	358	598	453	NA	407
Varicose Veins Stripping and Ligation	131	161	84	NA	122
Other procedures not listed above	38	36	38	34	37
<b>Total</b>	<b>42</b>	<b>77</b>	<b>49</b>	<b>41</b>	<b>50</b>
<b>Median waiting time by urgency category (days) Admissions</b>					
Category 1	22	14	14	10	18
Category 2	123	155	64	56	103
Category 3	209	269	120	56	168
<b>Total</b>	<b>42</b>	<b>77</b>	<b>49</b>	<b>41</b>	<b>58</b>

Major Tasmanian Public Reportable Hospitals	RHH	LGH	NWRH	MCH	Statewide
<b>Number of surgical episodes with one or more adverse event flags</b>					
Number of adverse event flags	93	49	20	15	177
<b>Number of unplanned readmissions within 28 days</b>					
Number of 28 day readmissions	1	0	0	0	1
<b>NEST Part 2 – Average overdue wait time in days for those patients still waiting and ready for care</b>					
Category 1	25	10	33	19	24
Category 2	162	208	104	45	180
Category 3	868	256	207	84	414

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

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Tasmanian  
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