Your Health and Human Services

Progress Chart

September 2011

Department of Health and Human Services

Tasmania
Explore the possibilities

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Contents

A note about the *MyHospitals* website

The *MyHospitals* Website, launched on 10 December 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 and emergency department care.

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?

Note: the figures for raw and weighted separations do not include outside referred patients or unqualified neonates.

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 2).

In the 12 months ending 30 June 2011 compared to the same period in the previous year, the number of raw separations:

- decreased by 1.8 per cent at the RHH.
- was not directly comparable with data from previous years for the LGH (see explanatory note 1).
- decreased by 3.7 per cent at the NWRH.
- increased by 9.9 per cent at the MCH (for the MCH, data prior to September 1 2008 is unavailable - see explanatory note 3).

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 2).

In the 12 months ending 30 June 2011 compared to the same period in the previous year, the number of weighted separations:

- remained steady at the RHH.
- was not directly comparable with data from previous years for the LGH (see explanatory note 1).
- remained steady at the NWRH.
- increased by 2.4 per cent at the MCH (for the MCH, data prior to September 1 2008 is unavailable - see explanatory note 3).

Figure 1: Admitted patients – number of raw separations

(for the 12 months ending 30 June 2011)

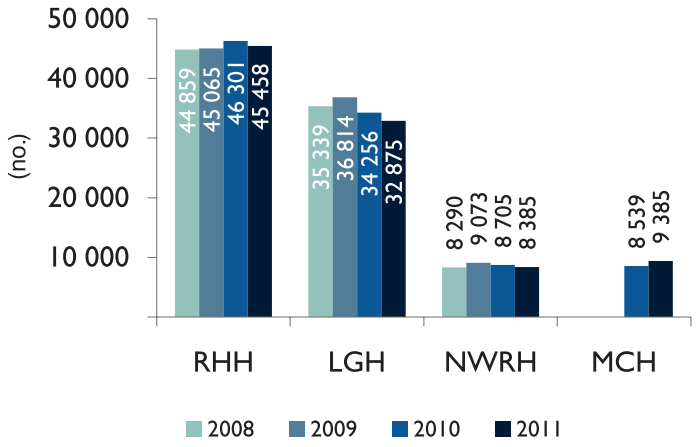
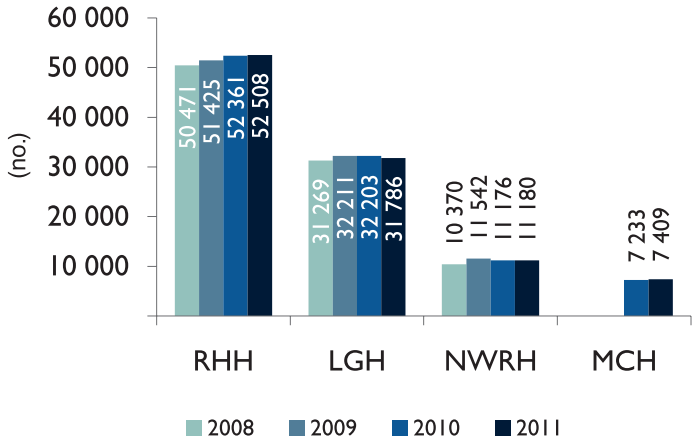


Figure 2: Admitted patients – number of weighted separations

(for the 12 months ending 30 June 2011)



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 2011, compared to the same period in the previous year, ED presentations remained steady at the RHH. At the other hospitals presentations increased:

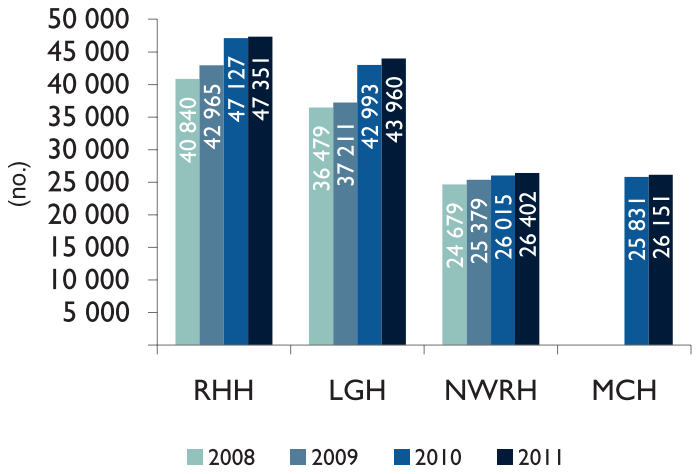
- by 2.3 per cent at the LGH.
- by 1.5 per cent at the NWRH.
- by 1.2 per cent at the MCH.

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, and the patient management protocols and procedures within EDs to maximise overall efficiency.
- improving patient flow within hospitals to free up inpatient beds.

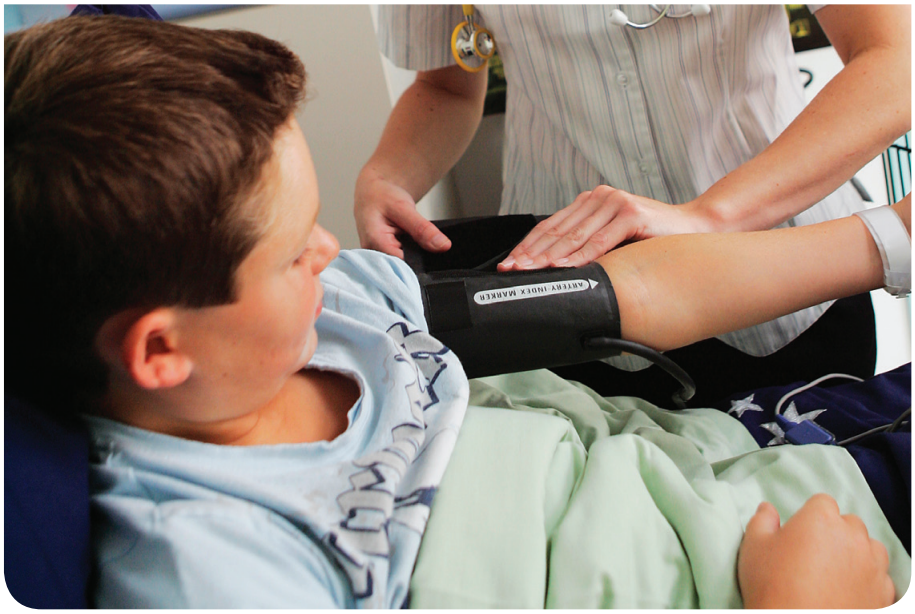
Figure 3: Emergency Department presentations

(for the 12 months ending 30 June 2011)



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 Categories are then allocated and recorded.



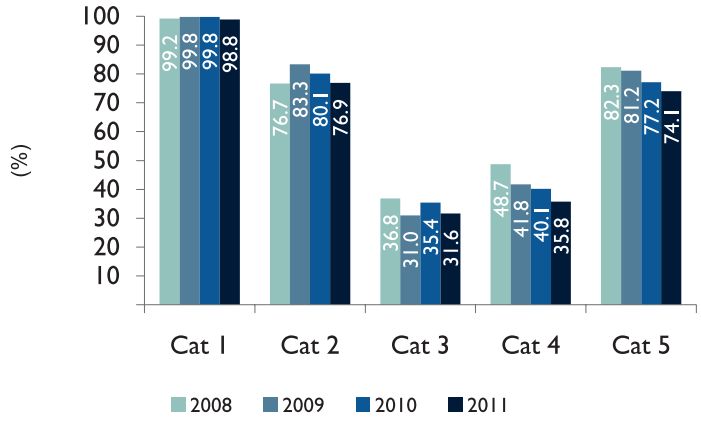
This indicator represents the percentage of patients assigned triage categories 1 through to 5 who commence medical assessment and treatment within the relevant waiting time from their time of arrival. The guidelines set by the Australasian College of Emergency Medicine ACEM) are as follows:

- **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 2011, all category 5 patients were seen within the ACEM benchmark at the RHH, with category 1 and 2 patients being seen at just outside the benchmark. Improving performance for category 3 and 4 patients remains a focus for the RHH. 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 Categories (RHH)

(for the 12 months ending 30 June 2011)



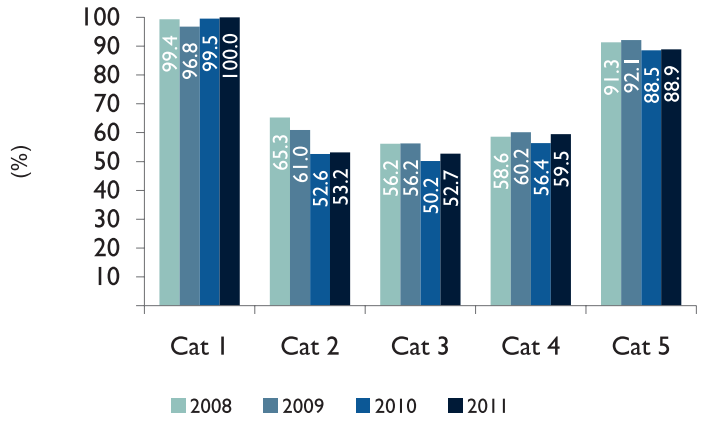
In the 12 months ending 30 June 2011 at the LGH, all category 1 and 5 patients were seen within the ACEM benchmarks, with improvements shown in categories 2, 3 and 4 compared to the same time period last year.

Over the period, performance in category 2 increased from 52.6 per cent to 53.2 per cent and category 3 from 50.2 per cent to 52.7 per cent. These improvements have been achieved through expansion of a fast track ED service, improving step-down care and addressing staff shortages.

The opening of the new ED in December 2011 and the establishment of an 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 Scales (LGH)

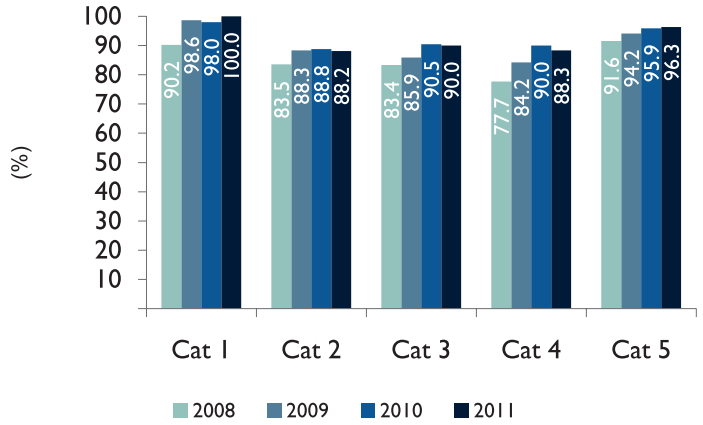
(for the 12 months ending 30 June 2011)



In the 12 months ending 30 June 2011 at the NWRH, all ED patients were seen within the ACEM benchmarks. Improvement has been shown in categories 1 and 5 compared to the same time period last year, with only slight decreases in the remaining categories.

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

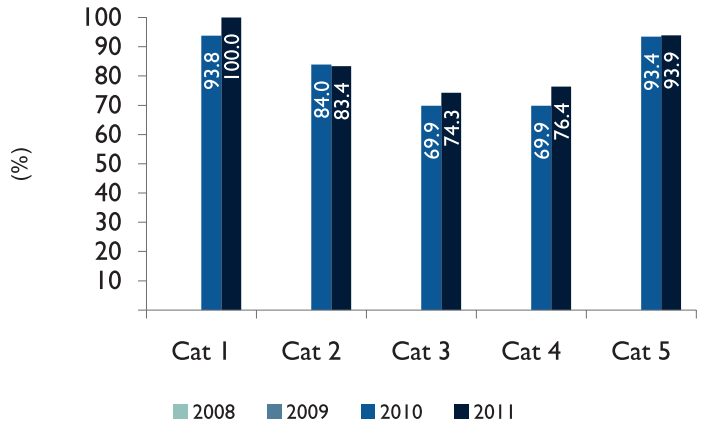
(for the 12 months ending 30 June 2011)



In the 12 months ending 30 June 2011 at the MCH, all category 1, 2, 4 and 5 patients were seen within the ACEM benchmarks, with category 3 patients being seen at just outside the benchmark. Improvement was seen in most categories compared to the same time period last year (data prior to 1 September 2008 is unavailable - see explanatory note 3). Extensive redevelopments have been occurring in the Emergency Department during this period.

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

(for the 12 months ending 30 June 2011)



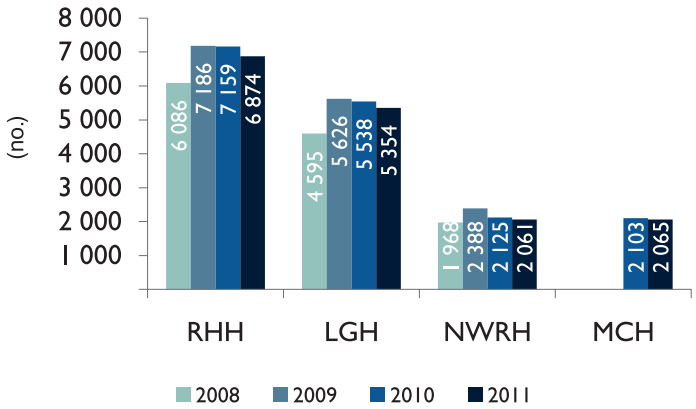
How many people were admitted from the elective surgery waiting list?

The National Partnership Agreement on the *Elective Surgery Waiting List Reduction Plan* was an agreement between the Commonwealth and State and Territory Governments and focused on increasing the throughput of elective surgery procedures and reducing the number of patients waiting longer than clinically recommended times for elective surgery during the period of the Agreement: July 2009-December 2010. The Agreement provided for reward payments to be made in recognition of improved performance.

Part 1 of the Agreement, aimed at increasing the volume of elective surgery admissions, and established a performance benchmark for Tasmania of 21 668 elective surgery admissions between 1 July 2009 and 31 December 2010. By the end of December 2010, Tasmania had exceeded this target with 24 616 admissions recorded, 13.6 per cent above the target.

Figure 8: Admissions from waiting list

(for the 12 months ending 30 June 2011)



There was a decrease in activity in the 12 months to June 2011 compared to the same time in the previous year. The conclusion of specific Program funding has led to reduced activity and the cessation of purchase of procedures from private sector providers. Other contributing factors include construction work at the LGH and a shortage of staff, particularly specialists. The increasing demand for emergency surgery across the State has reduced the number of elective surgery theatre sessions and therefore the number of admissions. Activity on the North West has remained constant when compared to the previous period.

What is the waiting list for elective surgery?

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

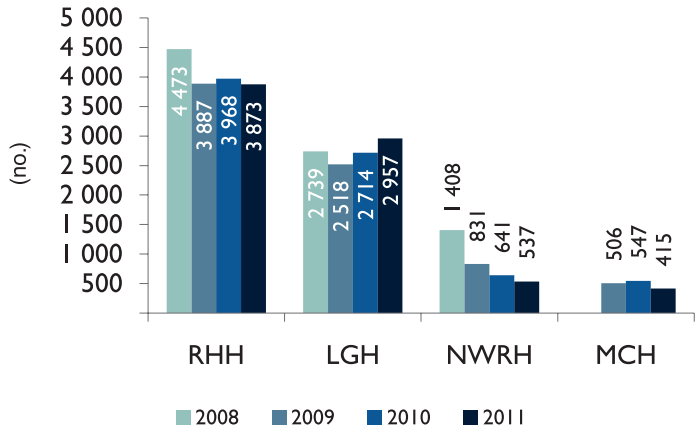
As at 30 June 2011 compared to the same time in the previous year, the number of patients waiting for elective surgery:

- decreased by 2.4 per cent at the RHH.
- increased by 8.9 per cent at the LGH.
- decreased by 16.2 per cent at the NWRH.
- decreased by 24.1 per cent at the MCH.

The active management and co-ordination of waiting lists across the State has reduced the median waiting times for elective surgery in most cases (see figure 10).

Figure 9: Waiting list

(as at 30 June 2011)



What is the usual time to wait for elective surgery?

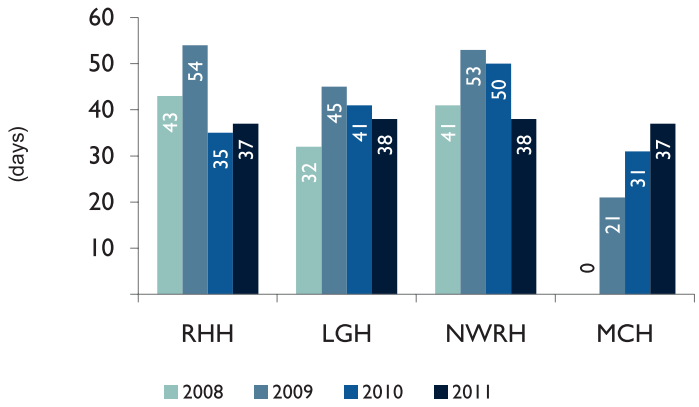
Generally, the key question for patients requiring surgery is not how many patients are on lists but how long they are likely to wait for their surgery.

Part 3 of the aforementioned *National Partnership Agreement on the Elective Surgery Waiting List Reduction Plan,* aimed at improving elective surgery waiting list management and established a median wait time performance benchmark for Tasmania of less than or equal to 48 days for patients admitted from the waiting list.

By the end of December 2010, all Tasmanian hospitals had achieved this benchmark and continue to do so as at 30 June 2011.

Figure 10: Median waiting times for elective patients admitted from the waiting list

(for the 12 months ending 30 June 2011)



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 interim standards that Tasmania must meet under the National Partnership Agreement on Improving Public Hospital Services for 2011 are 74.3 per cent of patients in Category 1, 57.2 per cent for Category 2 and 86.1 per cent for Category 3 (the final standards will be decided by the national Expert Panel in late 2011). The required timeframes are as follows:

- **Category 1:** Admission within 30 days is desirable for a condition that has the potential to deteriorate quickly to the point that it may become an emergency.
- **Category 2:** Admission within 90 days is desirable for a condition causing some pain, dysfunction or disability but is not likely to deteriorate quickly or become an emergency.
- **Category 3:** Admission within 12 months is acceptable for a condition causing minimal or no pain, dysfunction or disability, which is unlikely to deteriorate quickly and does not have the potential to become an emergency.

In the 12 months ending 30 June 2011 compared to the same time in the previous year the proportion of category 1 patients seen on time at the RHH decreased from 69 per cent to 60 per cent, increased in category 2 from 45 per cent to 53 per cent and decreased in category 3 from 86 per cent to 80 per cent.

At the LGH, the proportion seen on time decreased in all categories: from 92 per cent to 88 per cent in category 1, from 59 per cent to 55 per cent in category 2 and from 73 per cent to 62 per cent in category 3.

The proportion of patients seen on time for category 1 patients was above the interim standard of 74.3 per cent.

Figure 11: Patients seen within the recommended time for elective surgery at the RHH

(for the 12 months ending 30 June 2011)

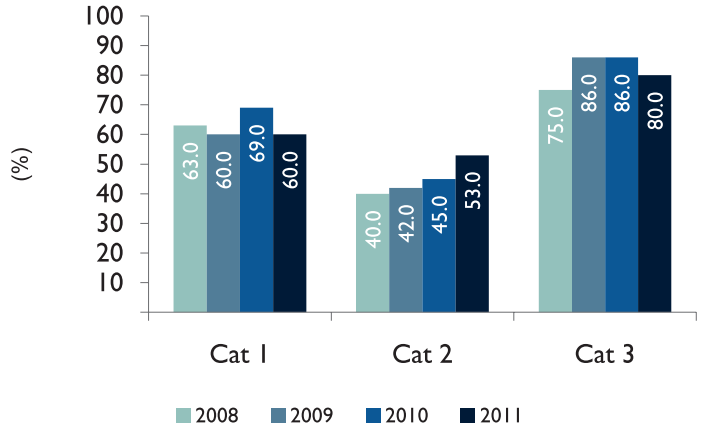


Figure 12: Patients seen within the recommended time for elective surgery at the LGH

(for the 12 months ending 30 June 2011)

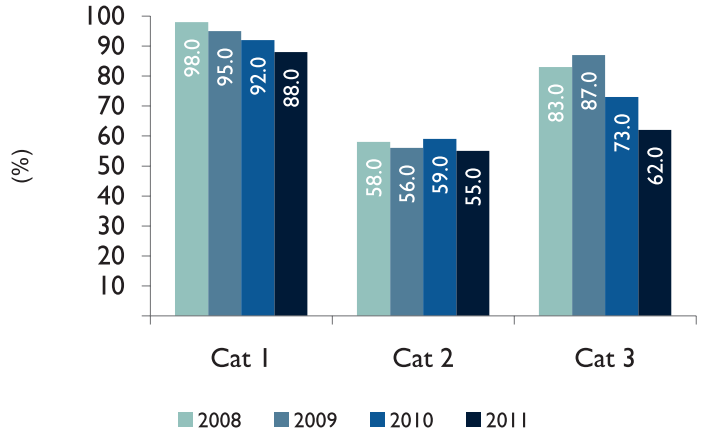
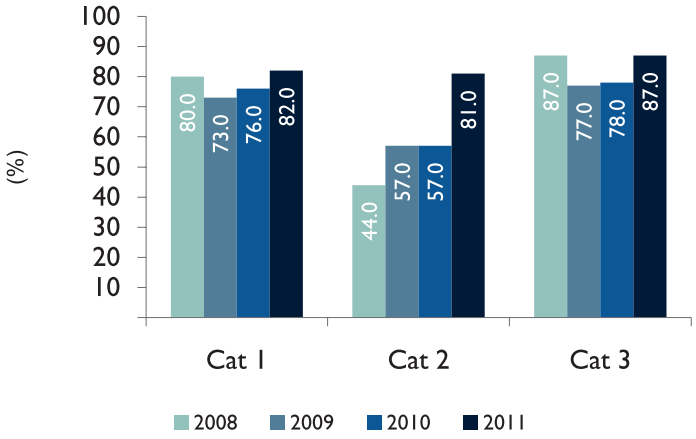


Figure 13: Patients seen within the recommended time for elective surgery at the NWRH

(for the 12 months ending 30 June 2011)



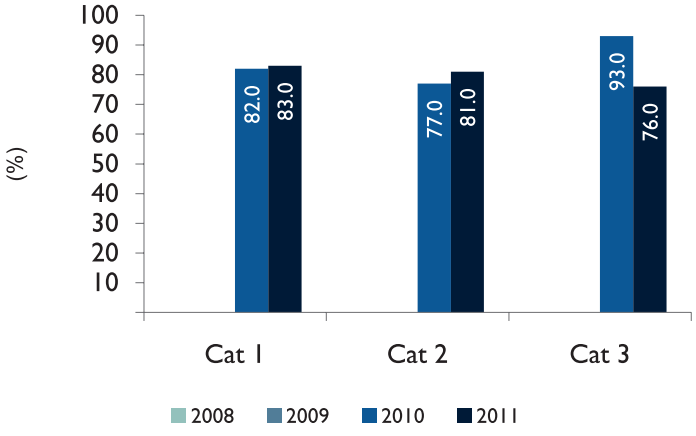
At the NWRH, the proportion of patients seen on time increased in all categories: from 76 per cent to 82 per cent in category 1, from 57 per cent to 81 per cent in category 2 and from 78 per cent to 87 per cent in category 3. The interim standards were achieved in all categories.

At the MCH, the proportion of patients seen on time increased in category 1 from 82 per cent to 83 per cent and in category 2 from 77 per cent to 81 per cent. Category 3 decreased from 93 per cent to 76 per cent (for the MCH, data prior to 1 September 2008 is unavailable - see explanatory note 3).

The interim standards were achieved in the two most urgent categories.

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

(for the 12 months ending 30 June 2011)



How many call outs has our Ambulance Service responded to?

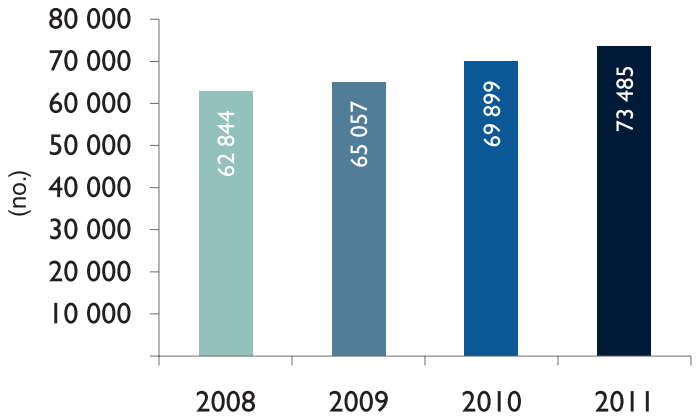
An ambulance response occurs when a vehicle or vehicles are sent to a pre-hospital incident or accident. This measure for the total ambulance responses includes emergency, urgent and non-urgent responses.

In the 12 months ending 30 June 2011 compared to the same period in the previous year, the total number of ambulance responses increased by 5.1 per cent.

There are many causes contributing to the increase in total number of responses. Key contributing factors include the ageing of the population and the increased numbers of people with chronic illnesses who are cared for at home and who require emergency or urgent care and transport when their conditions become acute.

Figure 15: Total ambulance responses

(for the 12 months ending 30 June 2011)



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.

For Tasmania as a whole, in the 12 months ending 30 June 2011 compared to the same period in the previous year, there was an increase of 24 seconds in the median emergency response time.

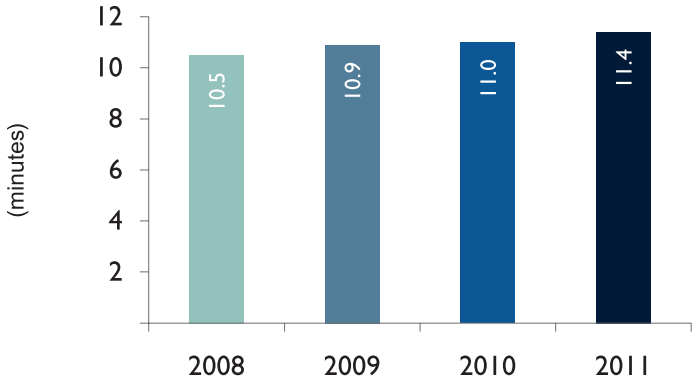
Photo by Richard Bugg

The emergency response time reported includes all emergency responses throughout Tasmania. This includes responses to rural and remote areas, and off shore islands. It also includes responses to emergencies by Ambulance Tasmania's volunteer ambulance officers.

Performance is a direct function of demand for ambulance services. Strategies to reduce the impact of demand are a focal point of Ambulance Tasmania operations. High levels of ramping at hospital emergency departments can also lead to deterioration in the ability of Ambulance Tasmania to respond in an emergency.

Figure 16: Ambulance emergency response times

(for the 12 months ending 30 June 2011)



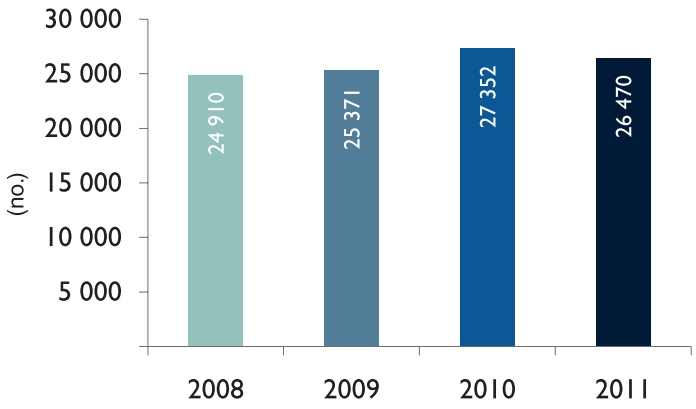
How many women are screened for breast cancer?

This is a measure of the number of eligible women screened for breast cancer. 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. 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.

In September 2010, BreastScreen Tasmania commenced replacement of analogue mammography equipment with new state-of-the-art Full Field digital mammography equipment. While down-time associated with these works resulted in a slight decrease in the number of women screened compared to the previous 12 months, the number of women screened represents an increase of 4.3 per cent compared to the same screening cohort for the same period in 2009. Increasing the number of women screened for breast cancer is necessary to keep pace with growth in the eligible population.

Figure 17: Eligible women screened for breast cancer

(for the 12 months ending 30 June 2011)

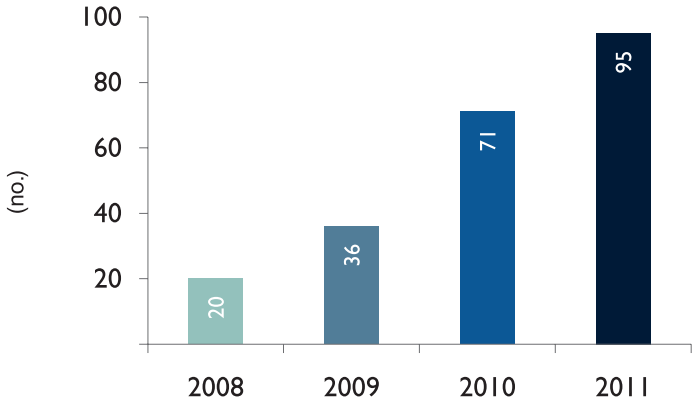


What proportion of BreastScreen clients were assessed within the recommended timeframe?

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

In the 12 months ending June 2011 compared to the same period in the previous year the proportion increased from 71 per cent to 95 per cent. This measure reflects both an improvement in the timeliness of screening mammogram results and improved access to assessment services for Tasmanian women (see explanatory note 4).

Figure 18: Clients assessed within 28 days of mammogram



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 2011, compared to the same period in the previous year, there was:

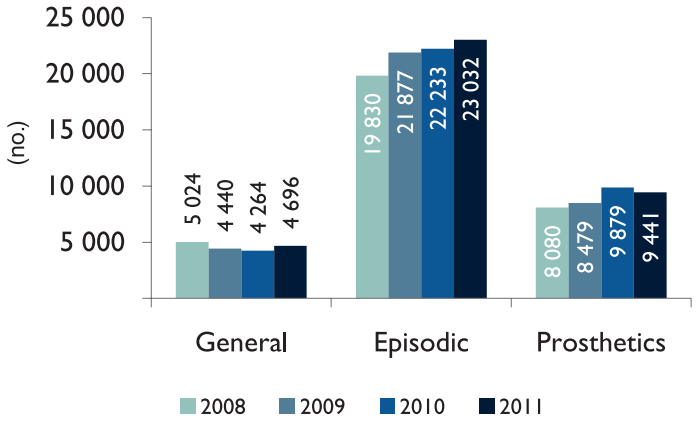
- a 10.1 per cent increase in the number of general occasions of service.
- a 3.6 per cent increase in the number of episodic occasions of service.
- a 4.4 per cent decrease in the number of prosthetics occasions of service.

Prosthetics activity has been lower due to infrastructure upgrades of statewide laboratory facilities, temporarily slowing production.

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.

Figure 19: Adults – occasions of service

(for the 12 months ending 30 June 2011)



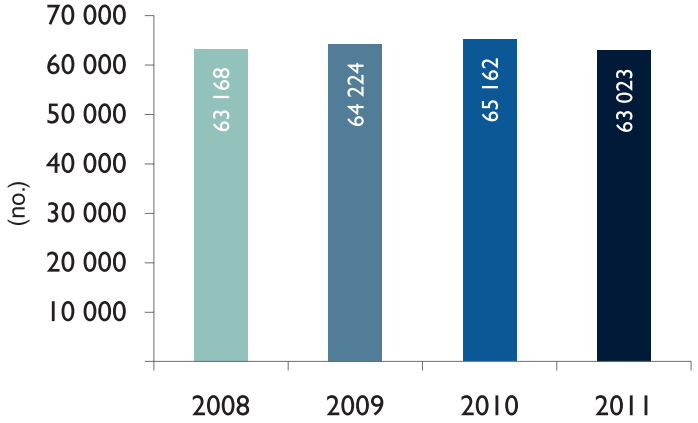
How many dental appointments have children accessed?

In the 12 months ending 30 June 2011 compared to the same period in the previous year, there has been a 3.3 per cent decrease 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.

Figure 20: Children – occasions of service

(for the 12 months ending 30 June 2011)



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 2011 compared to the same time in the previous year, there was a significant 15.3 per cent increase in the dentures waiting list. Waiting list growth after 2008 reflects increased demand following the purchase of additional general care services from the private sector and the as a result of which more people are identified as required dentures.

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.

The denture waiting list has reduced since the start of 2011, however less outsourcing is expected in 2012.

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

As at 30 June 2011 compared to the same time in the previous year, there has been a 33.2 per cent increase in the general care waiting list.

The purchase of general care services from the private sector between 2008 and 2010, plus the recruitment of additional dental officers in 2010 has seen a decrease in the median waiting time meaning that clients on the waiting list receive more timely care. The median waiting time has been maintained at between 19 and 20 months since December 2009.

Figure 21: Dentures – waiting list

(as at 30 June 2011)

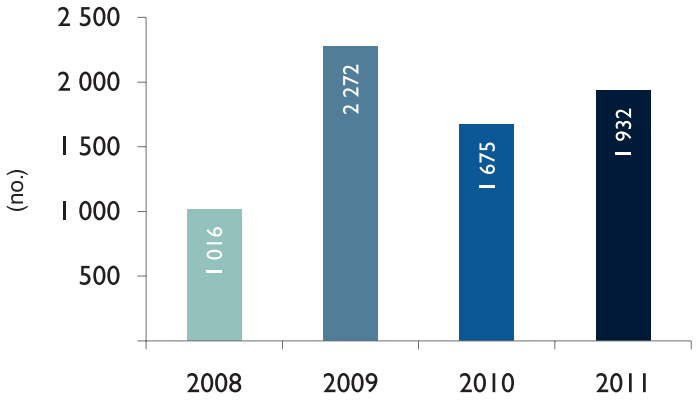
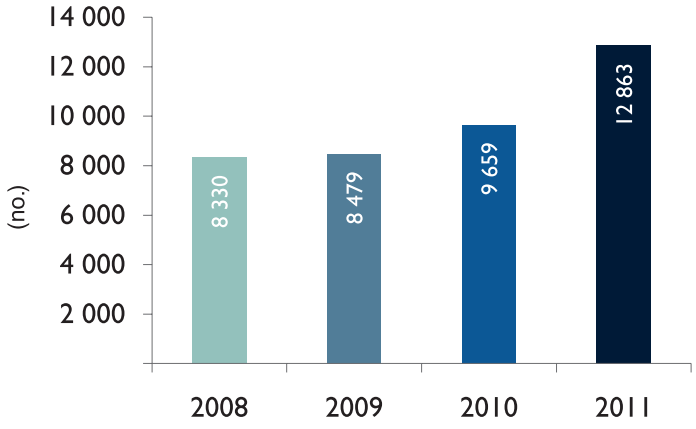


Figure 22: General care (adults) – waiting list

(as at 30 June 2011)



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.

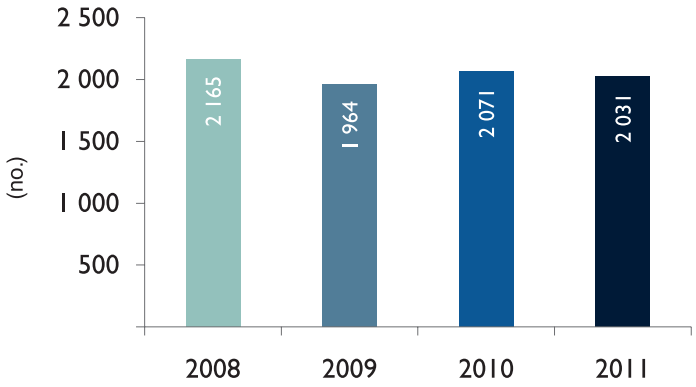
Activity rates are affected by the level of demand for services, the readmission rate, and service capacity to admit clients with less severe mental illnesses.

In the 12 months ending 30 June 2011 compared to the same period in the previous year, the number of people recorded as being treated in acute settings decreased slightly (see explanatory note 5).

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

Figure 23: Mental health services – inpatient separations

(for the 12 months ending 30 June 2011)



How many clients are accessing mental health services?

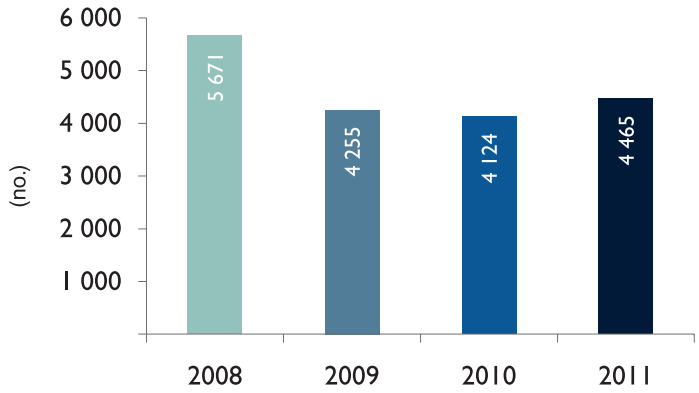
This indicator measures the number of community and residential clients under the care of Mental Health Services. Active community clients are people who live in local communities who are actively accessing services provided by community-based Mental Health Services teams. Active residential clients 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 increased by 8.3 per cent reflected both increased demand for services and improved data collection and reporting procedures.

Figure 24: Mental health services – community and residential – active clients

(for the 12 months ending 30 June 2011)



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.

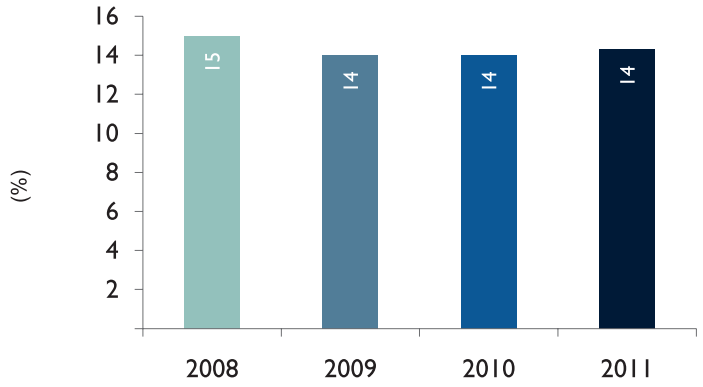
For people who experience mental illness, and particularly those who require acute mental health care, the episodic nature of their condition can often mean that they are likely to require further treatment.

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 2011 the 28-day readmission rate was 14 per cent being the same as the corresponding period in 2010.

Figure 25: 28-Day readmission rate – all hospitals

(for the 12 months ending 30 June 2011)



How many people have been housed?

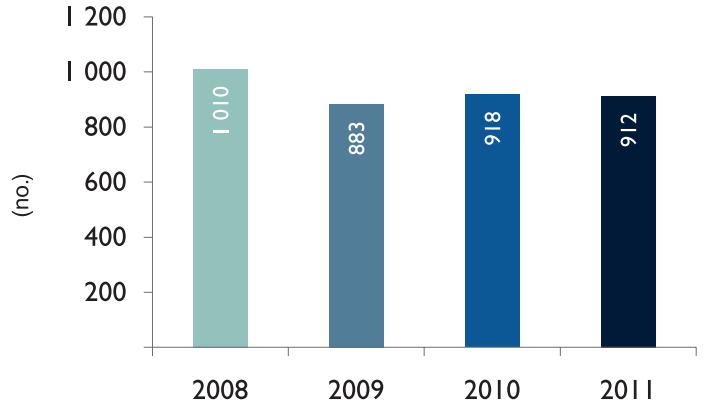
This information shows the number of people who have been allocated public housing.

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 tend to remain somewhat reluctant to leave secure, affordable tenure. As a result, occupancy rates in public housing remain high, and opportunities to house people from the wait list are limited.

In the 12 months ending 30 June 2011 compared to the same period in the previous year, the number of people housed remained steady.

Figure 26: Number of applicants housed

(for the 12 months ending 30 June 2011)

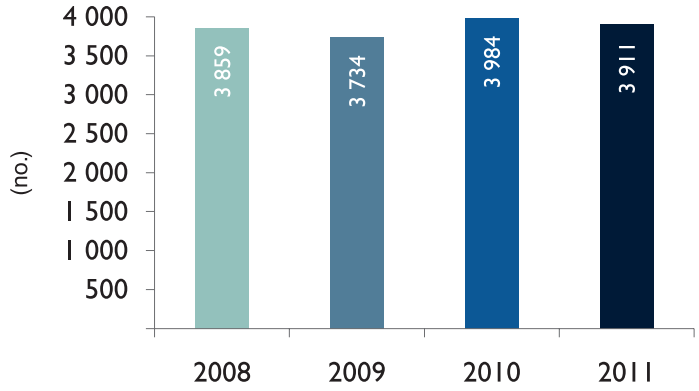


How many people receive private rental assistance?

In the 12 months ending 30 June 2011, 3 911 households received financial assistance through the Private Rental Support Scheme (PRSS), decreasing by 1.8 per cent compared to the same period in the previous year.

Figure 27: Number of households assisted through the private rental support scheme

(for the 12 months ending 30 June 2011)



What are the waiting lists for public housing?

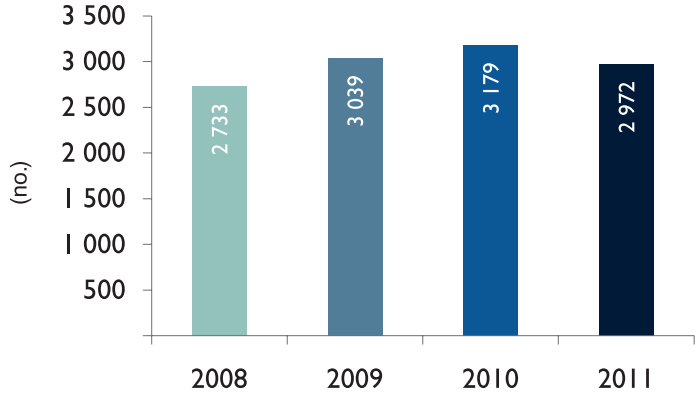
This indicator measures the total number of people who were waiting for public housing.

The public housing waitlist at 30 June 2011 decreased by 6.5 per cent compared to the previous year.

As at 30 June 2011 compared to the same time in the previous year, there was an decrease of 6.5 per cent in the waiting list for public housing.

Figure 28: Number of applicants on waitlist

(as at 30 June 2011)



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

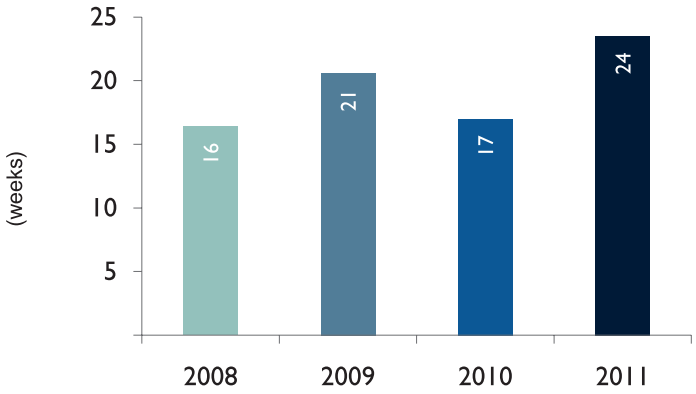
This indicates how long it takes to house applicants who have been assessed to have the highest level of need, category 1. The assessment of need is based on adequacy, affordability and appropriateness of housing.

In the 12 months ending 30 June 2011, the average time to house category 1 applicants was 24 weeks, an increase of seven 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 29: Average time to house category 1 applicants

(for the 12 months ending 30 June 2011)



How many child protection cases are referred for investigation?

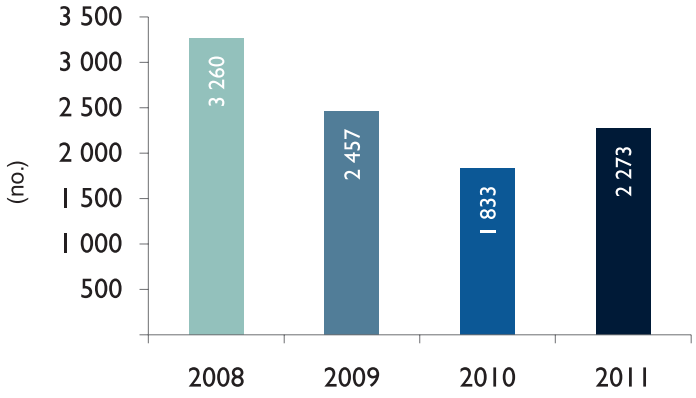
The newly implemented Gateway, Integrated Family Support Services and other reform initiatives have directed a greater focus on intervening earlier with family services and better integrating the delivery of child protection and family support services.

Nevertheless, fluctuations in cases referred are likely to be observed due to the need to meet statutory obligations and respond to demand.

In the 12 months ending 30 June 2011 compared to the same period in the previous year, there has been a 24 per cent increase in the number of notifications referred for investigation.

Figure 30: Number of notifications referred to service centres for further investigation

(for the 12 months ending 30 June 2011)



How many child protection notifications are not allocated within established time frames?

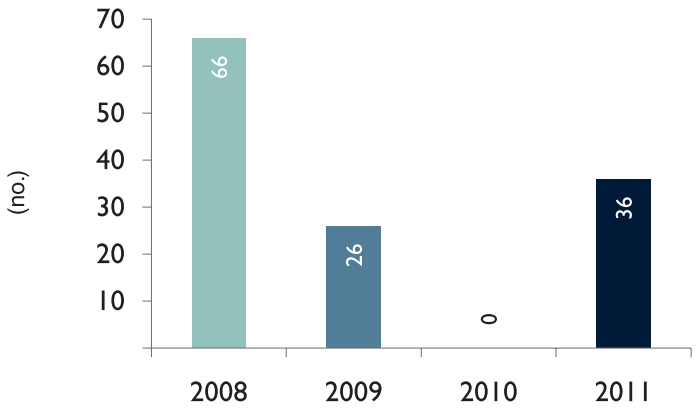
This refers to the number of notifications of child abuse and neglect received by DHHS that are not allocated for investigation within established time frames.

As at 30 June 2011, there were 36 unallocated cases compared to zero at the same time in the previous year. While the number of cases not allocated within timeframes has fluctuated in recent months due to difficulties with staff recruitment, DHHS remains committed to keeping this number low.

The overall reduction in recent years has been achieved as a result of several improvements including the introduction of a new operating model and information system in February 2008. The more recent introduction of a comprehensive Child Protection Information System (CPIS 2) is likely to further improve responsiveness to demand.

Figure 31: Child abuse or neglect: number of unallocated cases

(as at 30 June 2011)



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

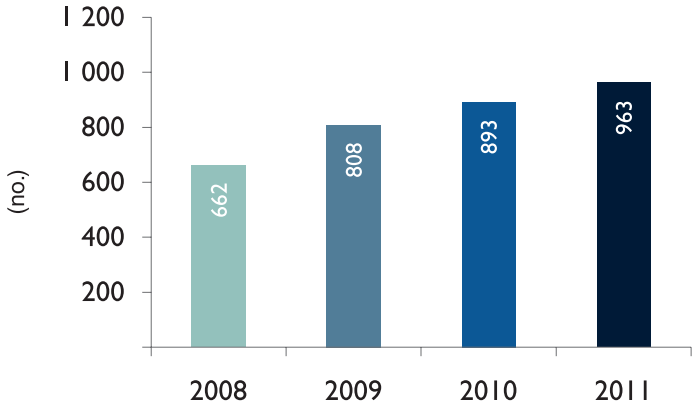
As at 30 June 2011 compared to the same time in the previous year there was a 7.8 per cent increase in the number of children in out-of-home care.

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.

As part of the overall commitment of DHHS to the health and wellbeing of all children in Tasmania, the recent project to redesign the Tasmanian family support service system is expected to improve early intervention and limit the need for out of home care services.

Figure 32: Children in out-of-home care

(as at 30 June 2011)



In addition, the new Pathway Home Reunification Service, which began operating in March 2011, will have a downward effect on the number of children in care by, reunifying those children where a return home is considered appropriate.

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?

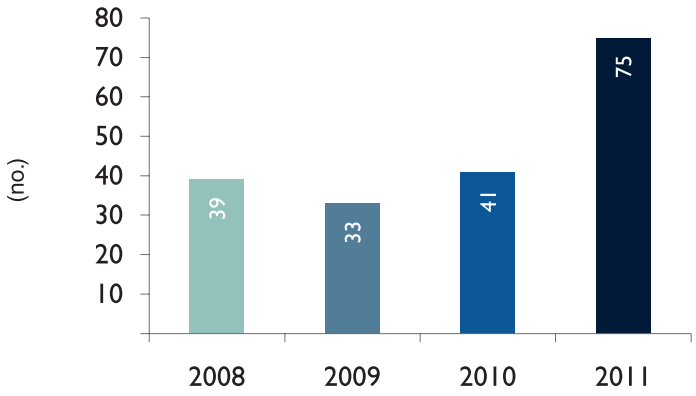
This indicator shows the number of people with a disability urgently waiting for a supported accommodation placement. Supported accommodation services provide assistance for people with a disability within a range of accommodation options, including group homes and other residential care settings.

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.

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.

Figure 33: Disability Services – supported accommodation – waiting list

(as at 30 June 2011)



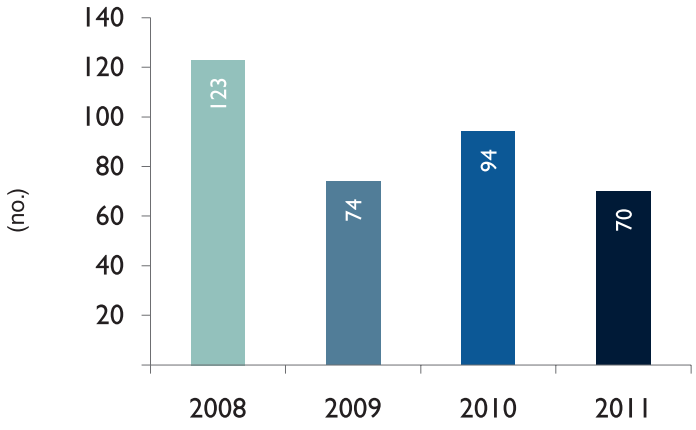
What is the waiting list for community access clients?

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.

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.

Figure 34: Disability Services – community access clients – waiting list

(as at 30 June 2011)



Explanatory notes

1. The 2010-2011 activity of the LGH is not directly comparable with earlier years at the present time due to the introduction of a new patient administration system (IPM) and associated business processes.
2. The figures for raw and weighted separations do not include outside referred patients or unqualified neonates.
3. 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.
4. Please note that end of year figures have been updated to reflect more accurate data being made available.
5. Due to more accurate data becoming available, data reported from previous *Progress Charts* may differ.
6. The 2010 Mental Health Services Inpatient Separation figure has been adjusted to reflect improved source data reporting systems.
7. 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

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