



Mental Health Commission
of New South Wales



Review of transparency and accountability of mental health funding to health services

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TO THE MINISTER



Under the *Mental Health Commission Act 2012*, the Commission may at any time prepare a report on the funding of mental health services in NSW. This is a Report on that issue under Section 14 (1) (c) of the Act.

The investments we choose to make in mental health speak volumes about our priorities in how we support people with a mental health condition, their families and carers. Funding, and how it is used, has an enormous influence in determining what services people get and how they experience them.

The Mental Health Commission of NSW does not fund services, but in line with *Living Well: A Strategic Plan for Mental Health in NSW 2014-2024* it seeks to influence a long-term transition towards an integrated mental health system that is primarily community-based, and is centred on the person and their recovery. Through its establishment legislation, the Commission is empowered to review and report on any system issue that affects people who experience mental illness.

With this in mind, the Commission in mid-2016 initiated this review of the transparency and accountability of mental health funding within NSW Health, in order to better understand how the funding that is notionally allocated to mental health is actually invested in services that support consumers.

This is not a new matter. The Commission first outlined these issues in 2014 in *Living Well* and we renewed our call for greater transparency in 2015's *One Year On* report, highlighting the continuing concerns of clinicians about this issue and its potential to undermine the progress of the *Living Well* reforms.

The present review describes a situation that is both more complex than these concerns suggested, and more positive in terms of the progress being made and the potential reform levers it provides.

It is clear, for example, that the progressive shift towards activity-based funding (ABF) as the engine of investment within the NSW health system presents particular challenges for mental health, which may not neatly align with the focus on units of activity that largely underlie it. Equally though, ABF offers an important opportunity to drive spending differentially towards those services and programs that we know are most effective by prioritising them within our planning and purchasing models. If we do it right, ABF can be a powerful incentive to drive the *Living Well* agenda in its next phase.

In an ABF world, the concept of a quarantined separate NSW mental health budget – a single pot of money to be expended on mental health services – has effectively been superseded. What takes its place is a more fluid, constantly contestable purchasing environment in which the funder buys a range of services from health service providers, paying a pre-determined “price” for each unit of activity.

Effective, evidence-based system planning is the key here: if we are clear about the number and mix of services we want to buy on behalf of consumers, we can powerfully orient how the money flows through the system at the same time as driving performance improvements. The Commission called in *Living Well* for the adoption of the National Mental Health Services Planning Framework and we renew this call here all the more urgently in the context of the ABF opportunity.

An elevation of the planning function presents another important opportunity: to return to first principles and decide what the responsibilities of a state-funded mental health system should really be. The Commonwealth has an essential role in providing mental health services, through Medicare and the Pharmaceutical Benefits Scheme and now through the regional Primary Health Networks (PHNs), to which it has devolved planning and service commissioning responsibility for aligning primary mental health care to a stepped care model based on local needs, including counselling, early intervention services, suicide prevention programs and co-ordination of care for people with complex needs.

If the state-funded Local Health Districts (LHDs) and PHNs plan together and where appropriate purchase together, we can hope to see more rational flows of resources and integrated networks of services to better meet the needs of consumers, their families and carers. We can also start a conversation about the programs and services for which the LHDs should not be responsible, so they can sharpen their focus on what they do best.

All these immensely positive opportunities however do not remove the need for fundamental change in one area: it remains essential that the NSW Ministry of Health and the LHDs (and Specialty Health Networks) make a major step in improving their reporting to the community. This is the only way to keep faith with consumers, families and carers, and members of the wider community who – rightly – want to have confidence that mental health funding is being used effectively to improve the lives of people who experience mental illness.

This review covers a wide territory – the funding and purchasing process for public mental health services, the performance management and accountability framework, key performance indicators (KPIs) and outcome measures and reporting to the community.

I would like to record my gratitude to the Ministry of Health and the four LHDs which contributed generously to this review: Northern Sydney; Western NSW, Western Sydney and Hunter New England. The Commission's review team received diligent responses to all their inquiries, and were welcomed with great courtesy on site visits. I appreciate the time and energy invested by the CEOs, Directors of Mental Health and their teams to ensure the Commission had access to the information it needed.

The NSW Branch of the Royal Australian and New Zealand College of Psychiatrists also offered invaluable perspectives on the financing of the system and advice on report drafts, for which I express my deep appreciation.

The terms of the review and its processes were shaped by two excellent consultants engaged to support the work: Dr Tim Smyth, a former Deputy Director General of NSW Health, and Mr Rob Mathie, a former Assistant Auditor General, Audit Office of NSW. Dr Smyth also structured and largely wrote this Report. I thank both of them for the tremendous knowledge and insights they brought to bear in this complex project.

The clarity and constructiveness of this work are testament to the commitment of all those who contributed. Ultimately we are all motivated by the same vision: a mental health system that is structured to do its very best, all the time, for the people who need it. I commend this Report to you and recommend it be made public immediately.



John Feneley

NSW Mental Health Commissioner

31 July 2017

1. ABOUT THIS REVIEW

The NSW Mental Health Commission was established under the *Mental Health Commission Act 2012* and commenced operations on 1 July 2012. The Commission is an independent statutory authority which reports to the Minister for Mental Health, the NSW Parliament and the public. Its functions include the review and evaluation of and reporting and advising on mental health services and other services and programs provided to people who have a mental illness, and other issues affecting people who have a mental illness. In particular, section 14(1) (d) of the Act provides that the Commission may prepare a report on “the funding of mental health services in New South Wales.”

Living Well: A Strategic Plan for Mental Health in NSW 2014-2024, developed by the Commission and accepted by the NSW Government in December 2014, included a number of actions relating to the expenditure and transparency of mental health funding¹:

9.1 A new outcomes agenda for mental health services in NSW. This will include a set of clear key performance indicators (KPIs) for LHDs under the NSW Health Performance Framework, including in relation to community mental health services. These should also be reported publicly, increasing the transparency of mental health spending, and the extent to which services are meeting need. For example, KPIs might include budgets and expenditure, staffing levels and vacancy rates in each LHD. These KPIs will also be implemented with community managed organisations where relevant.

9.2 Clearer service and performance agreements, which include clear performance parameters, between the Ministry and LHDs.

9.3 Clearer purchasing arrangements particularly in relation to community mental health care and community alternatives to in patient care and including the liaison between specialist mental health services and general health services both hospital-based and in the community.

9.4 Mechanisms for more robust mental health budget transparency, including acquittal and reporting processes, including considering the role of audit and risk committees.

9.5 Strengthened stakeholder engagement, particularly of people with a lived experience of mental illness, their families and carers, *around mental health service planning and review by LHDs*.

These actions remain highly pertinent. However the landscape in which they can be implemented has changed considerably in the intervening time, notably as a consequence of the roll-out of activity-based funding (ABF), first in in-patient settings and now progressively across more mental health services.

The Commission considered in this context that a formal review of the transparency and accountability of the acquittal of mental health funding in NSW would help clarify this changed environment for consumers, community organisations, advocacy groups, health professional peak bodies and clinicians not directly involved in mental health service management, setting the scene for constructive discussion about how the new funding regime can support the continuing evolution of a high quality, person-centred, evidence-based, recovery-oriented mental health system.

The review commenced in mid 2016 and included site visits to the selected LHDs in August 2016. A draft report was provided to the Ministry of Health, participating LHDs and the RANZCP in early 2017. Their comments have been extremely valuable in shaping this final Report.

1 NSW Mental Health Commission (2014) *Living Well: A Strategic Plan for Mental Health in NSW 2014-2024*. Sydney, NSW Mental Health Commission.

2. EXECUTIVE SUMMARY

The framework for funding, reporting and performance management of mental health services provided in NSW by the 15 Local Health Districts (LHDs) and the three Specialty Health Networks (SHNs)² has changed radically over the past five years.

There have been three principal drivers for this change:

- the adoption by the Ministry of Health of a purchasing framework for the funding of health services under a single Service Agreement between the Ministry and each health service
- the extension of activity based funding (ABF) to mental health services
- a policy decision by Government and the Ministry to move from centralised control of health services towards a more devolved accountability framework.

The framework has moved from a quarantined expenditure and revenue budget to purchasing of defined mental health activity under an ABF framework developed by the Ministry of Health, following the National Health Reform Agreement between the Commonwealth and the States and Territories in 2011.

Similarly, in conjunction with reform by NSW Treasury of NSW Government agency budget reporting, the reported expenditure on mental health services by NSW Health has changed from the aggregated quarantined expenditure and revenue budgets for mental health services to an estimate calculated using a detailed costing methodology aggregating direct, indirect and corporate overhead costs.

This fundamental change in mental health funding and accountability has not been fully understood by all players, including consumers, community organisations, advocacy groups, health professional peak bodies and clinicians not directly involved in mental health service management.

This changed context means the former quarantining and centralised control of mental health funding and services no longer exists. The new environment requires strong governance and accountability to support the continued implementation of the *Living Well* reforms and to ensure the availability of comprehensive, person-centred, high quality, evidence-based models of care for people experiencing a mental health issue.

Funding, performance and accountability need to be integrated into a single framework in order to meet this challenge.

2.1 THE HISTORY

In the decade prior to 2013, the funding, reporting and performance framework for mental health services provided by the then Area Health Services (AHS) was a detailed, centrally determined, quarantined, separate funding allocation, agreed in writing between AHS Chief Executives and the Director General of the then Department of Health.

Performance against the service agreement targets and indicators was separately managed by the Mental Health and Drug and Alcohol Office (MHDAO) within the Department, and reported under-expenditure of the quarantined mental health funds was either approved for use by the AHS as a rollover to the following year's mental health budget, or reallocated to other AHS or projects by MHDAO.

Directives were issued by the Department to AHS reinforcing the quarantining of mental health budgets, especially following the Commonwealth Government's allocation of additional mental health funding in 2005 and the NSW Government's enhancement funding in 2006. These directives concerned matters including speed of recruitment, internal allocation of the mental health budget and a percentage cap on the local cross-charging of overheads by AHS to the mental health budget.

2 Sydney Childrens' Hospitals Network, Justice and Forensic Mental Health Network and the St Vincent's Health Network.

2.2 ABF AND DEVOLVED PLANNING

Since the transition to activity based funding and devolved decision making, LHDs and SHNs are increasingly responsible for determining service mix, staffing levels and models of care.

A stronger local focus on planning and delivering mental health services, built on detailed knowledge of local communities and needs, is welcome. However this has left a state level planning and needs assessment vacuum. The Commission recommends the Ministry adopt the National Mental Health Service Planning Framework to guide service planning and models of care and to provide a context for discussions between the Ministry and health services about purchasing and resource allocation decisions.

ABF is solely a funding and purchasing model, and therefore cannot, by itself, ensure access to high quality, evidence-based models of care for people with a mental health condition and for their families and carers. The setting and funding of ABF targets by the Ministry raises a number of important questions:

- how is the activity target determined?
- is the activity target appropriate to the local mental health need, and role of the health service in meeting that need?
- does the activity target cover all elements required for a safe, high quality and effective mental health service?
- is the funding per unit of activity set at an evidence-based efficient price?
- are there consequences for not meeting the activity target?

There are concerns about using ABF to fund all elements of a comprehensive mental health service, because of the risk of perverse incentives towards episodic and admitted patient care.

2.3 THE WAY FORWARD

The Commission supports continuing development of non-admitted care classification, costing and funding systems, including the adoption of the new Australian Mental Health Care Classification (AMHCC) system, but recommends caution in the implementation of ABF for non-admitted (in particular, community based) mental health services.

Many people with chronic and complex mental health conditions will require longer term, coordinated care packages involving multiple providers across the health and human services sectors. Co-commissioning of mental health services in conjunction with Primary Health Networks and other funders and service providers is increasingly likely in the coming years.

The Commission recommends that the Ministry, in conjunction with the Commission, the NSW and ACT PHN Council and relevant State and Commonwealth agencies, should collectively explore in 2017/18 the appropriate role of NSW LHDs and Specialty Health Networks in the provision of mental health services. This work can then inform the further refinement of the purchasing framework, Service Agreements and KPIs for mental health.

This review confirms that there are significant challenges with data quality in mental health, especially for non-admitted and other community-based services. While mental health is not alone in having to address this challenge, a strong governance and accountability framework, appropriate and effective implementation of ABF and transparent public reporting on performance and outcomes are critically dependent on quality data.

All clinicians working in mental health need to actively engage in improving the scope and quality of data relating to needs, service provision, inputs and outputs, performance and outcomes. This requires data classification, recording and reporting systems that are clinically useful, integrated with the care process and supported by appropriate clinical software and technology.

People with a mental health condition and their families and carers need access to high quality, evidence-based models of care. Under devolved purchasing, this requires an effective, transparent performance framework with appropriate KPIs, and health service accountability for delivering the services and outcomes purchased by the Ministry.

This review, however, has highlighted a paucity of mental health KPIs in the Ministry's Service Agreements with health services, limited review of performance (apart from financial results and activity against ABF NWAU targets) in LHD senior executive and Board reports, and the absence of public reporting of outcomes for mental health services operated or funded by health services.

The Commission recommends inclusion of more appropriate KPIs in Service Agreements, development of a suite of outcome indicators and greater public reporting of health service performance and client outcomes for both inpatient and community settings. The Bureau of Health Information should also work with the Ministry (including the InforMH information systems unit), the Commission and health services to initiate a regular public report on mental health services.

Greater clarity about the fundamental changes that have occurred in the approach to funding, reporting and performance management of mental health services will increase confidence among consumers, advocacy groups, clinicians and the broader community that mental health funding is being used appropriately.

Implementation of the 17 recommendations in this Report will also support the principles of *Living Well*, and deliver a mental health system that better meets the needs of people in NSW who live with a mental health condition, and their families and carers.

3. RECOMMENDATIONS

INFORMATION FOR ACCOUNTABILITY

1. The Ministry of Health should prepare and maintain a publicly available website resource that clearly outlines the current status of implementation of activity-based funding (ABF) for mental health services, including planned next stages and timelines, classification systems in use and pricing.
2. Each Local Health District (LHD) and Speciality Health Network (SHN) should publish full details on its website of its mental health expenditure and outcomes, including:
 - a summary table, comprising audited outcomes for the previous financial year and quarterly updates for the current financial year, of:
 - total estimated mental health expenses
 - the mix, volume and funding of purchased services
 - expenditure and revenue budgets under the control of the Director of Mental Health and current reported activity against target.
 - a summary of its approach to the allocation of indirect and corporate overhead costs, maintenance of central reserves, and allocation of non-cash items to Service Groups.
 - a summary table reconciling the Service Agreement Schedule C activity targets and funding for mental health, the proportion of the budget directly allocated to the control of the Director of Mental Health, the estimated proportion of indirect and corporate overhead costs and a comparison with the previous financial year.
 - a summary table of the outcomes of mental health service provision using the current MH-OAT measures, pending further refinement of these measures as part of the national mental health outcome reporting framework.
3. The materials described in Recommendation 2 should be compiled and published by the Ministry of Health to promote transparency and comparison of approaches between LHDs and across different financial years.
4. LHDs and SHNs should continue to pursue direct allocation of indirect costs to mental health service cost centres where it is possible and administratively efficient to do so.
5. The Ministry of Health should promote and provide information for staff and the community summarising the ABF framework for mental health, the District Network Returns (DNR) process, and the process for estimating mental health Service Group 3.1 expenditure.
6. The Ministry of Health and the NSW Mental Health Commission should work with the Bureau of Health Information to initiate a regular reporting program on mental health service, performance and outcomes.

PLANNING AND PURCHASING

7. The Ministry of Health, LHDs and SHNs should adopt the National Mental Health Service Planning Framework to guide service planning and models of care and to provide a context for discussions between the Ministry and LHDs and SHNs on service need, workforce, gaps and purchasing decisions.
8. The Ministry of Health should include explicit criteria in the next version of the LHD Service Agreements for consideration of requests by health services to adjust mental health service activity and output targets.

9. The Ministry of Health, in conjunction with the NSW Mental Health Commission, the NSW and ACT PHN Council and relevant State and Commonwealth agencies, should collectively explore in 2017/18 the appropriate role of NSW LHDs and SHNs in the provision of mental health services to the people of NSW. The outcomes of this work should then inform further refinement of the purchasing framework, Service Agreements and KPIs for mental health.

KPIS AND OUTCOME MEASURES

10. Appropriate output and outcome targets and performance indicators for block funded services should be developed and included in future Service Agreements between the Ministry of Health and LHDs and SHNs.
11. The Ministry of Health, in conjunction with the NSW Mental Health Commission and LHDs and SHNs, should review the Performance Framework KPIs for mental health services and develop a three year program, commencing in 2018/19 to progressively adapt the KPIs to include a focus on:
 - service provision against assessed need
 - the outcomes of care
 - integration of care with primary care and the community-managed and private sectors
 - consumer, family and carer satisfaction.
12. The Performance Framework for health services should continue to support and require improved data quality, including mental health data quality as a performance measure for health services.
13. The Ministry of Health should continue development of the utility of the ABM portal for mental health service benchmarking.
14. The Clinical Information Benchmarking Reporting tool (CIBRE) should be expanded to include interstate and international comparative information.

CONTINUED TRANSITION OF MENTAL HEALTH SERVICES TO ABF

15. The Ministry of Health and each LHD and SHN should give priority to the successful implementation of the Australian Mental Health Care Classification (AMHCC) system.
16. The Ministry of Health should continue to proceed cautiously with its planned shadow funding on a NWAU basis, followed by replacement of block funding of community based and ambulatory care mental health services, pending progress on the models of care and service planning recommendations in this Report, successful implementation of the AMHCC in NSW and improvements in the data quality.
17. The Ministry of Health should continue to include funding for teaching, training and research as part of the resourcing of mental health services.

4. SETTING THE SCENE – THE CHANGED CONTEXT FOR MENTAL HEALTH FUNDING IN NSW

In the decade prior to 2013, the funding, reporting and performance framework for mental health services provided by the then Area Health Services (AHS) was a detailed, centrally determined, quarantined, separate funding allocation, agreed between AHS Chief Executives and the then Department of Health.

Performance against the service agreement targets and indicators was separately managed by the Mental Health and Drug and Alcohol Office (MHDAO) within the Department, and reported under-expenditure of the quarantined mental health funds was either approved for use by the AHS as a rollover to the following year's mental health budget, or reallocated to other AHS or projects by MHDAO.

Directives were issued by the Department to AHS reinforcing the quarantining of mental health budgets, especially following the Commonwealth Government's allocation of additional mental health funding in 2005 and the NSW Government's enhancement funding in 2006. These directives concerned matters including speed of recruitment, internal allocation of the mental health budget and the charging of overheads to the mental health budget.

The framework for funding, reporting and performance management of mental health services provided in NSW by the 15 Local Health Districts and the three Specialty Health Networks³ has changed radically over the past five years.

The framework has moved from a quarantined expenditure and revenue budget to purchasing of defined mental health activity under an ABF framework developed by the Ministry of Health, following the National Health Reform Agreement between the Commonwealth and the States and Territories in 2011.

Similarly, in conjunction with reform by NSW Treasury of NSW Government agency budget reporting, the reported expenditure on all health services (including mental health services) by NSW Health has changed from the aggregated quarantined expenditure and revenue budgets to an estimate calculated using a detailed costing methodology aggregating direct, indirect and corporate overhead costs.

This fundamental change in mental health funding and accountability has not been fully understood by all players, including consumers, community organisations, advocacy groups, health professional peak bodies and clinicians not directly involved in mental health service management.

Consequently, the meaning of the term “mental health budget” now varies depending on the context:

1. At a **state** level, the mental health budget in the State Budget papers is the estimated aggregated expenditure on mental health⁴, including direct, indirect and corporate overhead costs using a detailed patient costing methodology.
2. At a **Ministry of Health** level, the health service mental health budget is the dollar value of the purchased mental health activity under the Ministry's Service Agreement with the health service.⁵
3. At the **LHD and SHN level**, the mental health budget is the expenditure and revenue budgets allocated to the mental health service to manage. This budget will vary in its components, depending on an individual health service's capability to identify and charge costs incurred by other operating units and support services in the delivery of mental health services and its policies regarding decentralised management of leave and other accounting provisions.

3 Sydney Childrens' Hospitals Network, Justice and Forensic Mental Health Network and the St Vincent's Health Network.

4 The NSW Treasury and the State Budget currently categorise mental health as Service Group 3.1

5 This is the total of the proposed purchased acute admitted, subacute admitted and non admitted mental health activity, expressed in National Weighted Activity Units (NWAUs), multiplied by the State NWAU price, plus the \$ value of any block funded activity.

6 www.treasury.nsw.gov.au/documents-resources/documents-library

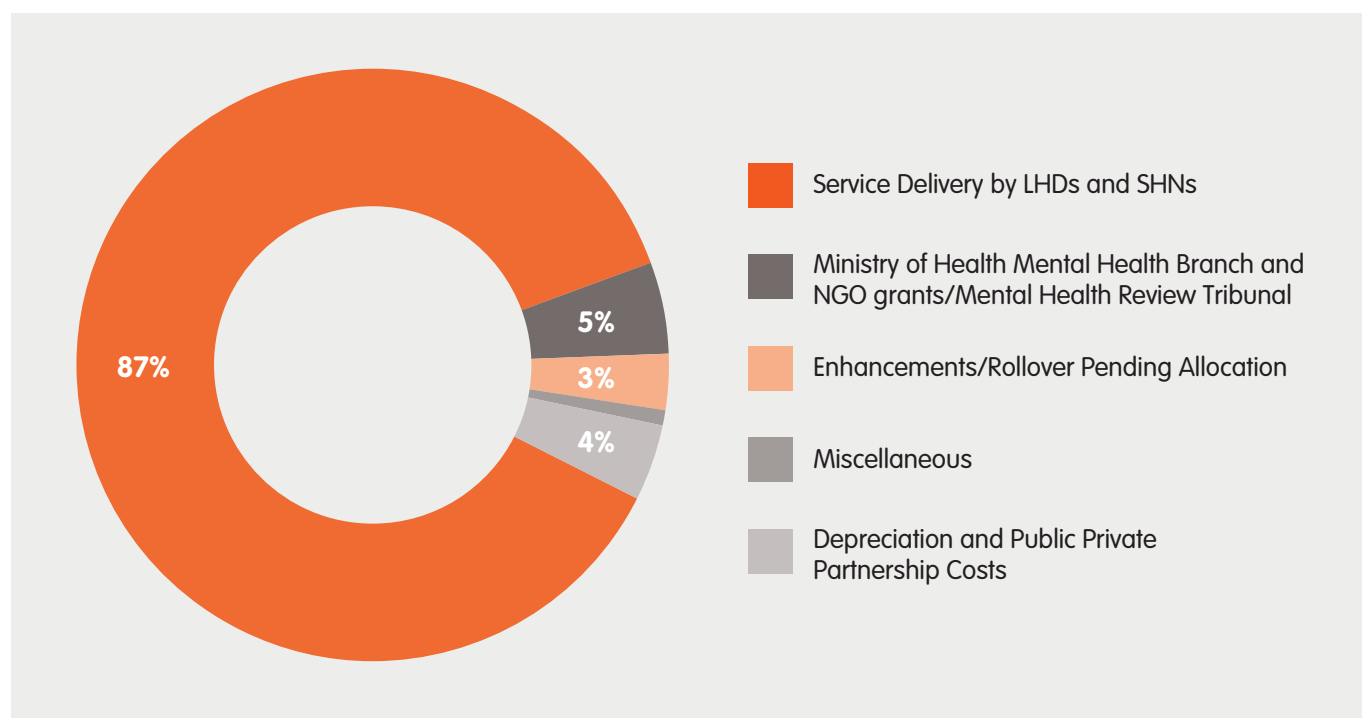
4.1 THE NSW BUDGET

The 2016/17 NSW Budget papers report an estimated expenditure⁶ on Service Group 3.1 Mental Health of \$1.824 billion. This figure is based on the audited actual expenditure figures for previous years and known adjustments for the coming year. The total includes the direct, indirect and overhead costs of providing mental health services, with indirect and overhead costs derived using a patient costing methodology.

The total also includes the estimated costs of other mental health functions of the health portfolio including the Mental Health Review Tribunal, the Mental Health Commission, grants to community-managed organisations, and the Ministry of Health mental health policy and planning functions.

Approximately 87 per cent of the estimated total of \$1.824 billion is anticipated to be mental health service delivery by the Local Health Districts and Specialty Health Networks.

Graphic 1: Composition of mental health funding in the NSW Budget 2016-17



4.2 WHAT IS ACTIVITY BASED FUNDING (ABF)

Since 2012-13 the NSW Ministry of Health has progressively extended activity based funding of health services provided by the Local Health Districts and the Sydney Childrens' Hospital Network and St Vincent's Health Network. The scope of ABF has grown from acute inpatient and emergency department services to now cover sub-acute admitted and non-admitted services.

Teaching, training and research, some non-admitted services and some specialist services remain block funded and are currently outside of the ABF system. Smaller rural and remote hospitals also remain largely block funded.

The impact that the future methodology for funding of teaching, training and research adopted by the Ministry may have on available funds for mental health services, is not yet clear. However it will be important to maintain funding for teaching, training and research as part of mental health funding.

At its core, ABF determines the funding provided to a health service by multiplying the *volume* of activity purchased by a State Price for each unit of activity. The unit of "currency" for activity and pricing is the National Weighted Activity Unit (NWAU), determined by the Independent Hospital Pricing Authority. As such, ABF produces a budget based on expected *outputs*, rather than as in the past, historical *inputs* (salaries, visiting medical officer (VMO) costs, goods and services and maintenance and minor capital expenditure).

In theory⁷, if a health service does not deliver the purchased target level of activity, its funding is reduced to reflect the lower level of activity provided. If the health service delivers more than the purchased level of activity, it is not guaranteed additional funding. However, the health service may be able to negotiate additional funding from the Ministry.

The State Price in NSW is based on the efficient cost of providing the unit of activity using data derived from a statewide patient costing analysis done each year. The State Price is not the same as the National Efficient Price (NEP) determined by the Independent Hospital Pricing Authority, as the NEP is based on national patient costing data.

Where a health service's actual cost is greater than the State Price, the Ministry may provide the health service with a transitional grant over an agreed period while the health service improves its cost efficiency.

This reform has required a considerable investment nationally in classification and information systems for patient activity and hospital costs. The Independent Hospital Pricing Authority (IHPA), established in December 2011 by the Commonwealth, has coordinated this work and set national prices for each of the types of patient activity to be purchased.

The types of activity to be purchased have been classified by diagnosis related resource groupings (AN-DRG). Each of these groupings is then allocated a proportional number of National Weighted Activity Units (NWAUs), reflecting the relative resources required to treat the patient in each AN-DRG group.

The price paid for each NWAU is then based on an average of fully-apportioned costs for treating that condition, which include the cost of direct patient treatment for that activity (eg nursing, medical and allied health staff, medications, consumables, diagnostic services, food and laundry) plus a share of indirect costs for providing those clinical services (payroll, human resources, finance, building maintenance) and overheads for the health system as a whole (senior executive, Board, clinical governance, internal audit, planning). The information used to derive these fully-apportioned costs is drawn from six monthly reports of actual costs from all hospitals in all states, using a standard national costing system.

The initial introduction of ABF in NSW in 2012-13 covered acute inpatient services and emergency services in

⁷ The review has noted that the Ministry has not automatically adjusted funding of mental health services in line with reported activity. The review team was advised that this is due largely to the variable quality of the activity data reported.

larger hospitals only. Mental health services were excluded altogether in the first year, along with sub-acute and non-admitted services in other specialties. By 2015-16, 76% of the services purchased by the Ministry under Service Agreements with health services were under ABF. In addition the total NSW health budget includes the costs of the Ministry of Health, the Health Care Complaints Commission, the Mental Health Review Tribunal, the Mental Health Commission, grants to community-managed organisations and other services. ABF funded services now comprise around 60% of the total State health budget.

4.3 ABF AND MENTAL HEALTH SERVICES

Admitted mental health services have now been incorporated into the scope of ABF in NSW, with non-admitted mental health services included in the Service Agreements between the Ministry and health services, but “shadow funded”,⁸ pending the introduction of the new mental health care classification system.

The National Health Reform Agreement anticipated that mental health services would be covered from 2013 onwards. However, after some initial research, IHPA concluded that a diagnosis-based costing and pricing system was not suitable for mental health services.

“This is because diagnosis is not as strong a driver of resource utilisation for mental health care services as it is in other acute services⁹.

Patients who receive specialist psychiatric care have a significantly different cost distribution than those who don’t, regardless of the diagnosis-related group (DRG) they are grouped to. Patients with a mental health primary diagnosis, also have a significantly different cost profile to other patients¹⁰.”

IHPA commissioned a new mental health classification system as a basis for future activity based funding of mental health services – the Australian Mental Health Care Classification (AMHCC). IHPA anticipated that this would be operational in July 2016. However, it has now been agreed to defer implementation of the AMHCC to 1 July 2018.¹¹

In the interim, IHPA proposed ABF funding of acute admitted mental health activity and sub-acute admitted activity using a “refined” diagnosis-related classification, with block funding of other mental health services (non-admitted activity and specialist mental health services). NSW commenced funding of non-admitted mental health services on a “shadow funded” ABF basis in 2015-16.

8 While block funding of these services is maintained, the Ministry also applies a formula to convert the baseline non admitted activity into NWAUs and allocates notional funding per NWAU based on the health service’s projected average cost for this activity. Actual activity is then monitored against this parallel “shadow funding”.

9 Independent Hospital Pricing Authority, Development of the Australian Mental Health Care Classification, p4. <https://www.iHPA.gov.au/what-we-do/development-australian-mental-health-care-classification>, downloaded September 2016.

10 Independent Hospital Pricing Authority The Pricing Framework for Australian Public Hospitals 2013-14, p18 February 2013 https://www.iHPA.gov.au/sites/g/files/net636/f/publications/2013-14_pricing_framework.pdf

11 The review team noted that at the time of the review, LHDs had not yet commenced training, collection and reporting of mental health service activity using the AMHCC. The Ministry has subsequently advised that training of clinicians is well advanced and the majority of health services have commenced collection and reporting of activity in line with AMHCC. The remaining health services will collect and report by the end of 2017.

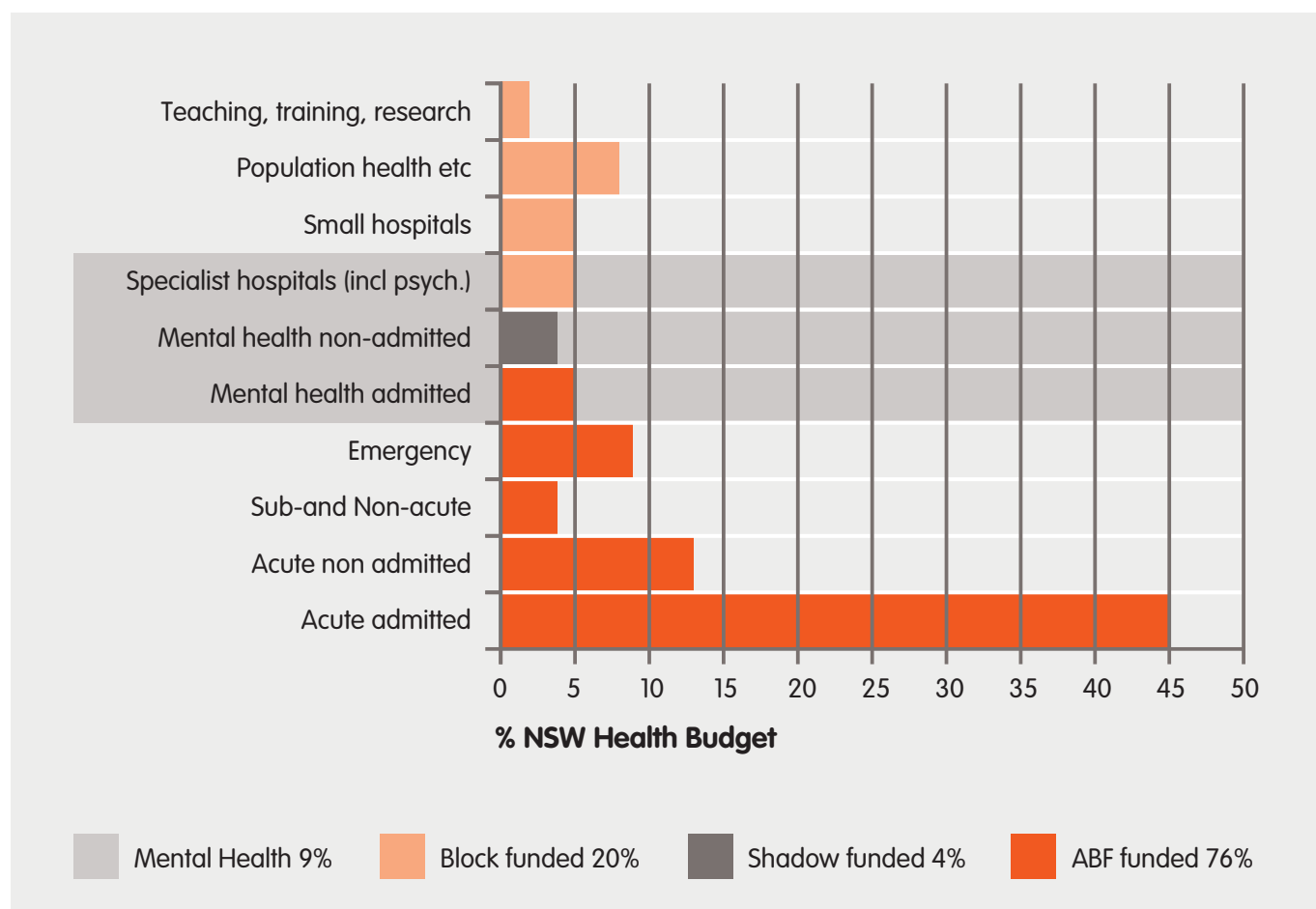
Table 1: Use of ABF to fund mental health services in NSW

Year	Patient Care Streams funded through ABF	ABF sites in NSW	Application to mental health services
2012-13	<ul style="list-style-type: none"> • Acute • Emergency Care 	59	IHPA concludes the diagnosis-based mechanism (DRG) used for activity based funding in other specialties not suitable long-term for mental health. It announces development of new classification system for activity based funding in the long term for mental health.
2013-14	<ul style="list-style-type: none"> • Acute • Emergency Care • Sub and Non-acute • Non-admitted • Mental Health (admitted)* 	84	<p>IHPA sets national prices for Mental Health Admitted * activity using “refined DRGs”. NSW Health uses them to develop State Prices for these activities and to allocate “shadow funding” to LHDs to indicate what activities would be purchased and at what cost if full activity based funding applied.</p> <p>The actual mental health budgets for LHDs continue to be based on historic trends in costs locally, so no LHD is disadvantaged. Mental health (non-admitted) continues to be block funded.</p>
2014-15	<ul style="list-style-type: none"> • Acute • Emergency Care • Sub and Non-acute • Non-admitted • Mental Health (admitted)* 	84	<p>Mental health (admitted) * continues to be shadow funded by NSW Health within historical budget.</p> <p>Mental health (non-admitted) continues to be block funded.</p>
2015-16	<ul style="list-style-type: none"> • Acute • Emergency Care • Sub and Non-acute • Non-admitted • Mental Health (admitted) • Mental Health (non-admitted)* 	98	<p>Increase in the number of facilities covered by ABF due to the changes to national threshold for regional and rural hospitals.</p> <p>NSW transitions mental health (admitted) to full activity-based funding, no longer shadow funded.</p> <p>NSW introduces “shadow-funding” for mental health (non-admitted)* service events, using interim proxy measures and historic trends in cost locally.</p>
2016-17	<ul style="list-style-type: none"> • Acute, • Emergency Care • Sub and Non-acute • Non-admitted • Mental Health (admitted) • Mental Health (non-admitted)* 	99	<p>NSW continues “shadow-funding” for mental health (non-admitted)* service events</p> <p>IHPA to pilot the application of the new Australian Mental Health Care Classification in sites across Australia, including NSW, for implementation in 2018.</p>

Source: Ministry of Health response to Mental Health Commission information request, September 2016 and IHPA website. Note: * signifies shadow funded services

Non-admitted mental health services and standalone psychiatric hospitals are among the relatively few NSW Health functions that have not transitioned to full ABF.

Graphic 2: Proportion of NSW Health budget funded via ABF 2015-16



Source: based on NSW Health Purchasing Framework 2015-16 v0.3, Fig 5 and NSW Health budget papers

4.4 IMPLICATIONS OF THE CHANGED CONTEXT

The changed context for mental health funding and reporting in NSW raises a number of important issues. The first is that the historical approach to assessing the commitment to mental health by simply monitoring the amount “spent” on mental health is no longer the right approach.

As the reported expenses on mental health under Service Group 3.1 in the State budget papers now include indirect and overhead costs, the focus now needs to be not only on the total estimated expenses, but also the efficiency of the indirect and corporate overhead services, so that more of each available dollar is able to be allocated to direct service delivery, integration of care and ongoing support of clients, their families and carers.

NSW has moved from an “input” based approach to funding of mental health services to an approach based on purchasing “outputs”. The traditional focus on a mental health “budget” is no longer appropriate as the funds available will now largely be determined by the level of purchased activity and adjusted by the actual level of delivered activity.

The focus now needs to be much more on the types of activity purchased and the volume of each type of activity purchased and actually delivered. What is purchased requires a consensus on best practice models of care. The principles and directions established in *Living Well*, alongside the needs identified through use of the National Mental Health Services Planning Framework, should be the major drivers of what is purchased.

Purchasing decisions need to be based on an assessment of the community’s mental health needs, and an agreed role for Local Health Districts and Specialty Health Networks in meeting those needs, taking into account the availability of alternative service providers and options. Mental health clinical service plans need updating. NSW does not currently have an agreed mental health service planning and demand estimate tool. ABF and a purchasing of outputs approach requires data that is relevant, reliable, accurate, and comparable. It is clear that much of the non-admitted mental activity data in NSW does not meet these criteria. The need for a more robust and appropriate classification system for mental health care services has been recognised and NSW needs to actively pursue effective implementation of the new AMHCC.

An ABF based purchasing framework also requires reporting on outcomes achieved for clients, families and carers and communities. Reporting of outputs is not sufficient. Some mental health outcome data is collected, including the Health of the Nation Outcomes Scales (HoNOS) and the Life Skills Profile (LSP). The six-monthly Clinical Information Benchmarking Reporting tool (CIBRE) provides other outcome and performance data, but the current ABF and purchasing framework does not reward or incentivise better outcomes.

A purchasing framework using ABF also needs to drive quality and value: improved cost efficiency, effectiveness, safety and quality, client-centred care and an environment that attracts and retains quality staff. This will require broader, deeper and stronger performance reporting and benchmarking in NSW.

Having moved from historical inputs to purchasing outputs, NSW and the other jurisdictions need to ask the question – *what is ABF driving?* If it only drives more cost-effective outputs, particularly admitted patient activity, rather than building an integrated mental health system centred on support in the community and partnerships with Primary Health Networks and the community-managed, private and broader human services sectors, it will frustrate implementation of *Living Well*.

The recommendations in this Report are intended to support the development of a better mental health system in an ABF environment and the effective implementation of *Living Well*.

5. WHAT MENTAL HEALTH SERVICES SHOULD BE PURCHASED UNDER ACTIVITY BASED FUNDING

In using a purchasing framework and activity based funding it is essential to ask the question: what *mix* and *volume* of services should be purchased?

The purchaser of public sector mental health services is the NSW Ministry of Health. The Ministry purchases mental health services in consultation with the Local Health District or Specialty Health Network under a Purchasing Framework. Once determined, the agreed mix of services and volumes is then set out in a Service Agreement between the Ministry and the health service.¹²

The Purchasing Framework appropriately highlights that decisions about the volume and mix of services to be purchased must be made in the context of key national, NSW and local goals and objectives. These goals and objectives for health more generally are set out in the *NSW State Health Plan – Towards 2021*, while for mental health they are set out in *Living Well: A Strategic Plan for Mental Health in NSW 2014-2024*.

The NSW public sector health system devolves local planning to the Local Health Districts and Specialty Health Networks, within planning guidelines determined by the Ministry for the whole of the system. Each health service is required to have a mental health plan.

This review has confirmed that each District and Network does have a mental health plan. However, these vary significantly in content and currency. Western NSW LHD undertook a major review of its mental health service in 2013-14 and has commenced a significant realignment of its mental health service models of care and resourcing.¹³ Hunter New England LHD's Mental Health Services Plan covers the period 2014-2018. The other LHDs have commenced, or are about to commence, updating older mental health plans.¹⁴

Living Well provides a core context for mental health planning in NSW, setting out principles and objectives, but it is not a detailed service planning framework.

Prior to ABF, NSW mental health services had used a resource projection tool developed internally by the then Department of Health. This tool, the *Mental Health Clinical Care and Prevention (MH-CCP) Model*, was introduced in 2001. It provided a methodology to estimate service requirements for both inpatient and community-based mental health services for a given demographic population based on core, common models of care.

In 2010, the MH-CCP was updated in line with the evidence base and new population projections and the new version distributed in 2011. It was used by LHDs to help with estimating need for beds, community mental health and workforce in planning their mental health services. While not prescriptive, and only part of the planning process, the Commission was advised by LHDs that the MH-CCP provided a useful benchmark for identifying service and resource gaps and a tool for estimating future resource requirements.

The Commission was also told that the MH-CCP is not used by the Ministry in negotiations about the mix and volume of mental health services to be purchased under ABF.

5.1 A NEW APPROACH TO PLANNING

In 2011, the then Australian Government Department of Health and Ageing provided funding to the NSW Ministry of Health to develop a National Mental Health Service Planning Framework (NMHSPF) under the Fourth National Mental Health Plan. The first phase of this project was completed in September 2013.

The Ministry has advised the Commission that the NMHSPF model built upon the structure and modeling of the

¹² A copy of the 2016-17 template Service Agreement is at Appendix A

¹³ Western NSW Local Health District MHDA Service Transformation Project Implementation Plan 2016-2017. This followed an external review of mental health by Health Partners Consulting Group in 2013/14.

¹⁴ At the time of this review, Western Sydney LHD was finalising a Mental Health Clinical Services Plan 2015-2026. Northern Sydney LHD had commenced work on a District Mental Health Plan to replace the former NSCC Area Health Service Mental Health Services plan 2005-2016.

MH-CCP. It was developed by more than a hundred experts in mental health and/or service modelling from around Australia, including state and territory mental health directors, Commonwealth representatives, medical, nursing, allied health, consumer and carer representatives, the community-managed sector, peak bodies and university based research organisations.

In 2015, the Australian Government Department of Health funded the Queensland Centre for Mental Health Research to lead the refinement of the NMHSPF. NSW remains a key contributor and the intellectual property from the project vests with the NSW Government.

The updated model¹⁵ is intended to serve as a framework and guide for planning processes and for understanding the link between population need and services by:

- indicating the specific requirements of a comprehensive population-based mental health service, including mental health promotion and prevention of illness for people with severe mental illness in NSW and those at risk of developing severe mental illness
- providing summaries of epidemiological, clinical, and expected service utilisation data
- predicting the resources and activity needed to provide an adequate level of care to age-grouped clinical cohorts
- assisting priority setting by providing estimates of the proportions of various service needs that can be met with current or future planned levels of resources.

A Mental Health Drug and Alcohol Principal Committee (MHDAPC) Steering Group has guided the revision and is considering approaches to central coordination for longer term maintenance and development, a controlled strategy for release of the NMHSPF, a Decision Support Tool (DST) and an overarching governance of the NMHSPF.

It is clear from the Commission's consultations that there is currently a mental health service planning vacuum in NSW as the NMHSPF has not been finalised and adopted, and the MH-CCP (which has not been updated since 2011) is no longer actively used by the Ministry or health services to inform mental health service purchasing under ABF. While health services value the devolution from the Ministry and lessening of central control over how they structure and deliver their mental health services locally, they would value the adoption of the evidence-based NMHSPF.

This review confirms that there is a need in NSW for the NMHSPF, which aligns with the objectives of *Living Well* and would provide a valuable context for negotiations between health services and the Ministry about the service mix that should be purchased.

Adoption of the NMHSPF would also support reporting on mental health needs, service provision and utilisation, gaps and service planning priorities, which would in turn guide local decision-making by health services and inform the community. Publication of these reports and constructive benchmarking of performance would also promote improved governance and accountability.

Under ABF, the Ministry mostly purchases three *types* of mental health services: acute admitted, sub-acute admitted and non-admitted. Some mental health service components continue to be block funded. The admitted and non-admitted services are then funded on a National Weighted Activity Unit (NWAU) basis. The principle is that the funding provided to the health service for its mental health services is directly linked to the health service's reported number of units of activity.

15 The Commission notes that further work is required on the model to better address mental health service needs for Aboriginal people and rural and remote communities.

5.2 SERVICE TYPE AND VOLUME

Local Health Districts confirmed that negotiations with the Ministry on the *volume* of the activity for each type of mental health service were largely derived from the previous year as a base, and making a number of marginal adjustments.

It is clear that the quality of the reported mental health non-admitted activity data varies significantly across health services, and the Ministry and LHDs acknowledge that much more work is required to improve the accuracy and value of this activity reporting.

The Commission requested advice from the Ministry about its approach to determining the volume of activity to be purchased for each service type.

The Ministry advised that the activity target negotiation enabled health services to raise local service delivery issues, and associated impacts on activity. These issues may include inter District/Network flows, implementation of new services, or opening of new capacity.

Additionally, health services may negotiate to shift their activity growth between the three service streams to reflect changing models of care – for example, an increase in the mental health non-admitted service stream and corresponding decrease in the mental health acute service stream in response to increased provision of out-of-hospital care in line with *Living Well*. The Ministry also confirmed it is possible in some circumstances for health services to negotiate a shift from ABF NWAU activity to block funding to support elements of mental health service models.

Provisional activity estimates for each ABF service stream, based on all facilities in scope for ABF funding, are provided by the Ministry to each health service. These estimates are the basis for negotiations about the future financial year activity targets.

The Ministry advised that the 2016-17 activity targets were informed by:

- Weighted population change - providing an indication of expected growth
- Recent trends in activity growth for each District/Network
- Rate of unplanned re-admissions within 28 days
- Specific measures of service quality and appropriateness (including an adjustor based on health service performance against the national post-discharge follow-up within 7 days indicator)
- Inter-district and cross-border flows (where relevant)
- Current year activity relative to targets (for adjustment of baseline volumes, where relevant)
- Known service changes and developments, including planned capacity increases.

The Ministry summarised this approach in tables 2A and 2B below.

Once activity target negotiations have concluded, the final activity targets for each ABF service stream are articulated in Schedule D (Service Volumes and Levels) in each health service's Service Agreement, with the relevant pricing schedule (Schedule C) applied to the weighted volumes. Performance against the activity targets is monitored in line with the NSW Health Performance Framework.

Table 2A: 2016-17 ABF activity estimates methodology and adjustments

SERVICE STREAM	METHODOLOGY	2016-17 ADJUSTMENTS
Acute admitted services	<p>A baseline representing 2015-16 activity levels is set. To this baseline is added expected population growth.</p> <p>An equity allocation is also added to LHDs where residents consume relatively lower acute health services (Relative Utilisation Rate adjusted for age, sex and socio-economic factors).</p>	<p>Rate of unplanned re-admissions within 28 days</p> <p>Potentially preventable hospitalisation</p> <p>Measures of safety / quality and appropriateness</p> <p>Inter-LHD and cross-border flows will be examined and considered as necessary.</p>
Emergency department services	<p>A baseline representing 2015-16 activity levels is set. To this baseline is added expected population growth.</p> <p>An equity allocation is also added to LHDs where residents consume relatively lower ED services (Relative Utilisation Rate adjusted for age, sex and socio-economic factors).</p>	<p>Rate of unplanned re-presentations within 48 hours</p> <p>Emergency Treatment Performance (within four hours) across LHD hospitals</p> <p>Inter-LHD and cross-border flows will be examined and considered as necessary</p>
Mental health services (admitted)	<p>Acute and Sub Acute</p> <p>A baseline representing 2015-16 activity levels is set.</p> <p>To this baseline is added expected population growth.</p>	<p>Acute - the mental health readmission rate.</p>
Sub-acute and non- acute services	<p>A baseline representing 2015-16 activity levels is set.</p> <p>To this baseline is added expected population growth.</p> <p>An equity allocation is also added to LHDs where residents consume relatively lower sub acute services (Relative Utilisation Rate adjusted for age, sex and socio-economic factors).</p>	
Non-admitted patient services (including outpatients)	<p>A baseline representing 2015-16 activity levels is set.</p> <p>To this baseline is added expected population growth.</p> <p>Community mental health and dental activity is included in the baseline.</p>	<p>Improvements in Telehealth access performance.</p> <p>Number of mental health community follow ups within 7 days performance.</p>

Table 2B: How the 2016-17 adjustments are applied

FACTOR	DESCRIPTION	ADJUSTMENT
Weighted population change	Change in the size of LHDs' resident population adjusted to reflect different use of acute health care services by people of different age and sex. For example, an LHD that is expected to experience a greater percentage increase in their elderly population will have a weighted population change which is greater than their unadjusted population change.	Weighted population was calculated by multiplying age-sex specific service utilisation rates with numbers of people in corresponding age-sex groups in each LHD. Notwithstanding other factors, weighted population change provides the best indication of expected natural growth.
Rate of readmissions / representations (ED) within 28 days	Rates of unplanned re-admissions/ presentations within 28 days calculated using standard NSW KPI definition. Episodes in the numerator and denominator were then age/sex, peer and casemix standardised and NWAU-weighted.	A portion of readmission rate exceeding the best performing LHD/SHN is used to offset growth.
Potentially Preventable Hospitalisation (PPH) rate	Rate of admissions related to conditions that could be prevented if appropriate care were provided in other healthcare settings; eg, vaccine preventable diseases. Episodes in the numerator and denominator were then age/sex standardised and NWAU-weighted. ED-only and Hospital in the Home (incl. Cellulitis) are excluded.	A portion of PPH rate exceeding the best performing LHD/SHN is used to offset growth.
Equity - Adjusted Relative Utilisation	LHD population's rate of the use of acute hospital services (both public and private) relative to the State average after adjusting for age, socioeconomic status, education, occupation and Aboriginality. Districts with an RU above zero (average) have populations that access acute hospitals services at a rate higher than the average rate for NSW population as a whole.	Districts with RU significantly lower than zero (average) may have their growth increased to bring their RU closer to the average over 8 years
Appropriateness	To incentivise best practice models of care leading to better patient outcomes.	<ul style="list-style-type: none"> • Extra NWAU for expanding access to Telehealth services. • Reduced NWAU for underperformance on mental health follow-up within 7 days.
Quality improvement	To incentivise service quality improvements leading to better patient outcomes.	<p>Extra NWAU for above target Emergency Treatment Performance (within four hours) across individual hospitals.</p> <p>A portion of NWAU associated with potentially preventable adverse events are withdrawn. For 2016-17 the events targeted are:</p> <ul style="list-style-type: none"> • Venous Thromboembolism (DVT) • Pressure injuries (grade 3 and 4) • Pulmonary Embolism

5.3 THE REFORM CONTEXT

The Commission acknowledges the Ministry's purchasing under ABF needs to take into account agreements with the Commonwealth, the classification structure for service types used by the Independent Hospital Pricing Authority and the emerging maturity of mental health clinical service coding and classification. However after conducting this review, the Commission is concerned that purchasing mostly on the basis of activity, and funding this activity solely on the basis of NWAUs, will not provide the necessary drivers for advancing the implementation of *Living Well*, especially the strengthened provision of comprehensive community-based mental health services.

This is because:

- there is a risk that the ABF framework incentivises admitted activity over community-based service provision;
- the methodology, counting and reporting framework for non-admitted mental health services is very much a “work in progress”;
- some types of mental health services delivered through other clinical units may “fall between the cracks” under ABF, depending on whether they are classified as part of mental health or another ABF funded clinical service. Consultation liaison psychiatry was raised with the Commission as an example of this issue.
- support of carers, advocacy and partnering with community-managed and other organisations, and the provision of comprehensive integrated clinical care, rehabilitation, support and other social care services do not attract NWAU funding unless they generate a unit of activity meeting current activity classification, counting and reporting systems¹⁶; and
- there is no agreed mental health service planning framework to provide a context for ABF purchasing decisions about the type of services and the volume of activity to be purchased.

The Commission recognises that ABF does bring significant advantages: greater transparency, improved cost efficiency, greater specificity in purchasing; and facilitating benchmarking. However, the funding framework and methodology must also:

- support flexible provision of stepped mental health care in the appropriate care setting
- provide for integrated and coordinated care models across the health and human services sectors, including general practice and primary care, community-managed organisations and private sector providers
- allow for funded care packages for clients with complex and chronic care and support needs
- support person-centred care models based on client needs and desired clinical and social outcomes.

ABF should not create barriers to access to the right service, in the right setting at the right time. The Commission recommends a careful, selective progressive implementation of activity based funding for non-admitted (in particular, community based) mental health services to avoid such barriers.

¹⁶ While codes for activities such as group work, prevention, health promotion and partnership do exist under current NSW Health classification systems, they are not routinely utilised and their conversion to non admitted activity for funding purposes is complex.

6. ARE NWAUS THE ONLY ACTIVITY THAT SHOULD BE PURCHASED?

For many people living with a chronic mental health condition and psychosocial disability, effective person-centred care also requires integrated care and services across a much broader spectrum of settings extending beyond health to housing, employment support, rehabilitation and social support. These are provided by a variety of organisations including Local Health Districts and Specialty Health Networks, other government agencies, community-managed organisations and community and consumer support groups.

The shift to Activity Based Funding of mental health services by the NSW Ministry of Health reflects a worldwide drive to improve the efficiency and cost effectiveness of hospital services, implements a nationally agreed health reform agreement and, appropriately, shifts the focus from inputs to outputs and outcomes.

However, as illustrated by the Health Care Home, My Aged Care and National Disability Insurance Scheme reforms, there is also a strong trend towards individualised funding packages to support person-centred co-ordinated care and support for people with chronic and complex needs.

For a person who has a one-off acute admission to a mental health inpatient unit via the emergency department, with mental health follow-up provided by their GP and private sector support, the ABF funding framework appropriately allocates National Weighted Activity Units (NWAUs) for the ED attendance and acute mental health admission.

However, for a person who needs intensive support in the community, a case manager and a broad range of social support services, ABF and NWAUs do not work as well. At times, the ABF and NWAU funding framework needs to be “massaged” to ensure that the complex mix of health service staff time and services, multidisciplinary and multiple organisation case review and services from multiple providers generate activity and episodes of care that are recognised under ABF and generate a NWAU to ensure that they attract funding. In the absence of NWAUs, the mental health service must rely on its block funding.

6.1 ABF/NWAU FUNDING FRAMEWORK FOR NON-ADMITTED MENTAL HEALTH SERVICES

There is a real risk that service provision in the non-admitted ambulatory care setting has to fit the ABF/NWAU framework, rather than the person-centred best practice clinical care model.

This risk also presents a challenge in implementing *Living Well*, which seeks a shift to a mental health system centred on high quality, safe, comprehensive, evidence-based, person-centred and co-ordinated care, treatment and support in a community setting. This community-based core will continue to be supported by high quality acute admission, sub-acute and longer term admitted care, emergency department assessment and specialist inpatient services.

The mental health system will comprise an effective stepped mental health care model across care settings – prevention and building mental health resilience, self care, general practice and primary health care, mental health services provided by public and private sectors, specialist mental health services, other government agencies, community-managed organisations and community and consumer support groups.

Successful implementation of *Living Well* requires an appropriate mix of incentives and drivers. At this time, it is unclear whether the ABF/NWAU framework provides the appropriate mix.

As outlined later in this Report, the current state of non-admitted mental health activity data classification, collection and reporting is poor. NSW is not alone in this. Discussions with Local Health Districts as part of this review confirmed the wide variability in the quality of reported “service event” activity. Currently, calculation of an NWAU for non-admitted activity in NSW requires application of a formula to reported non inpatient occasions of service (NAPOOS) to convert these to service events. The service events are then converted using another formula into NWAUs. These formulae are not aligned to best practice models of care and NAPOOS data collection and reporting remains very variable across service units and health services.

The implementation of the AMHCC in 2017-18 will partly address the issues of data classification, recording and reporting. However, this will require diligent recording of the activity and will not address the underlying issue with ABF funding: that care, treatment and support of a client always has to generate a reportable activity that leads to a NWAU in order to attract funding.

The Ministry of Health has confirmed that health services can if they wish continue to be block funded for their non-admitted mental health services. The Commission supports this cautious approach to implementing ABF for non-admitted services, pending progress on the models of care and service planning recommendations in this Report, successful implementation of the AMHCC in NSW and improvements in the data quality. Block funding must also be accompanied by output and outcome targets and transparent performance reporting.

7. WHAT IS THE LOCAL HEALTH DISTRICT MENTAL HEALTH BUDGET?

A number of external reports have questioned whether the budget allocated by the Ministry of Health to Local Health Districts and Specialty Health Networks for mental health services in NSW are all spent on mental health. For example, in 2010, the NSW Audit Office found:¹⁷

‘.....although mental health funding is supposed to be ‘protected’, and spent on mental health, poor data and management have allowed some leakage to other areas of health. This risk may increase during the impending reorganisation of Area Health Services.’

The Commission’s *One Year On* report on the implementation of *Living Well* noted that the extent to which the funds allocated by Parliament are fully spent on mental health services remains among the most frequent concerns raised with the Commission.

These concerns were a key driver for this review, and were specifically identified within the scope of this project, so both the Commission and the community can have an informed and contemporary understanding of the fundamental change in the purchasing and funding environment following the introduction of ABF in NSW.

Based on discussions with the Ministry and four Local Health Districts, this chapter examines how mental health funds are now allocated and spent on mental health services.

7.1 THREE LEVELS OF MENTAL HEALTH EXPENDITURE

In response to the Commission’s enquiry on this issue, the Ministry advised:¹⁸

what “budget” means (and what it includes) will vary in different contexts, from the high level expenditure estimates included in NSW State budget, to the budget under the control of the manager at an individual mental health service.

It seems most useful to distinguish three different mental health “budgets”, or budget compositions:

- the expenditure estimates for mental health services as a whole included in NSW State Budget Paper 3.
- the expenditure estimates for mental health services for each Local Health District, included as Schedule C in the annual Service Agreement between the LHD and the Ministry
- the budget that is actually allocated to each manager within mental health over which they have financial control of the expenditure and for which they are accountable.

7.2 ESTIMATED MENTAL HEALTH SERVICE EXPENSES IN NSW BUDGET

The expenditure estimates for mental health services as a whole are included in NSW Budget Paper 3. The 2016-17 estimate is set out below. NSW Treasury uses a similar process across all agencies in respect of forward year budget funding and expenditure estimates.

17 Performance Audit of Mental Health Workforce, NSW Audit Office, 2010 http://www.audit.nsw.gov.au/ArticleDocuments/142/210_Mental_Health_Workforce.pdf.aspx?Embed=Y.

18 Ministry of Health response to Mental Health Commission information request, Q2, Sept 2016

Table 3: Mental health services in the NSW Budget 2016-17

Service description

This service group covers the provision of an integrated and comprehensive network of services by Local Health Districts and community based organisations for people seriously affected by mental illnesses and mental health problems. It also covers the development of preventative programs that meet the needs of specific client groups.

	Units	2013-14 Actual	2014-15 Actual	2015-16 Forecast	2015-16 Revised	2016-17 Forecast
Service measures:						
Acute mental health service overnight separations	no.	32,722	34,129	33,435	34,304	34,994
Non-acute mental health inpatient days ^(a)	thous	281	303	290	307	302
Employees:	FTE	12,488	12,542	12,698	12,850	13,055
				2015-16		2016-17
				Budget \$000	Revised \$000	Budget \$000
Financial indicators:						
Total Expenses Excluding Losses				1,729,261	1,718,320	1,824,265
Total expenses include the following:						
Employee related				1,188,493	1,188,493	1,236,663
Other operating expenses				351,354	340,854	367,134
Grants and subsidies				99,053	98,612	127,876
Capital Expenditure				65,634	63,904	63,644

(a) The 2015-16 Forecast did not fully reflect the impact of new non-acute facilities becoming operational during 2015, which had an impact on the Revised activity for 2015-16. The full impact of facilities established in 2015 is projected in the 2015-16 Revised estimates. In 2016-17, some existing non-acute capacity is being re-classified to an acute type care, transferring from mental health non-acute to acute overnight separations.

Source: NSW Budget 2016-17. Paper 3.

The Ministry of Health advised the Commission as follows:¹⁹

NSW agency operating budgets are allocated by NSW Treasury on an accrued budget basis (ie salary and wages, insurance, goods and services, depreciation etc) and include cash and non-cash budget estimates. For the purpose of State Budget reporting, this total accrued operating budget is then apportioned across a range of agency-nominated service groups. For NSW Health, there are currently nine Service groups which are reported in both the State Budget papers and the Annual Financial Statements. Service Group 3.1 is mental health services.

For NSW Health, the distribution of its total annual recurrent budget to Service Groups has predominantly utilised the full cost distribution processes (currently the District Network Returns (DNR), applied by the reporting entities within NSW Health) to calculate a base for each service group. Then, known in-year variations (ie approved rollovers or expected under or over budget forecast results) for the current budget year are applied to produce a revised forecast for the current budget year that is shown in the State Budget Paper 3. This revised budget estimate is then used as the estimated base for the coming financial year by adding a calculated share of escalation and non-cash items (eg depreciation, leave provisions etc), plus the negotiated growth to meet service demands and any specific enhancements pertaining directly to a Service Group.

With the advent of improved activity based costing information, and the application of Independent Hospital Pricing Authority costing definitions and guidelines, the annual financial reporting of service groups as part of the program reporting within the Audited Financial statements has allowed for a more defined set of data that aligns closer to the actual level of service delivery for each Service group, and incorporates the full cost attributions particularly for Local Health District and Specialty Health Networks.

As the calculation of each year's budget by service group takes into account the expected service demands and enhancements known at a point in time, the annual actual results will generally differ as they will take into account final costs as determined in the most recent DNR and the final actual costs recorded by each of the 30 reporting entities that form part of NSW Health.

Following discussion with the Ministry, the following points are noted:

1. The figures provided in the NSW Budget Paper 3 are **estimates** based on the most recent District and Network Return which distributes direct costs, indirect costs, corporate overhead costs and some other centrally held and accounted costs across the nine Service Groups, including to Service Group 3.1 Mental Health.
2. Known specific enhancements, other expenditure related to Service Group 3.1 Mental Health and non cash items attributable to mental health services are then added to this base figure.
3. The estimates recorded in the previous financial year's NSW Budget are then updated to provide a more accurate comparator.

The end result is that this estimate of Service Group 3.1 Mental Health expenses for the coming year is a combination of:

- the expected direct expenditure on mental health services (including known enhancements and indexation); plus
- Service Group 3.1's *fair share* of:
 - the expected Local Health District and Specialty Health Networks indirect costs and corporate overhead costs (using a robust patient level costing methodology);

¹⁹ Ministry of Health response to Mental Health Commission information request, Q1.2, Sept 2016

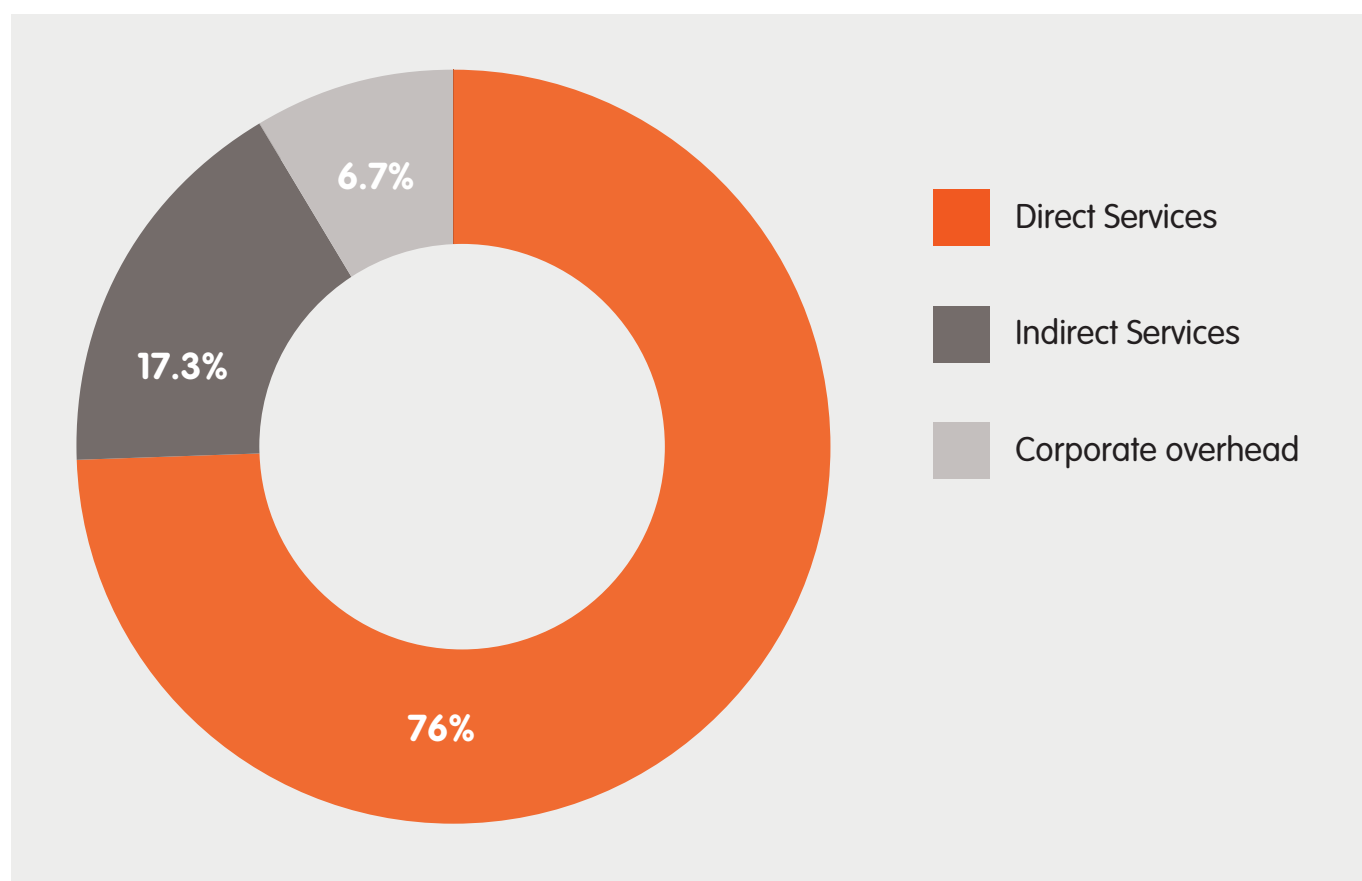
- NSW Health system wide service costs not able to be directly allocated to mental health cost centres (eg HealthShare, eHealth, NSW Pathology and NSW Ambulance);
- Ministry of Health operating costs;
- costs of the Pillars (Clinical Excellence Commission, Agency for Clinical Innovation, Health Education and Training Institute, Bureau of Health Information); and
- other costs (eg public private partnership financing costs).

The Ministry has also advised that NSW Treasury has embarked on a Financial Management Transformation project. Mental health will continue to be a separate program for NSW Budget reporting purposes. While still recording inputs, the reporting in the budget papers will become more output and outcome focussed.

While further refinement of the patient costing methodology continues and health services improve their ability to directly link indirect costs to specific patient and clinical service activity, the distribution and allocation of indirect costs and corporate overhead costs to Service Groups is still heavily reliant on the costing methodology formulae.

Acknowledging the imperfections associated with the use of formulae, the review notes that the same methodology is applied to the other Service Groups and the DNRs for each health service are internally and externally audited. Subject to the allocation of the share of indirect and corporate overhead costs being appropriate, the estimates included in the NSW Budget papers are a reasonable estimate of aggregated mental health expenditure, including indirect and corporate overhead costs.

Graphic 3: Composition of LHD and SHN mental health expenditure



As indirect and corporate overhead costs comprise around a quarter of the estimated mental health expenditure, there would be value in maintaining clear visibility and transparency regarding the allocation of these costs by health services to mental health. An example of these allocations is at Appendix B.

7.3 MENTAL HEALTH BUDGET AT LOCAL HEALTH DISTRICT AND SPECIALTY HEALTH NETWORK LEVEL

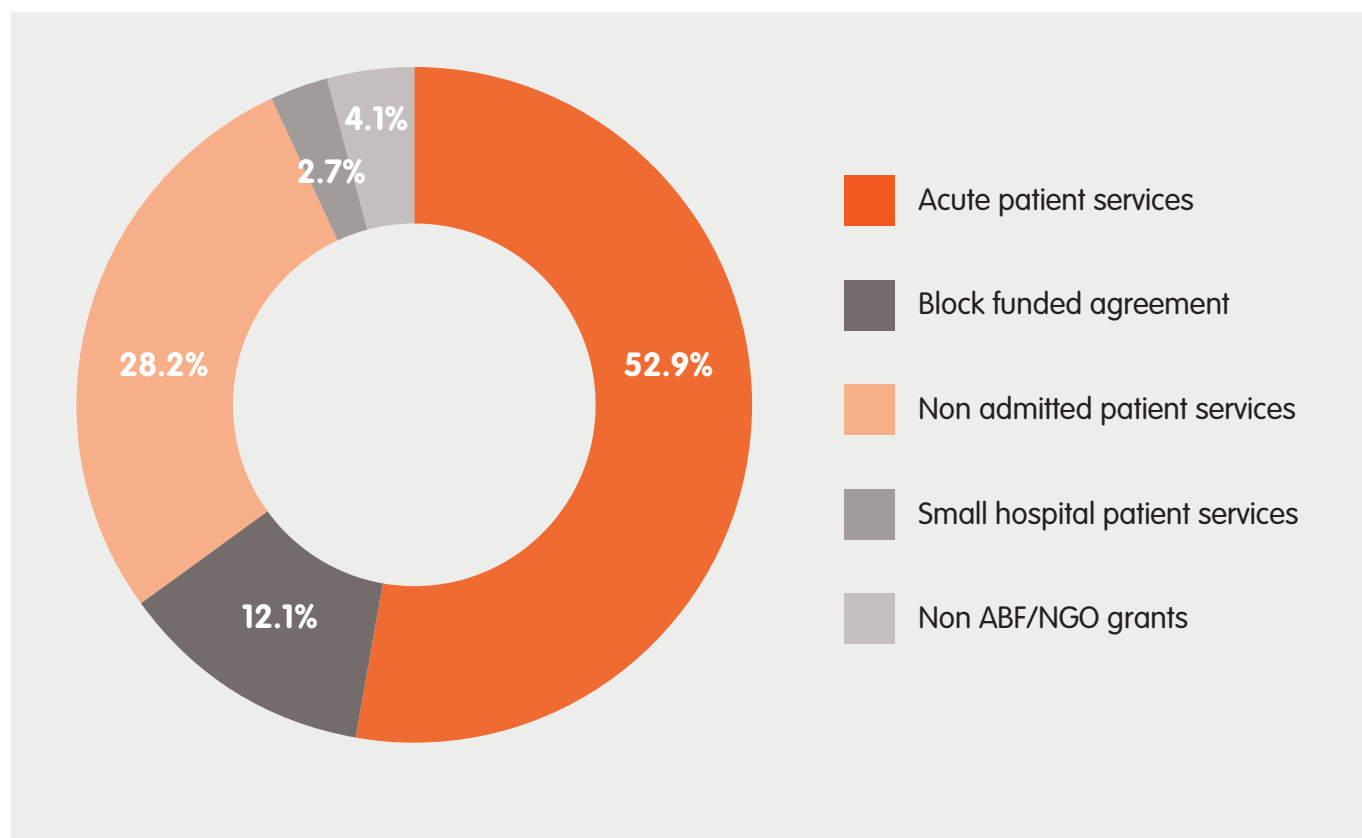
The expenditure estimates for mental health services at each Local Health District and Specialty Health Network are included as Schedule C in the annual Service Agreement between the health service and the Ministry.

Schedule C in each health service's annual Service Agreement includes a budget allocation for mental health, and for all other Service Groups, to deliver agreed outputs and performance in the coming year. The budget allocations are derived differently depending whether the services are funded on an ABF basis or through specific block funding.

For services funded by ABF, which now include mental health acute and sub-acute admitted patient episodes, activity targets are agreed between the Ministry and the LHD or SHN and these are then used to set the budget for the service streams. Each type of activity in the target is weighted, using the national weighted activity unit (NWAU) which reflects the relative cost of the activity. The aggregated NWAU targets are then multiplied by the State Price per NWAU (currently \$4605) to arrive at the overall expense budget allocated by the Ministry to deliver that service.

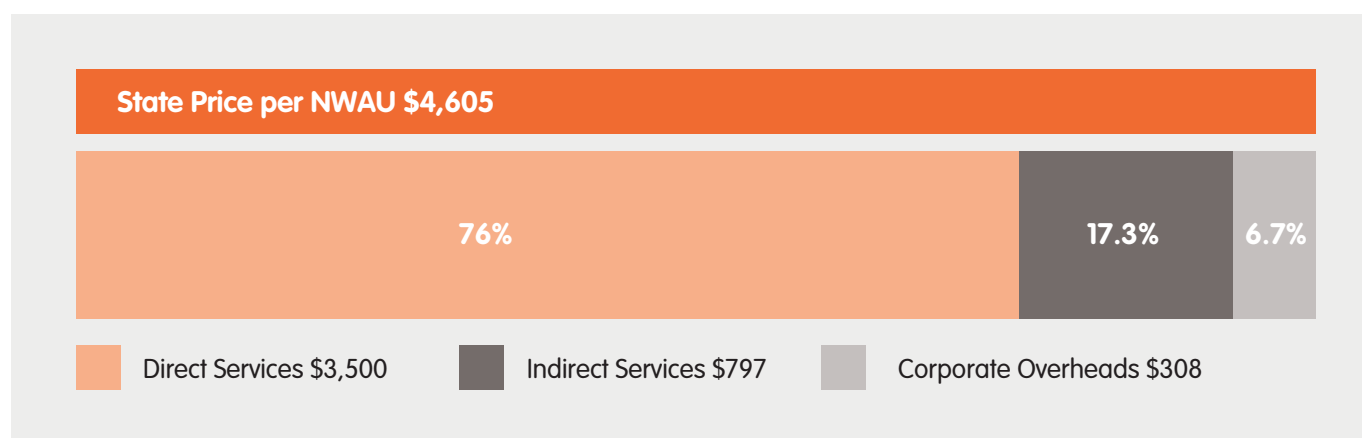
Funding allocations to the health services are on the basis of a price based on “fully absorbed” costs. This price

Graphic 4: Consolidated mental health funding for LHDs and SHNs, 2016-17 Budget



includes indirect, corporate overhead and other centrally held costs of the health service. These indirect and overhead costs are allocated to the cost base of the various clinical services, based on that service's share of the services provided by those overheads.²⁰

Graphic 5: State Price per NWAU



This means that the actual payment received by a facility or clinical service within the health service will always be less than the State Price times the NWAU activity target it is to achieve. A varying proportion of the State Price funds the indirect and corporate overhead costs.

Much of the “debate” about the mental health budget at a health service level and the “charging” of external costs to this budget by the LHD or SHN, is linked to misunderstandings about the price, patient costing methodology and the degree to which the health service is able to directly allocate indirect costs to the mental health service cost centres. Better information and greater transparency on this issue by health services will assist in clarifying these misunderstandings.

As with all clinical services, mental health services require a broad range of corporate, hotel type and other support services to function effectively. There is also a need to have transparency around these to support benchmarking and drive efficiency in these costs to maximise the proportion of each “health dollar” that is available for direct service provision.

Where the costs of delivering a particular service group are higher than the State Price, then a transition grant may be provided by the Ministry to make up the shortfall in the short-term to “keep the health system safe, operational and stable while promoting service efficiency”.²¹

²⁰ The NSW Health Costing guidelines contains detailed instructions on how these different overhead costs are to be apportioned (what apportionment measures should be used; what process should be followed when) and these are a key risk, and a key component of the DNR audit process designed to ensure consistency of application of these guidelines

²¹ NSW Health NSW Activity Based Management Compendium (2016 – 2017), unpublished, section 1.3.4; quoted in Ministry response of September 2016, to the Mental Health Commission’s Information Request

To maintain transparency of mental health funding, the Ministry has included in Service Agreements for 2016-17 the following note:

As in previous years, a separate transition grant has been identified for Mental Health Admitted stream to maintain the visibility of Government funding commitments for these services.²²

Services not currently funded on an ABF basis include:

- mental health non-admitted services
- mental health services provided at small hospitals
- specialist psychiatric hospitals
- teaching, training and research
- services deemed to be out of scope for the National Health Reform Agreement (such as some child and adolescent services).

These are block-funded, rather than funded on a level of activity to be achieved. Funding is generally based on the previous year plus specific service enhancements, indexation and adjustments for population growth.

7.4 SHADOW FUNDING OF NON-ADMITTED MENTAL HEALTH SERVICES

Funding for mental health non-admitted services in NSW now uses a hybrid shadow funded ABF mechanism. There is confusion surrounding the operation of this shadow funding at an LHD and SHN level. This confusion has been reinforced by the application of shadow funding to a broad range of non-admitted services and the introduction by the Ministry of transition grants.

Because the information on the costs, volume and classification of these non-admitted mental health services is not always available, is often incomplete, not representative of cost drivers and of variable quality, it cannot reliably generate NWAU price weights. The Ministry of Health uses information on the health service's average costs for the previous year and the number of non-admitted service events recorded, to estimate the next year's funding requirements on a NWAU basis.

This process effectively takes the health service's estimated expenditure on non-admitted mental health services from the previous year to generate an expected level of service events and NWAUs for the coming year. The underlying block funding of the non-admitted mental health services continues. In using shadow funding, the Ministry's aim is:

to improve counting and costing processes in preparation for the national mental health classification which is being implemented in NSW during 2017/18.²³

7.5 THE MENTAL HEALTH "BUDGET" ALLOCATED TO THE HEALTH SERVICE MENTAL HEALTH SERVICE

In contrast to the consistent approach to costing and activity measurement supporting budgets at State level and in the Ministry's allocation of funding to health services under the Service Agreements, within LHDs and SHNs there is, understandably, far more variability and flexibility on how, and down to what level, budgets and activity targets are allocated for operational management, performance and financial control purposes.

²² Service Agreement 2016-17, Notes to Schedule C, p 32

²³ Service Agreement 2016-17, Notes to Schedule C, p 32

As the Service Agreements outline:²⁴

Schedule C sets out the key budget elements linking activity and service streams to funding. In line with our devolved health system governance, Districts/Networks have the flexibility to determine the application and reconfiguration of resources between service streams that will best meet local needs and priorities. Districts/Networks are also responsible for determining the allocation of activity and budgets to its individual hospitals and other services, noting the state-wide priorities identified in Part A of this Service Agreement.

An example of a Schedule C is at Appendix C

In response to the Commission's Information Request, the Ministry confirmed:²⁵

... each District will have variations as to how they manage and allocate internal cost centre budgets for the individual financial inputs for the service/program area. The format of these and what is and isn't included should be 'fit for purpose' for the management and accountability needed within each LHD.

This review confirmed the variability at an LHD and SHN level. The variability reflected a combination of factors:

- the health service organisation structure for its mental health services
- the sophistication of the health service's internal cost allocation systems, especially the degree to which they were able to allocate indirect costs to mental health service cost centres and clinical activity
- the health service's policy on centralisation of management of various expenses (for example, some LHDs managed parental leave costs from a central reserve)
- the health service's approach to allocation of certain expenses and non cash items (eg recruitment and other non-payroll HR expenses, public private partnership financing costs and depreciation)
- the health service's approach to allocation of block funded elements to mental health cost centres (eg some LHDs attempted to allocate teaching, training and research block funding)
- the sophistication of the business management and financial management resources within the mental health services
- the ABF and data collection and reporting skills base and resources within the mental health service.

This variability is reflected in the percentage of the health service's estimated Service Group 3.1 mental health expenses that are allocated by the health service to the direct control of the health service's mental health service director.

LHD	% of budget "directly controlled"
Hunter New England	71%
Northern Sydney	79%
Western Sydney	89%
Western NSW	91%

Source: LHD responses to Mental Health Commission Information Request, July/August 2016.

²⁴ Service Agreement 2016-17, Notes to Schedule C, p 34

²⁵ Ministry of Health response to Mental Health Commission Information request, Q3, Sept 2016

It is important to note that this variability reflects the different structures and approaches taken to cost allocation by the health services and does not represent a de facto withholding of mental health funds and/or their use for other purposes.

7.6 IS THE HEALTH SERVICE MENTAL HEALTH BUDGET QUARANTINED?

As noted in Chapter 1, this question of quarantining or protection is frequently raised by mental health consumer organisations and some mental health clinicians.

In 2014 in *Living Well*, the Commission observed:

“Our observations, in engaging with LHDs, were that, although funds for mental health are ostensibly quarantined, in practice they may be diverted to other areas within LHDs. The current difficult financial environment within the health sector and Government more generally has amplified the risk that mental health services may not receive their funding allocation, and this is particularly true for community mental health services. A lack of transparency in mental health funding within many LHDs makes this difficult to challenge when it occurs.”¹

Discussions with LHDs confirmed that there is still a belief amongst some staff that a quarantining of funding for mental health commitment continues to exist and that the expenditure estimates announced by the government for mental health represent a commitment to spend that amount exclusively on mental health.

As this review clarifies, the historical approach focussed on quarantining inputs (such as the dollars allocated) for a particular purpose is no longer appropriate to an ABF environment focussed on purchasing of outputs (such as units of activity).

NSW's move to activity based funding as part of the National Health Reform Agreement, now means that the Ministry's purchasing and performance framework is focused on holding health services to account for achieving agreed activity targets (fixing output budgets).

Health services are, theoretically, free to allocate the funding they receive under their Service Agreement with the Ministry in the way that best meets their Service Agreement activity targets and the health service's priorities.

Under the Service Agreements, the Ministry agrees to provide health services with funding to deliver the targeted level of activity, based on a standard statewide price produced by a standard costing procedure, for each activity.

If a health service can deliver the activity more efficiently than the State Price then they can invest the freed up funds elsewhere to meet priorities, including mental health. If a health service does not deliver the target level of activity, its funding provided by the Ministry may be reduced. If it exceeds the targeted level of activity, it may be able to negotiate an increase in funding from the Ministry.

Under the Ministry's Performance Framework, during the financial year the funding provided may vary according to achievement of the activity targets. In practice, funding to a health service is rarely reduced during, or between, financial years due to underachievement of activity targets. The focus is on working with the health service to identify the reasons for the underperformance.

What is now effectively “quarantined” is not the mental health budget, but the Schedule C activity target for mental health services (currently acute and sub-acute admitted services with shadow funding of non-admitted mental services). While a health service can approach the Ministry to request a reallocation of the Schedule C activity targets *between* Service Groups (eg from non mental health to mental health or vice versa), the Ministry has advised that the health service would need to be able to demonstrate that it was meeting the community need for the services concerned and that the reallocation between Service Groups would better meet those needs.

While an internal *within* Service Group reallocation of Schedule C activity targets often occurs (eg between mental health acute admitted and mental health sub-acute admitted), the Ministry has advised that it has not been approached to consider a reallocation *between* Service Groups.

The Commission notes that in the Ministry's Service Agreements with health services, mental health continues to have a separate activity budget, unlike most other clinical services. While separate activity targets are allocated for Emergency Department services, there are no separate medicine, surgery, maternity or paediatric NWAU activity budgets in the Service Agreements.²⁶

If the question being asked is, "is there a government commitment to a fixed sum of money from Treasury that can only be spent on mental health services?", the answer is no. However, if the question asked is, "is there a Ministry of Health requirement that a health service deliver against a mental health activity target?", the answer is clearly yes.

As noted elsewhere in this Report, the key issues that flow from this answer include:

- how is the activity target determined?
- is the activity target appropriate to the mental health "need" and role of the health service in meeting that "need"?
- does the activity target cover all elements required for a safe, high quality and effective mental health service?
- is the funding per unit of activity set at an evidence-based efficient price?
- are there consequences for not meeting the activity target?

The Commission has further noted that much of the reported concern about the use of "quarantined" mental health funding for non mental health service purposes, relates not to the Ministry's Service Agreement with the health service, but to the allocation and use of the funding received by the health service under the Service Agreement, including the allocation of indirect and corporate overhead costs to the mental health services.

With the replacement of the historical quarantining of mental health funding and MHDAO's centralised, separate monitoring of performance by the broader purchasing and performance framework and ABF, effective governance and accountability are now important components of delivering quality mental health services.

ABF, in isolation, will not achieve this outcome. If the activity targets are not appropriate, performance is not measured and the consequences for underperformance are not activated, many of the concerns of the past will continue and/or re-emerge.

Examples of such concerns provided to the Commission included:

- deferral of recruitment (deferring five positions for three months will generate a saving of \$100,000)
- imposition of "efficiency dividends"
- restrictions on minor capital works expenditure
- restrictions on training and professional development expenditure
- absorption of favourability rather than a rollover to the following year.

Some of these concerns are also linked to misunderstandings about the allocation of indirect and corporate overhead costs to Service Group 3.1 and their incorporation into reported expenditure on mental health services under Service Group 3.1. Greater availability of information and transparency of this allocation process will help clarify this.

²⁶ Planned surgery has a maximum wait time target for each clinical priority category which indirectly sets a minimum NWAU activity target for planned surgery.

There is now a standard costing regime in place across all health services for allocating such costs to activity for costing, reporting and pricing purposes, in which mental health is treated in the same way as the other Service Groups.

The standardised, fully-apportioned costing approach across all health services is verified by a detailed annual audit process. It also allows stakeholders to compare cost allocations and unit costs by activity at facility, district and statewide levels, through the reports from the NSW ABM portal to which LHDs and SHNs have access. However, because of the current data quality and classification limitations in mental health (especially non-admitted services), the ability to undertake this benchmarking for mental health service provision is still significantly behind the capability for comparing other acute admitted and emergency department services data.

More will be gained by moving from a detailed focus on the funding inputs to a focus on meeting the mental health outputs and client outcomes required under evidence-based models of care within an appropriate mental health service planning framework.

The Commission also welcomes advice from the Ministry of Health of an intention to explore a move to purchasing for “value” under the Purchasing Framework.

8. WHAT SHOULD BE THE KPIS IN A PURCHASING ENVIRONMENT?

Prior to the introduction of ABF, and the move to the more devolved purchaser and provider roles for the Ministry and the LHDs, the performance of the health services in mental health was centrally managed by MHDAO using a mix of input, activity, efficiency and quality measures set out in the separate mental health service agreements.

These indicators included volume measures (bed days, patients treated, community client contacts and hours), FTE mental health staff numbers, efficiency measures (reported cost per bed day, client contact hours per FTE and bed occupancy). Outcome and effectiveness indicators were not a feature of this performance framework.²⁷

With the establishment of LHDs and the change to a Ministry of Health, the performance framework for LHDs underwent a major review. Separate detailed service agreements on mental health lapsed and performance monitoring of mental health became part of a consolidated performance reporting and review process. The introduction of ABF reinforced this change.

Health services are now funded under a Purchasing Framework and their performance assessed under a Performance Framework²⁸. The Performance Framework sets out a range of key performance indicators (KPIs), prioritises these KPIs into Tiers and outlines an escalation process where the KPIs are not being met.

The KPIs are grouped into domains:

- Safety and quality
- Service access and patient flow
- Integrated care
- Finance and activity
- People and culture
- Population health
- Maternal, child, youth and family services.

While the Ministry's Mental Health Branch, the mental health data unit InforMH and health services each have a range of KPIs to assess performance of mental health funded programs or services, the current Ministry of Health Service Agreements with health services and the Performance Framework have relatively few nominated KPIs for mental health services. The majority of these relate to activity – acute admitted, sub-acute admitted and non-admitted NWAUs.

Safety and quality KPIs monitor delays in emergency departments, readmissions within 28 days and seclusion rates. There is one process indicator relating to community follow-up within seven days of discharge.

There are no indicators that relate to patient and client outcomes.

Two indicators are tagged as “mental health reform” indicators – the number of people who have been assessed for Pathways to Community Living Initiative (PCLI) and Mental Health Peer Workforce FTEs. Both are among the reform priorities of *Living Well*.

There are no or few KPIs monitoring access to care, integrated care or people and culture. Apart from the patient survey undertaken by the Bureau of Health Information, and the Your Experience of Service (YES) questionnaire offered to mental health service clients, there are no KPIs monitoring person-centred care.

²⁷ Effectiveness and outcome data collections using SCI-MHOAT were commenced and a report on mental health service effectiveness was prepared by the then Centre for Mental Health in 2006.

²⁸ These frameworks are available on the NSW Health website www.health.nsw.gov.au - see System Relationships and Frameworks Branch section.

The Commission's discussions with the four LHDs confirmed that reports to the LHD Executives and Boards about their mental health services, not surprisingly, were largely focused on activity against NWAU targets.

The development of appropriate performance indicators is a challenge for health systems around the world. However, in a purchasing environment, especially one with ABF as its core, it is vital that what is being purchased aligns with community needs, best practice models of care and person-centred care, while driving improved health outcomes, safe high quality services and cost efficiency.

As the focus of the Ministry and funders around Australia has moved from inputs to outputs and outcomes, appropriate KPIs focused on outputs and outcomes are now more important.

Development and refinement of appropriate KPIs for Local Health District and Specialty Health Network mental health services also requires an agreed context incorporating:

- clarity about the role of public sector mental health services in delivering mental health services to the NSW community
- adoption of an agreed service planning framework to estimate need, project service requirements and identify gaps in service provision
- best practice models of care
- implementation of the AMHCC
- agreement on feasible outcome measures
- ability to compare and benchmark performance.

As these contextual elements are not yet in place, the Commission recognises that development and use of appropriate KPIs will take time. However, it is important that the task commences.

9. HOW MATURE ARE DATA COLLECTIONS, CLASSIFICATIONS, COSTING AND COUNTING?

The new funding and management arrangements for mental health and other services requires detailed information about the types of services provided to patients and the cost of these services. To derive this information, high quality data is needed in two areas:

- **service activity** classified in ways that are clinically meaningful and into sub-categories of treatment that involve similar resource use and can be related to outputs and, if possible, outcomes; and
- **costs** classified as those directly related to the delivery of each patient service and those indirect or overhead costs which are not, but which are apportioned across all patient services to better reflect the full cost of the service.

Experience with the introduction of clinical and casemix classification systems, prior to the introduction of ABF, has clearly demonstrated that clinical engagement is essential to achieve meaningful high quality data. The experience has also shown that data quality and comprehensiveness improves over time as it is put to greater use.

The challenge is to embed appropriate data recording, reporting and analysis as part of the clinical assessment, treatment and review process and to use appropriate technology to simplify the data capture and improve the timeliness and quality of the data collected.

9.1 DATA ABOUT MENTAL HEALTH ACTIVITY AND OUTCOMES

Data classification, recording and outcome reporting systems for mental health services historically have not been as well developed or as well used as in other service groups, both in NSW and nationally. As the consultants responsible for developing the new mental health classification system for IHPA commented in 2016:

“At the time of commissioning the [new mental health classification system], there had been a number of national mental health-specific data collections and one classification system developed and implemented in Australia, including:

- *Admitted Consumer Mental Health Care (APMHC) NMDS*;*
- *Community Mental Health Care (CMHC) NMDS;*
- *Residential Mental Health Care (RMHC) NMDS;*
- *Mental Health Establishments (MHE) NMDS;*
- *National Outcomes and Casemix Collection (NOCC); and*
- *Mental Health Classification and Services Cost (MH-CASC) project (one-off study).*

None of these data collections nor the MH-CASC system were widely accepted within the mental health sector”²⁹

Part of the difficulty has been the widely divergent cost profiles for patients with the same mental health diagnosis; this differs from other specialties with more “standard” diagnosis-related cost profiles.

“Mental health costs are driven by multiple factors, including (but not limited to) complications and comorbidities, symptom severity and function as well as some contribution from patient diagnosis as a lesser contributing factor.”³⁰

As IHPA commented in 2015:

“Since 1 July 2013, IHPA has priced admitted mental health services using Australian Refined Diagnosis Related Groups (AR-DRGs) as the classification system with a modified pricing model. This is not ideal in the

29 HealthConsult Mental Health Costing Study, January 2016, p5 www.ihipa.gov.au/sites/g/files/net636/f/publications/mental_health_costing_study.pdf

30 Ibid, p21

longer term because diagnosis is not as strong a driver of resource utilisation for mental health services as it is in other acute services, and it can only be applied in the admitted setting.

*The purpose of developing the Australian Mental Health Care Classification system (AMHCC) is to improve the clinical meaningfulness of mental health classification, leading to an improvement in the cost predictiveness, and to support the new models of care being implemented in all states and territories with a classification that can be applied in all settings.*³¹

More information on the new *Australian Mental Health Care Classification system (AMHCC)* is set out in *Appendix D*.

Compounding this problem has been the very limited data collection and costing for mental health services in community and other ambulatory care settings.

*“Non-admitted specialist mental health services have not traditionally been the focus of hospital costing processes, and as such, there is little data available to IHPA to derive price weights. This is further compounded by the fact the scope of public hospital services eligible for Commonwealth funding under the Agreement has yet to be resolved, making it unclear which services need to be priced. As a result, IHPA has determined that in 2013-14, these services will need to be block funded, with IHPA working with states and territories to determine the appropriate amounts.”*³²

In NSW, the Ministry of Health has sought to encourage improvements in data collection for mental health services, and to make maximum use of what information is currently collected, for both admitted and non-admitted services, by including both within an ABF framework, even if the latter is only in a “shadow-funded” arrangement.

However, the completeness, reliability, accuracy and timeliness of data collected and reported by mental health services, other than acute admitted data, remains a major issue. As just one example, the reported recording of HoNOS and other outcome data for mental health clients remains well below targets, particularly in non-admitted care settings.³³

Completion rates on outcome measures for mental health patients Jan-June 2015			
	Target	Actual Admitted	Actual Non-admitted
NSW	80%	74%	23%
Highest completion rate in LHD	80%	96%	43%
Lowest completion rate in LHD	80%	0%	0%

Source: NSW Health ABF Taskforce. *District and Network Return Audit Program October 2015, Appendix 5*

There was no improvement in recording levels for these measures between 2009 and 2015. The limited information seen by the Commission in a sample of DNR audit reports since 2015, do not indicate that there has been a significant improvement. In the outcome indicator information that is recorded for ambulatory (non-admitted) mental health clients, more than one-third of contact records in 2014-15 were created when the client was not present³⁴, further raising issues of data quality and reliability.

31 IHPA AMHCC Consultation Paper, January 2015, p4 www.ihipa.gov.au/sites/g/files/net636/f/amhcc_consultation_paper.pdf NMDS – National Minimum Data Set

32 ibid p43

33 The reviewers were also advised that there are issues with the business rules for this data collection and that the application of these rules affects data completion rates.

34 NSW Health ABF Taskforce. *District and Network Return Audit Program October 2015, Appendix 4*

LHDs confirmed that much of the movement from year to year in reported non-admitted mental health activity was due to a greater focus on recording and counting rather than changes in the underlying quantity and/or range of services provided.

The data quality issues prevent the Ministry's ABM portal from providing comparative reports for non-admitted mental health services. These reports are available for mental health admitted services and for other clinical specialties. This comparative information is one of the key benefits of activity-based funding. Without it, the management of mental health is relatively disadvantaged.

9.2 TRANSITION TO THE AUSTRALIAN MENTAL HEALTH CARE CLASSIFICATION SYSTEM (AMHCC)

Rather than pursuing better counting of NAPOOS and service events for non-admitted mental health services, the Commission believes it will be more productive now to focus on the effective implementation in NSW of the new AMHCC classification system.

The experience of the pilot sites testing the new classification system around "phase of care", and the comments of those LHDs which contributed to this review, indicate that the transition to the AHMCC will be a big challenge for mental health clinicians, managers and health services.

As the report on the national pilot sites for the new classification found:

"In general, phase of care was a concept that NSW sites struggled with, particularly in the admitted setting. Clinicians expressed confusion in relation to what was required to be captured, and the frequency with which this data element was to be reviewed, updated and recorded. Some sites reported that phase of care was determined by relevant clinicians on the wards, and other sites reported that a clinician or study site coordinator reviewed the medical records and associated clinical notes and made a judgement as to whether there had been any changes in the phases of care during the admitted episode. For ambulatory consumers, phase of care was collected for each service contact.

*The general feeling was the use of MHIC codes was subjective. The language within the existing list of MHIC codes had different meanings to different members of staff, which in turn led to varying interpretations and applications. Staff involved in providing extensive multidisciplinary assessments did not find it easy to fully capture the interventions provided with the available MHIC codes. The process of collecting MHIC codes was found to be very labour intensive. One site reported that there was a lack of medical engagement in the collection of MHIC codes, which provided the additional challenge of education of medical staff to use a new set of definitions. For these reasons NSW sites felt there was a lack of consistency in the use and application of MHIC codes."*³⁵

It is clear that the transition to the AMHCC in NSW will take a number of years to complete and embed into mental health service delivery, performance reporting, costing, benchmarking and analysis.

This reinforces the recommendation to proceed cautiously with the replacement of block funding for non-admitted mental health services while a robust data quality framework covering services, costs, performance and outcomes is put in place.

35 HealthConsult Mental Health Costing Study, 2016 op.cit. p46,47 https://www.ihsa.gov.au/sites/g/files/net636/f/publications/mental_health_costing_study.pdf

9.3 DATA ABOUT COSTS AND COST ALLOCATION

In its 2015 report about the introduction of ABF, the NSW Audit Office commented:³⁶

“It is fundamental to Activity Based Funding that information is available on how much an individual patient’s admission has cost the hospital. This information comes from patient activity data and financial data. The method to ‘match’ patient activity data to the relevant financial data is known as the ‘costing process’.”

Across NSW Health, the collection and allocation of cost information has improved enormously over the last four years with the introduction of a comprehensive patient cost collection and allocation system across all health services to support ABF.

In the mental health sphere, the recording of costs has similarly improved, as has the ability to allocate indirect and overhead costs to admitted mental health activity. Due to the data quality issues and lack of an appropriate standardised classification system for non-admitted mental health care, the ability to accurately allocate costs to the types of non-admitted mental health care or to individual clients remains very problematic.

As outlined by the Independent Hospital Pricing Authority patient costing standards, the allocation processes are complex, and good allocation requires advanced knowledge of health service operations.³⁷ Broadly the process of costing services involves four steps:

1. Analysing and grouping the costs recorded in the general ledger to identify costs relevant to the service, mapping these costs to cost centres and categorising the cost centres as final or overhead cost centres.
2. Apportioning the costs in the overhead cost centres to the final cost centres using an appropriate methodology relevant to the type of cost being apportioned and the final cost centre’s fair share of that cost.
3. Partitioning the final cost centres into the patient/client service categories. Ideally, a final cost centre will align with a particular patient/client service category. In most cases, this is not the case and apportionment methodology across patient/client service category becomes very important.
4. The final step is then allocating the costs in each final cost centre patient/client service category to the different classes of service within that category (eg the specific class of admitted mental health care within the admitted mental health care category).

The Audit Office noted:³⁸

“There is a set of statewide guidelines, called ‘Cost Accounting Guidelines’, that govern the costing process at Local Health Districts.We observed a high level of consistency in the governance of costing processes at the Local Health Districts we visited.”

There is also a detailed internal audit process undertaken each year in all health services to help ensure the consistency and integrity of the DNR returns submitted by health services to support the costing process. Together, these appear to provide a sound framework to support ABF with reservations, in relation to mental health, about the completeness and appropriateness of the current diagnosis-based activity classification system, and recording and reporting of non-admitted activity.

36 NSW Audit Office Performance Audit on Activity Based Funding Data Quality, 2015, p9 http://www.audit.nsw.gov.au/ArticleDocuments/554/01_Activity_Based_Funding_Data_Quality_Full_Report.pdf.aspx?Embed=Y.

37 IHPA Australian Hospitals Patient Costing Standards V3.1, 2014, p5 www.ihsa.gov.au/sites/g/files/net636/f/publications/ahpcs-version3.1.pdf

38 NSW Audit Office Performance Audit on Activity Based Funding Data Quality, 2015, p9 http://www.audit.nsw.gov.au/ArticleDocuments/554/01_Activity_Based_Funding_Data_Quality_Full_Report.pdf.aspx?Embed=Y

With mental health services, the core challenge is not with capturing and recording costs or the cost centre structures. The challenge is the lack of a high quality classification system for mental health services and the poor data quality on activity, outputs and outcomes, especially for non-admitted mental health care.

9.4 ALLOCATION OF CORPORATE OVERHEAD AND INDIRECT COSTS

Because of the concerns expressed to the Commission about the allocation of overheads to mental health budgets in some services, it is important to describe the process used for allocating all costs to service groups and patient activity. The NSW Cost Accounting Guidelines provide detailed rules, processes and controls to support appropriate allocation of these corporate overheads and indirect costs.

The costs in designated overhead cost centres are allocated to final cost centres using either direct consumption data (bed days for example) where available or an appropriate allocation statistic. This process yields a set of final cost centres containing fully-absorbed costs that can then be assigned to product categories (mental health admitted patient episodes for example).

The Guidelines list all the 50 overhead cost centres and, for each, the recommended allocation measure to be used, with alternatives where appropriate.³⁹ The following examples illustrate the range of overhead cost centres and allocation measures used.

Overhead cost allocation measure		
Overhead cost centre	Allocation Measure Preferred	Alternative measure
Human resource management	Head count	Full Time Equivalent staff
Redundancy payments	\$ Expenditure on salaries and wages	None
Medical Indemnity insurance	\$ VMO payment	None
Financial administration	Number of transactions in General Ledger	All Expenditure
Linen and Laundry	Actual consumption units by cost centre	Occupied bed days

Overhead costs are allocated initially to final cost centres such as mental health admitted patient services, according to relative levels of resources in these final cost centres (eg overheads for human resources are apportioned according to the headcount in each final cost centre). So, inaccuracies and incompleteness in the recording of activity in mental health non-admitted services, for example, do not lead in themselves to any greater or lesser apportionment of overheads to mental health.

39 NSW Health Cost Accounting Guidelines Vol 2 2015, Appendix 7

However, such incompleteness and poor data quality can lead to over or under estimates of the unit cost for each activity recorded (total costs divided by the volume of activity). This in turn may lead to a mismatch of NWAU pricing using national and state costing studies under the Service Agreement with the Ministry, and an LHD's or SHN's actual costs. In some situations, this may lead to an inappropriate imposition of a transition grant component in the Service Agreement.

9.5 OUTCOME DATA

There is a paucity of publicly reported outcome data for mental health services. This is a feature across the health system, with the possible exceptions of rehabilitation services and cancer services. The Commission also confirmed there are no outcome KPIs for mental health included in the Service Agreements between the Ministry and health services.

The challenges in determining and reporting of outcomes are very real. Outcome measures may require data from a range of care settings and health service providers within and outside of the health service, data from other human service agencies, community-managed organisations and patient and client self-reported data. Reconciliation of patient and client identities in different clinical systems is another challenge. Clinical information systems for admitted, non-admitted and community-based care need to collect the base data required to determine and report outcomes.

Reporting of outcome measures under the Mental Health Outcomes Assessment Tool (MH-OAT) is incomplete. MH-OAT has both clinician-rated and consumer-rated measures. Clinician-rated measures are intended to be completed at assessment, review and discharge/transfer of care. There are different measures addressing the three consumer age groups: child and adolescent (0-17 years), adult (18-64) and older persons (65+).

Consumers are given the opportunity to complete a consumer self-report measure. The adult and older person consumer measure is the Kessler-10 (K10) and the child and adolescent measure is the Strength and Difficulties Questionnaire (SDQ). The K10 provides information on how the consumer has been feeling recently. The SDQ provides information on how an adolescent consumer has been feeling and doing recently.

While the recorded outcome data is included in the six-monthly Clinical Information Benchmarking Reporting tool (CIBRE) provided to NSW mental health services, the LHDs that were part of this review confirmed they were not able to provide a routine summary report on the outcomes for their mental health clients. Summary outcome information is not publicly available for consumers, families and carers or the wider community.

As experienced with other casemix information and ABF data, commencement of reporting of outcomes will provide a catalyst to improve the data quality and utility of the outcome reports.

10. WHAT IS THE RIGHT ROLE FOR NSW LOCAL HEALTH DISTRICTS AND SPECIALITY NETWORKS IN THE FUTURE?

The environment in which NSW public sector mental health services operate is changing significantly.

The creation of 10 Primary Health Networks (PHNs) by the Commonwealth across NSW in July 2015, and the subsequent designated role of the PHNs in mental health service planning, implementation of stepped mental health care, commissioning of headspace and other services for young people and the planned trial of funding for care packages for people living with chronic and complex mental health care needs, is a major change. The PHNs are also taking a greater role in service planning and services for people with alcohol and other drug problems.

The rollout of the National Disability Insurance Scheme over the next two financial years, following pilots across Australia including the Hunter region in NSW, requires a changed approach to meeting the support needs of children, young people and adults living with a chronic mental illness and, importantly, their carers.

For older people with a mental health condition, the consumer directed care and My Aged Care reforms will significantly change the process and provision of social and other support services for these clients.

Major studies are underway to explore better approaches to suicide prevention involving a whole-of-community approach.

Improving social and emotional wellbeing outcomes and closing the gap for Aboriginal and Torres Strait Islander people remains a priority.

Another issue requiring action is the significantly lower life expectancy of people with a chronic mental health condition due to cardiovascular disease, diabetes, high rates of smoking, cancer and other physical health issues. Addressing this issue requires coordination and integration of care, especially between mental health, general practice and other primary health care.

Local Health Districts confirmed that these factors were already changing the way their mental health services were structured and the range of services they offered. One LHD has now withdrawn completely from providing generalist counselling, referring clients instead to community-managed and private sector services.

Increasingly, digital mental health will also change the shape of public sector mental health service provision, providing greater scope for web and mobile based information and support, self care, care co-ordination by other providers and telehealth.

The Ministry has confirmed the need to explore a co-ordinated commissioning approach to mental health services with the public sector health services and the 10 NSW and the ACT PHNs. The Ministry is proposing to map and validate existing services, develop an agreed service mix for people with mental illness and identify and agree service responsibilities with key providers, funders and stakeholders.

The Commission supports an in-depth review of the role of public sector mental health services which has the potential to facilitate:

- better integration of care for consumers, their families and carers;
- implementation of stepped mental health care;
- alignment with the NDIS and My Aged Care initiatives;
- adoption of evidence-based models of care;
- accelerated implementation of *Living Well*; and
- improved purchasing of mental health services by the Ministry under Service Agreements with health services.

11. IMPROVING TRANSPARENCY TO ENHANCE BENCHMARKING, EFFICIENCY, EFFECTIVENESS AND OUTCOMES

NSW LHDs and SHNs now have access to a rich source of information on benchmarked performance and costs for their acute admitted services. Online tools have been developed by the Ministry of Health to support clinicians and managers in the environment of activity-based management. The Activity Based Management Portal (ABM Portal) is a key tool to assist in evaluating the efficiency and efficacy of local health service delivery. It is available to all users across the NSW Health.

The ABM Portal contains patient level activity and costing data for all patient care streams including mental health admitted activity. The data in the ABM Portal covers a period for the last three years and is updated after each DNR costing study (ie six month and annual study). Users can transparently benchmark facilities across NSW public hospitals as well as assess variance and models of care. The ABM Portal also has drilldown capabilities for a detailed review of frequent patient visits to examine journey histories and characteristics and treatment costs.

A National Benchmarking Portal was released by the Independent Hospital Pricing Authority (IHPA) in August this year which is modelled on the NSW ABM Portal and hosted by NSW Health. The National Benchmarking Portal uses data collected through the national Hospital Cost Data Collection provided by states and territories and allows similar benchmarking across all ABF facilities nationally. Consequently, the data is one year older than the NSW ABM Portal and is only updated annually.

The Monthly Monitor is an application that complements the ABM Portal as it contains year-to-date results for all NSW public hospitals – aggregated at the District and Network level. The Monthly Monitor allows users to monitor hospital costs and activity performance on a monthly basis. It also provides for analysis at a class level such as Diagnosis Related Groups (DRGs) and across patient care streams (eg acute admitted stream). It provides immediate visibility on District and Network performance against their Projected Average Cost (PAC), purchased activity and Schedule C expenditure allocation.

However, classification and data quality issues mean that, at present, the comparable information for the cost of mental health services is not as comprehensive as it is for other health services where ABF information is more developed. Cost information is now reported through the ABM Portal for mental health admitted activity, but not yet for non-admitted services.

While benchmarking by health services of the costs and efficiency of their acute admitted services against other NSW health services is now well developed, benchmarking against other Australian, New Zealand and international services is not as well advanced.

A voluntary group of health services across Australia and New Zealand participate in the Health Roundtable.⁴⁰ The Roundtable is a non-profit membership organisation promoting interstate and international collaboration and networking amongst health organisation executives. It collects, analyses and publishes to its members information comparing organisations and identifying ways to improve operational practices. The Roundtable has an active mental health service improvement group.

Among the four LHDs considered in this review, with the exception of Western NSW LHD the reporting to the LHD Executive and Boards did not include benchmarked comparative performance with other LHDs, interstate or international mental health services.

There is very little information easily available to consumers and the general public about the performance of public sector mental health services in NSW.

Comparative benchmarked performance information is an important driver of quality and service improvement for all health services. It is also a catalyst and driver for continuing improvement in data quality and reporting.

40 www.healthroundtable.org

As NSW has now moved from an input focused funding system for mental health services to an output based activity funding system, comparative benchmarked information on performance is needed to inform purchasing decisions and performance monitoring and improvement.

Another perspective for improved transparency is consumer, family and carer opinion and feedback. The Scottish and English National Health Services have now moved to complement patient and consumer surveys with web-based portals enabling patients, families and carers to provide feedback on line.⁴¹

The Bureau of Health Information does not report on the performance of mental health services, other than in its quarterly reports on activity. There is an opportunity for the Bureau to play a role in assisting mental health consumers and the general community, as well as health services, in comparing performance.

41 See Patient Opinion www.patientopinion.org.uk.

12. APPENDICES

12.1 APPENDIX A: 2016-17 TEMPLATE SERVICE AGREEMENT: PERFORMANCE MEASURES

NSW: Making it Happen – Performance Measures

Premier's Priorities

Improving Service Levels at Hospitals – '81 per cent of patients through emergency departments within four hours.'

Key Performance Indicator		Target	Not Performing X	Under Performing ↘	Performing ✓
SERVICE ACCESS AND PATIENT FLOW					
Tier 1	Emergency Treatment Performance - Patients with total time in ED ≤ 4 hrs (%)	≥ 81	< 71	≥ 71 and < 81	≥ 81

Tackling Childhood Obesity – 'Reduce overweight and obesity rates of children by 5 per cent over 10 years'

Key Performance Indicator		Target	Not Performing X	Under Performing ↘	Performing ✓
POPULATION HEALTH					
Tier 2	Healthy Children Initiative - (centre based early childhood service sites) – Adopted (% cumulative)	≥70% of sites adopting KPI target , with ≥ 80% of practices adopted	<60%	60 – 69%	≥70% of sites adopting KPI target , with ≥ 80% of practices adopted
Tier 2	Healthy Children Initiative - (primary school sites) - Adopted (% cumulative)	≥70% of sites adopting KPI target , with ≥ 80% of practices adopted	<60%	60 – 69%	≥70% of sites adopting KPI target , with ≥ 80% of practices adopted

State Priority

Cutting wait times for planned surgeries – 'Increase on-time admissions for planned surgery, in accordance with medical advice.'

Key Performance Indicator		Target	Not Performing X	Under Performing ↘	Performing ✓
SERVICE ACCESS AND PATIENT FLOW					
Elective Surgery Access Performance: Elective Surgery Patients Treated on Time (%):					
Tier 1	• Category 1	100	< 100	N/A	100
Tier 1	• Category 2	≥ 97	< 93	≥ 93 and < 97	≥ 97
Tier 1	• Category 3	≥ 97	< 95	≥ 95 and < 97	≥ 97
Overdue Elective Surgery Patients (number)					
Tier 1	• Category 1	0	≥ 1	N/A	0
Tier 1	• Category 2	0	≥ 1	N/A	0
Tier 1	• Category 3	0	≥ 1	N/A	0

Key Performance Indicators

Key Performance Indicator		Target	Not Performing ✗	Under Performing ⚠	Performing ✓
SERVICE ACCESS AND PATIENT FLOW					
Tier 1	Transfer of Care – patients transferred from Ambulance to ED ≤ 30 minutes (%)	≥ 90	< 80	≥ 80 and < 90	≥ 90
Tier 1	Emergency Treatment Performance - Patients with total time in ED ≤ 4 hrs (%)	≥ 81	< 71	≥ 71 and < 81	≥ 81
Tier 2	Presentations staying in ED > 24 hours (number)	0	>5	≥1 and ≤5	0
Elective Surgery Access Performance: Elective Surgery Patients Treated on Time (%):					
Tier 1	• Category 1	100	< 100	N/A	100
Tier 1	• Category 2	≥ 97	< 93	≥ 93 and < 97	≥ 97
Tier 1	• Category 3	≥ 97	< 95	≥ 95 and < 97	≥ 97
Overdue Elective Surgery Patients (number)					
Tier 1	• Category 1	0	≥ 1	N/A	0
Tier 1	• Category 2	0	≥ 1	N/A	0
Tier 1	• Category 3	0	≥ 1	N/A	0
Tier 2	Mental Health: Presentations staying in ED > 24 hours (number)	0	> 5	≥ 1 and ≤ 5	0
Tier 2	Non-Urgent Patients waiting > 365 days for an initial specialist outpatient services appointment (Number)	0	Increase from previous Year	Decrease from previous Year	0
Tier 2	Electronic Discharge Summaries Completed (%)	Increase	Decrease from previous month	No change	Increase on previous month
PEOPLE AND CULTURE					
Tier 2	Staff who have had a performance review within the last 12 months (%)	100	< 85	≥ 85 and < 90	≥ 90
INTEGRATED CARE					
Tier 2	Integrated Care Program transition performance (%)	See Data Dictionary Item	< 80	≥ 80 and < 100	= 100

Key Performance Indicator		Target	Not Performing ✗	Under Performing ⬇️	Performing ✓
FINANCE AND ACTIVITY					
Variation against purchased volume (%)					
Tier 1	Acute Inpatient Services (NWAU)	See Schedule D	> +/- 2.0 variation from target	+/- >1.0 - ≤2.0 variation from target	+/- 1.0 variation from target
Tier 1	Emergency Department Services (NWAU)	See Schedule D	> +/- 2.0 variation from target	+/- >1.0 - ≤2.0 variation from target	+/- 1.0 variation from target
Tier 1	Sub and Non Acute Inpatient Services (NWAU)	See Schedule D	> +/- 2.0 variation from target	+/- >1.0 - ≤2.0 variation from target	+/- 1.0 variation from target
Tier 1	Non Admitted Patient Services – Tier 2 Clinics (NWAU)	See Schedule D	> +/- 2.0 variation from target	+/- >1.0 - ≤2.0 variation from target	+/- 1.0 variation from target
Tier 1	Mental Health Inpatient Activity Acute Inpatients (NWAU)	See Schedule D	> +/- 2.0 variation from target	+/- >1.0 - ≤2.0 variation from target	+/- 1.0 variation from target
Tier 1	Mental Health Inpatient Activity Non Acute Inpatients (NWAU)	See Schedule D	> +/- 2.0 variation from target	+/- >1.0 - ≤2.0 variation from target	+/- 1.0 variation from target
Tier 2	Mental Health Non Admitted services (NWAU)	See Schedule D	> +/- 2.0 variation from target	+/- >1.0 - ≤2.0 variation from target	+/- 1.0 variation from target
Tier 2	Public Dental Clinical Service (DWAU)	100	<100	N/A	≥ 100
Expenditure matched to budget (General Fund):					
Tier 1	a) Year to date - General Fund (%)	On budget or Favourable	> 0.5 Unfavourable	> 0 but ≤ 0.5 Unfavourable	On budget or Favourable
Tier 1	b) June projection - General Fund (%)	On budget or Favourable	> 0.5 Unfavourable	> 0 but ≤ 0.5 Unfavourable	On budget or Favourable
Own Source Revenue Matched to budget (General Fund):					
Tier 1	a) Year to date - General Fund (%)	On budget or Favourable	> 0.5 Unfavourable	> 0 but ≤ 0.5 Unfavourable	On budget or Favourable
Tier 1	b) June projection - General Fund (%)	On budget or Favourable	> 0.5 Unfavourable	>0 but ≤ 0.5 Unfavourable	On budget or Favourable
Liquidity					
Tier 1	Recurrent Trade Creditors > 45 days correct and ready for payment (\$)	0	> 0	N/A	0
Tier 1	Small Business Creditors paid within 30 days from receipt of a correctly rendered invoice (%)	100	< 100	N/A	100

Key Performance Indicator		Target	Not Performing ✗	Under Performing ⬇️	Performing ✓
POPULATION HEALTH					
Tier 2	HIV testing increase within publicly-funded HIV and sexual health services (% increase)	See Data Dictionary Item	> 5.0 % variation below Target	≤ 5.0 % variation below Target	Met or exceeded Target
Tier 2	Get Healthy Information and Coaching Service – Health Professional Referrals (% increase)	See Data Dictionary Item	> 10.0 % variation below Target	≤ 10.0 % variation below Target	Met or exceeded Target
Tier 2	Healthy Children Initiative Program (centre based childhood service sites) - Adopted (% cumulative)	≥70% of sites adopting KPI target , with ≥ 80% of practices adopted	<60%	60 – 69%	≥70% of sites adopting KPI target , with ≥ 80% of practices adopted
Tier 2	Healthy Children Initiative Program (primary school sites) - Adopted (% cumulative)	≥70% of sites adopting KPI target , with ≥ 80% of practices adopted	<60%	60 – 69%	≥70% of sites adopting KPI target , with ≥ 80% of practices adopted
SAFETY AND QUALITY					
Tier 1	Staphylococcus aureus bloodstream infections (SA-BSI) (per 10,000 occupied bed days)	< 2	≥ 2.0	N/A	< 2
Tier 2	Patient Experience Survey following treatment: Overall rating of care received - Adult Admitted Patients - good or very good (%)	Increase	Decrease from previous Year	No change	Increase from previous Year
Tier 2	Hospital acquired pressure injuries (rate per 1,000 completed inpatient stays)	Decrease	Increase from previous Year	No change	Decrease from previous Year
Tier 2	Mental Health: Acute readmission within 28 days (%)	≤ 13	≥ 20	> 13 and < 20	≤ 13
Tier 2	Mental Health: Acute Post-Discharge Community Care - follow up within seven days (%)	≥ 70	< 50	≥ 50 and < 70	≥ 70
Tier 2	Mental Health: Acute Seclusion rate (episodes per 1,000 bed days)	< 6.8	≥ 9.9	≥ 6.8 and < 9.9	< 6.8

Key Performance Indicator		Target	Not Performing X	Under Performing ↘	Performing ✓
MENTAL HEALTH REFORM					
Tier 2	Pathways to Community Living Initiative - People comprehensively assessed (Number)	Increase	Decrease from previous quarter	No change	Increase on previous quarter
Tier 2	Mental Health Peer Workforce FTEs (Number)	Increase	Decrease from previous quarter	No change	Increase on previous quarter

Service Measures

SAFETY AND QUALITY	
Deteriorating Patients (rate per 1,000 separations): <ul style="list-style-type: none"> Rapid response calls Cardio respiratory arrests 	
Unplanned hospital readmission rates (%) for patients discharged following management of: <ul style="list-style-type: none"> Acute Myocardial Infarction Heart Failure Knee and hip replacements Pediatric tonsillectomy and adenoidectomy 	
ICU Central Line Associated Bloodstream (CLAB) Infections (number)	
Incorrect procedures: Operating Theatre - resulting in death or major permanent loss of function (number)	
Hospital acquired venous thromboembolism (rate per 1,000 separations)	
Inpatients who were discharged against medical advice (%): <ul style="list-style-type: none"> Aboriginal Non-Aboriginal 	
Re-treatment following restorative treatment: Number of permanent teeth re-treated within 6 months of an episode of restorative treatment. Performance target: less than 6% (less than 6 teeth re-treated per 100 teeth restored).	
Denture remakes: Number of same denture type (full or partial) and same arch remade within 12 months. Performance target: less than 3% (less than 3 per 100 dentures).	
Patient Experience Survey – Emergency Department Patients: Overall rating of care - good and very good (%)	
Mental Health: <ul style="list-style-type: none"> Outcomes readiness (HoNOS completion rates) - (% of mental health episodes with completed HoNOS outcome measures) Consumer Experience Measure (YES) Completion Rate - (% of episodes) Average duration of seclusion - (Hours) Frequency of seclusion - (% of acute mental-health admitted care episodes with seclusion) Involuntary patients absconded from an inpatient mental health unit (number) 	
SERVICE ACCESS AND PATIENT FLOW	
Patients with total time in ED ≤ 4 hrs (%): <ul style="list-style-type: none"> Admitted (to a ward/ICU/theatre from ED) Not Admitted (to an Inpatient Unit from ED) Mental Health Patients (admitted to a ward from ED) 	

SERVICE ACCESS AND PATIENT FLOW (continues)

ED presentations treated within benchmark times (%):

- Triage 1
- Triage 2
- Triage 3
- Triage 4
- Triage 5

Elective Surgery: Activity compared to previous year (Number)

Elective Surgery Theatre Utilisation: Operating Room Occupancy (%)

Surgery for Children - Proportion of children (to 16 years) treated within their LHD of residence:

- Emergency Surgery (%)
- Planned Surgery (%)

Average Length of Episode Stay - Overnight Patients (days)

Acute to Aged-Related Care Services patients seen (number)

Aged Care Services in Emergency Teams patients seen (number)

Breast Screen Participation Rates, disaggregated by Aboriginality and cultural and linguistic diversity (%):

- Women, aged 50-69
- Women, aged 70-74

Home Based Dialysis – Proportion of renal dialysis service events that are home based (%)

INTEGRATED CARE

Unplanned hospital readmissions: all admissions within 28 days of separation (%):

- All persons
- Aboriginal persons
- ABF hospitals (rate in NWAU)

Unplanned and Emergency Re-Presentations to same ED within 48 hours (%):

- All persons
- Aboriginal persons
- ABF hospitals (rate in NWAU)

Hospital in the Home (HITH) Admitted activity (%)

Potentially Preventable Hospitalisations (Rate per 100,000 population)

Electronic Discharge Summaries (%):

- accepted by a General Practitioner (GP) system
- acknowledged by a patient's GP

FINANCE AND ACTIVITY

Specialist Outpatient Services (Service events)

- Initial
- Subsequent

Patient Fee Debtors > 45 days as a percentage of rolling prior 12 months Patient Fee Revenues (%)

Coding timeliness: % uncoded acute separations

ED records unable to be grouped:

- to URG with a breakdown for error codes: E1, E2, E3, E6, E7 and E8 (number and %)
- to UDG with a breakdown for error codes: E1 and E2 (number and %)

NAP data completeness:

- Patient Level (%)

FINANCE AND ACTIVITY (continued)

Wait List Enterprise Data Warehouse data errors, reported separately and disaggregated by error source (%):

- Source System error (issues related to the EDW extract or mappings defects)
- Data collection error (issues related to the actual data collected or reported)
- System Vendor error (issues related to source system defects)

Sub and Non Acute Inpatient Services - Grouped to an AN-SNAP class (%)

PEOPLE AND CULTURE

Workplace Injuries:

- Claims (rate per 100 FTEs)
- Return to work experience -Continuous Average Duration (days)

Premium staff usage - average paid hours per FTE (Hours):

- Medical
- Nursing

Reduction in the number of employees with accrued annual leave balances of more than 30 days(Number)

Recruitment: improvement on baseline average time taken from request to recruit to decision to approve/decline/defer recruitment (days)

Aboriginal Workforce as a proportion of total workforce (%)

Public Service Commission (PSC) People Matter Survey (%)

- Estimated Response Rate
- Engagement Index

POPULATION HEALTH

Quit for New Life Program (%)

- Referred to the Quitline
- Provided Nicotine Replacement Therapy (NRT)
- Booked follow-up Appointment

Children fully immunised (%)

- At one year of age: Non- Aboriginal children
- At one year of age: Aboriginal children
- At four years of age: Non- Aboriginal children
- At four years of age: Aboriginal children

Human papillomavirus vaccine – year 7 students receiving the third dose through the NSW Adolescent Vaccination Program (%)

Comprehensive antenatal visits for all pregnant women before 14 weeks gestation (%)

- Who are Aboriginal
- Who are non-Aboriginal with an Aboriginal baby
- Who are non-Aboriginal with a non-Aboriginal baby
- All women

Women who smoked at any time during pregnancy (%):

- Aboriginal women
- Non-Aboriginal women

Tobacco compliance monitoring: compliance with the Smoke-free Health Care Policy (%)

Organ and Tissue donation –

- Family discussed (%)
- Family consented (%)

MATERNAL, CHILD, YOUTH AND FAMILY SERVICES

Domestic and Family Violence Screening - Routine Domestic Violence Screens conducted (%)

Out of Home Care Health Pathway Program - Children and young people that complete a primary health assessment (%)

Sexual Assault Services – High priority referrals to Sexual Assault Services receiving an initial psychosocial assessment (%)

12.2 APPENDIX B:

EXAMPLE OF AN LHD MENTAL HEALTH BUDGET: OVERVIEW, ALLOCATION TO DIRECTOR OF MENTAL HEALTH AND ALLOCATION BY SERVICE STREAM

Mental Health Approved budget, allocation of the budget and financial result				
Schedule C BUDGETS	2013/14	2014/15	2015/16	
Initial Budget - As per Schedule C: Item C	\$143,692,404	\$163,538,612	\$177,235,975	
Initial Budget - As per Schedule C: Item D	\$4,091,767	\$6,966,864	\$8,772,361	
Initial Budget - As per Schedule C: Item E	\$2,333,890	\$2,218,289	\$3,995,693	
Total Schedule C Initial Budget	\$150,118,061	\$172,723,765	\$190,004,029	
Supplementations				
Final Budget (Fully absorbed)	\$150,118,061	\$172,723,765	\$190,004,029	
Budget allocations - As per GL				
Schedule C related	\$139,399,110	\$142,184,162	\$146,202,699	SMRS verifiable
Non Sched C related (refer table XX)	\$497,464	\$69,379	\$334,054	SMRS verifiable
Directly Allocated to Director, MH:	\$139,896,574	\$142,253,541	\$146,536,753	SMRS verifiable
Budget not directly allocated to Dir, MH #:	\$10,221,487	\$30,470,224	\$43,467,276	Balancing item
Grand Total:	\$150,118,061	\$172,723,765	\$190,004,029	
# Pharmacy etc for which budgets are held elsewhere				
Expenditure against budgets	2013/14	2014/15	2015/16	
Schedule C related	\$137,765,651	\$141,010,732	\$147,340,115	SMRS verifiable
Non Sched C related (refer table XX)	\$497,463	70,136	\$213,966	SMRS verifiable
As per GL: Directly expensed by Director, MH:	\$138,263,114	\$141,080,867	\$147,554,080	SMRS verifiable
Expense not directly allocated to Dir, MH:	\$49,349,580	\$58,772,206	\$61,468,850	Balancing item
DNR Grand Total :	\$187,612,695	\$199,853,073	\$209,022,930	from Costing
Schedule C related DNR Expense	\$172,867,111	\$184,503,593	\$192,969,170	
Non Sched C related (refer table XX) DNR Expense	\$14,745,584	\$15,349,480	\$16,053,760	
Variance - Budget to Expenditure:	\$22,749,050	\$11,779,828	\$2,965,141	

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Mental Health Approved budget, allocation of the budget and financial result

EXPENDITURE AGAINST BUDGETS GROUPED INTO ITEMS

	6 months escalated		
	2013/14	2014/15	2015/16
Total Expenditure			
Employee Related	17,451,904	124,180,092	129,877,846
VMO Payments	4,928,342	5,500,524	5,752,904
Goods & Services	44,293,606	47,168,195	49,332,413
Repairs, Maintenance & Renewals	4,347,337	5,785,678	6,051,143
Grants	1,845,921	1,869,104	1,954,864
Total DNR Expenditure	\$172,867,111	\$184,503,593	\$192,969,170
Depreciation, Amortisation and Non Sched C expenditure	14,745,584	\$15,349,480	\$16,053,760
Total Expenditure	\$187,612,695	\$199,853,073	\$209,022,930
Budget Expenditure by Streams:	2013/14	2014/15	2015/16
Acute Admitted	78,897,228	82,305,111	86,081,516
Sub-Acute Admitted	40,583,933	41,724,243	43,638,676
Non-Admitted & Community	64,333,951	64,106,492	67,047,890
Teaching, Training & Research	3,797,582	11,717,227	12,254,848
Others	\$187,612,695	\$199,853,073	\$209,022,930
FTE Split: Overall	2013/14	2014/15	2015/16
Medical	111.9	117.0	114.6
Nursing	638.5	625.0	648.6
Allied Health	231.1	236.3	237.8
Other	184.7	198.3	204.0

SCHEDULE C: Budget

Part 1

Northern Sydney LHD - Budget 2016/17									
2016/17 BUDGET									
	A	B	C	D	E	F	G	H	I
	Target Volume (NWAU16)	Volume (Admissions & Attendances) Indicative only	State Price per NWAU16	LHD/SHN Projected Average Cost per NWAU16	Initial Budget 2016/17 (\$ '000)	2015/16 Annualised Budget (\$ '000)	Variance Initial and Annualised (\$ '000)	Variance (%)	Volume Forecast 2015/16 (NWAU16)
A	Acute Admitted	126,795			\$583,890	\$562,910	\$20,980		124,157
	Incl. activity for Spinal Plastics and Rehabilitation Services								
	Emergency Department	28,225	\$4,605	\$4,700	\$129,975	\$123,463	\$6,511		27,323
	Incl. activity for Increased ED Demand								
A	Non Admitted Patients ^α	30,853			\$113,535	\$109,087	\$4,448		30,415
	Total	185,873			\$827,400	\$795,461	\$31,939	4.0%	181,895
B	Sub-Acute Services - Admitted	14,561			\$67,056	\$64,663	\$2,393		14,354
	Sub-Acute Services - Non Admitted ^α	1,771			\$6,495	\$6,356	\$139		1,771
B	Total	16,333			\$73,551	\$71,019	\$2,532	3.6%	16,125
C	Mental Health - Admitted (Acute and Sub-Acute)	18,952			\$87,275	\$84,542	\$2,733		18,764
	Mental Health - Block Funded Hospitals				\$4,999	\$4,892	\$107		
	Mental Health - Non Admitted ^α	25,384	\$4,605	\$4,700	\$58,282	\$55,745	\$2,537		25,104
	Mental Health - Transition Grant				\$10,655	\$10,427	\$228		
C	Total	44,336			\$161,210	\$155,606	\$5,604	3.6%	43,868
D	Block Funding Allocation								
	Block Funded Hospitals (Small Hospitals)				\$29,037	\$28,415	\$622		
	Block Funded Services In-Scope								
	- Teaching, Training and Research				\$53,294	\$52,153	\$1,141		
D	Total				\$82,331	\$80,569	\$1,762	2.2%	
E	State Only Block Funded Services Total				\$255,970	\$250,490	\$5,479	2.2%	
	Transition Grant				\$2,841				
F	Total Transition Grant (excluding Mental Health) ^β				\$2,841	\$2,781	\$61	2.2%	
G	Gross-Up (Private Patient Service Adjustments)				\$65,350	\$63,951	\$1,399	2.2%	
H	Provision for Specific Initiatives & TMF Adjustments (not included above)								
	Highly Specialised Services				\$460				
	Syrian Refugees Health Services				\$97				
	Premier's Priority - Tackling Obesity (Healthy Children's Initiative)				\$576				
	TMF Premium Adjustments				\$789				
	JIRT Enhancement				\$163				
	Security Action Plan - Additional Security staff				\$84				
	Commonwealth Dental (NPA)				\$1,747				
	Election Commitment - Additional Nursing, Midwifery and Support positions				\$601				
	Total				\$4,516		\$4,516		
I	Restricted Financial Asset Expenses				\$15,433	\$15,433			
J	Depreciation (General Funds only)				\$66,691	\$66,691			
K	Total Expenses (K=A+B+C+D+E+F+G+H+I+J)				\$1,555,292	\$1,501,999	\$53,293	3.5%	
L	Other - Gain/Loss on disposal of assets etc				\$1,500	\$1,500			
M	LHD Revenue				-\$1,511,796	-\$1,436,465	-\$75,331		
N	Net Result (N=K+L+M)				\$44,996	\$67,034			

General Note - ABF Growth is funded at 100% of State Price for Acute, Acute Mental Health, ED, Non Admitted and Sub-Acute Admitted services.

^α See Notes and Glossary for calculation of Non Admitted Budget

^β Part of the Acute and ED transition grant has been used to fund growth (see Schedule C glossary).

Part 2

Schedule C Part 2	2016/17	
	Northern Sydney LHD	\$ (000's)
	<u>Government Grants</u>	
A	Subsidy*	-\$866,428
B	In-Scope Services - Block Funded	-\$124,528
C	Out of Scope Services - Block Funded	-\$199,131
D	Capital Subsidy and Grants (incl. MWE>\$10k)	-\$20,733
E	Crown Acceptance (Super, LSL)	-\$27,841
F	Total Government Contribution (F=A+B+C+D+E)	-\$1,238,660
	<u>Own Source revenue</u>	
G	GF Revenue	-\$256,620
H	Restricted Financial Asset Revenue	-\$16,516
I	Total Own Source Revenue (I=G+H)	-\$273,136
J	Total Revenue (J=F+I)	-\$1,511,796
K	Total Expense Budget - General Funds	\$1,539,859
L	Restricted Financial Asset Expense Budget	\$15,433
M	Other Expense Budget	\$1,500
N	Total Expense Budget as per Attachment C Part 1 (N=K+L+M)	\$1,556,792
O	Net Result (O=J+N)	\$44,996
	<u>Net Result Represented by:</u>	
P	Asset Movements	\$42,966
Q	Liability Movements	\$2,030
R	Entity Transfers	
S	Total (S=P+Q+R)	\$44,996
Note: The minimum weekly cash reserve buffer for unrestricted cash at bank has been updated for FY 2016/17 to \$5.9m and remains at approximately 4 days' cash expenses after removing Depreciation, Crown Acceptance and MOH Holdbacks). Based on final June 2016 cash balances, adjustments will be made in July 2016 to ensure alignment with the cash buffer requirements of NSW Treasury Circular TC15_01 Cash Management – Expanding the Scope of the Treasury Banking System. The Ministry will closely monitor cash at bank balances during the year to ensure compliance with this NSW Treasury policy. * The subsidy amount does not include items E and G, which are revenue receipts retained by the LHDs/SHNs and sit outside the National Pool.		

Part 3

2016/17 Shared Services & Consolidated Statewide Payment Schedule			
Schedule C Part 3	Northern Sydney LHD		\$ (000's)
	HS Charges	HS Service Centres	\$5,980
		HS Service Centres Warehousing	\$20,560
		HS Enable NSW	\$3,440
		HS Food Services	\$17,282
		HS Linen Services	\$7,933
		HS Recoups	\$8,100
		HS IPTAAS	\$16
		HS Non Emergency Patient Transport (NEPT)	\$2,831
		Total HSS Charges	\$66,142
	eHealth	EH Corporate IT	\$3,293
		EH Information Services SPA	\$8,500
		Total eHealth Charges	\$11,794
	IH Transports	Interhospital Ambulance Transports	\$3,851
		Interhospital Ambulance NETS	\$61
		Total Interhospital Ambulance Charges	\$3,912
		Interhospital NETS Charges - SCHN	\$157
	Payroll	Total Payroll (including SGC, FSS, Excluding LSL & PAYG)	\$754,400
	Loans	MoH Loan Repayments	
		Treasury Loan (SEDA)	\$104
		Total Loans	\$104
	Blood and Blood Products		\$9,010
	NSW Pathology		\$35,521
	Compacts (HSSG)		\$2,519
	TMF Insurances (WC, MV & Property)		\$11,555
	Energy Australia		\$8,486
	Total		\$903,600
	Note: This schedule represents initial estimates of Statewide recoveries processed by the Ministry on behalf of Service Providers. LHD's are responsible for regularly reviewing these estimates and liaising with the Ministry where there are discrepancies. The Ministry will work with LHD's and Service Providers throughout the year to ensure cash held back for these payments reflects actual trends.		

Part 4

2016-17 National Health Funding Body Service Agreement - Northern Sydney LHD

Period: 1 July 2016 - 30 June 2017

Schedule C Part 4			
		National Reform Agreement In-Scope Estimated National Weighted Activity Units	Commonwealth Funding Contribution
	Acute	117,087	
	ED	26,502	
	Mental Health	11,686	
	Sub Acute	20,370	
	Non Admitted	27,505	
	Activity Based Funding Total	203,150	
	Block Funding Total		\$62,431,512
	Total	203,150	\$62,431,512

12.4 APPENDIX D: THE AUSTRALIAN MENTAL HEALTH CARE CLASSIFICATION SYSTEM [AMHCC]

The Australian Mental Health Care Classification System and the “phase of care” concept

The mental health phase of care concept was developed in 2012, through a project commissioned by the Independent Hospital Pricing Authority (IHPA). This project identified possible cost drivers for further examination and considered options for a classification architecture. More than 500 stakeholders were consulted.

The proposed architecture segregated an episode of care into defined mental health phases of care. The episode of care is defined as the period between the commencement and completion of care characterised by the mental health care type⁴². The new concept of mental health phase of care was initially tested in the Mental Health Costing Study, a national study that involved 26 hospital service sites across Australia.

The mental health phase of care concept was also tested in the AMHCC pilot in late 2015, at four hospital service sites across Australia. The following guide was originally trialled in the pilot and has since been further refined through additional consultation to ensure mental health phase of care is adequately described.

The guide also includes exemplars developed by experienced clinicians to offer guidance in assigning the correct mental health phase of care to a consumer. These exemplars describe a range of symptoms, behaviours and functional abilities that consumers may experience while in contact with services and do not describe real people or events.

Definition⁴³

The mental health phase of care is a prospective description of the primary goal of care for a consumer at a point in time. While many factors can impact on the consumer’s mental health care plan, the mental health phase of care is intended to identify the primary goal of care by the treating professional(s) through engagement with the consumer. The mental health phase of care is independent of both the treatment setting and the designation of the treating service, and does not reflect service unit type.

The setting in which the consumer is treated depends upon the level of risk, the responsiveness of the consumer to engage with services, treatments and supports, and the type of care to be delivered.

A new mental health phase of care may begin either when a consumer commences an episode of care or when the primary goal of care changes in an existing episode of care. Mental health phase of care should be therefore be considered as a subset of an episode of care, meaning that for each episode there can be multiple mental health phases of care. The clinician’s description of the mental health phase of care is not a replacement for a comprehensive mental health care plan.

There are five mental health phases of care:

- Acute
- Functional gain
- Intensive extended
- Consolidating gain

42 meteor.aihw.gov.au/content/index.phtml/itemId/614240 (accessed on 30 May 2016)

43 <https://www.ihsa.gov.au/publications/mental-health-phase-care-guide-p5>

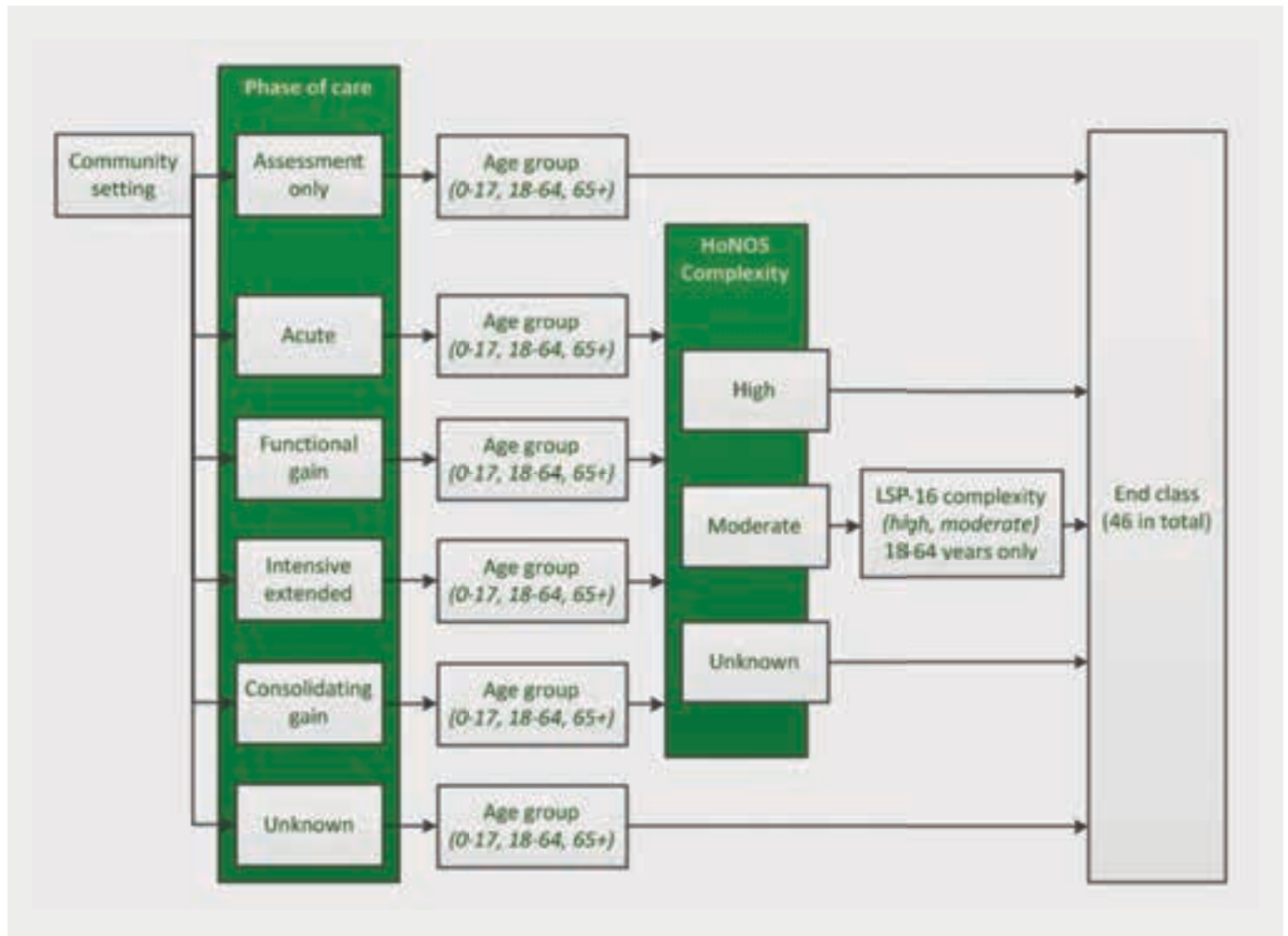
- Assessment only

The concept of mental health phase of care forms part of the AMHCC which also includes the collection of the Health of the Nation Outcomes Scales (HoNOS), a brief measure of the severity of consumer's problems, and the Life Skills Profile (LSP-16), a measure of consumer functioning.⁴⁴

The mental health phase of care concept provides additional information describing the complexity of the consumer's presentation and the primary goal of care.

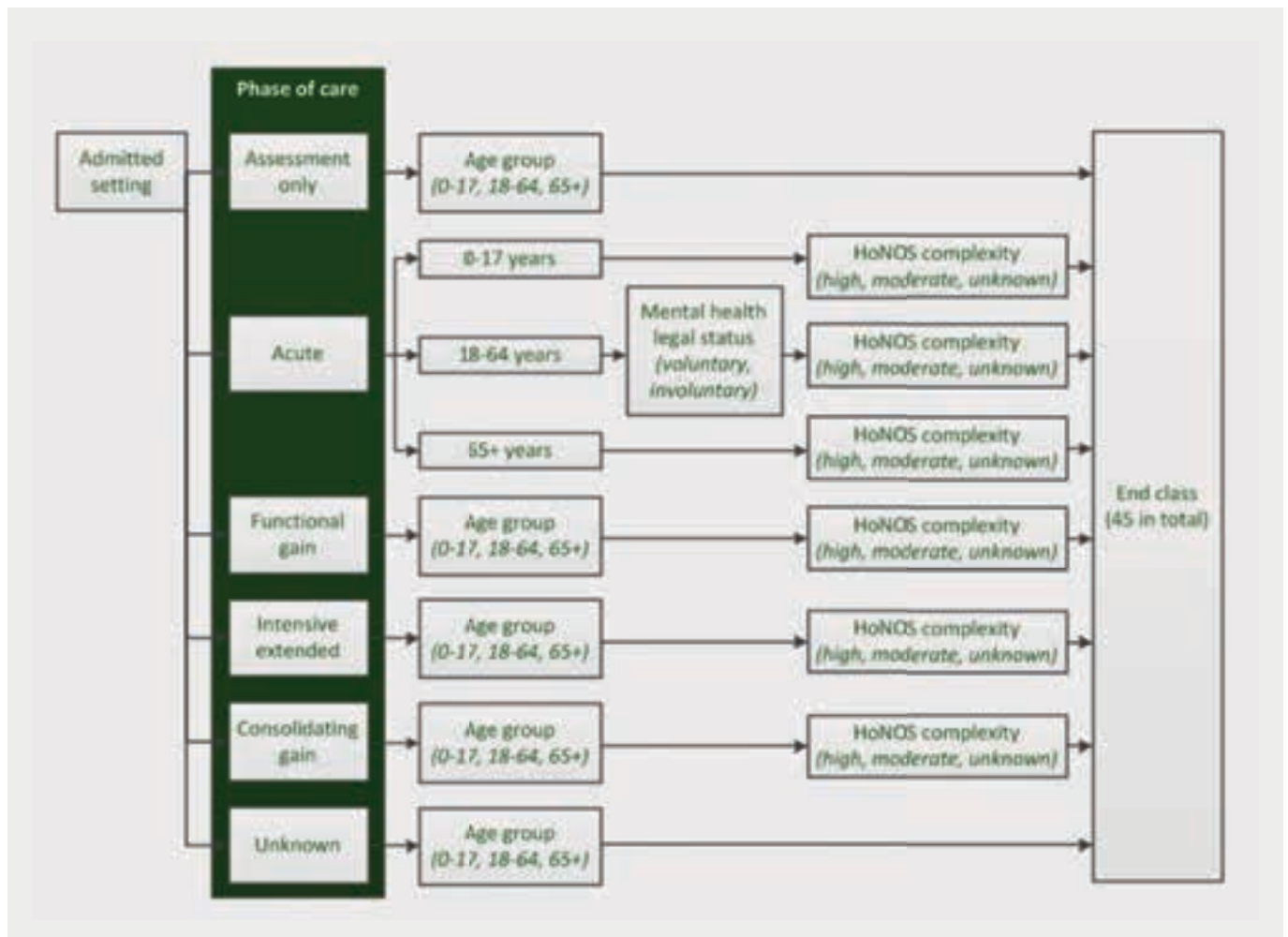
There are a total of 46 classes in the community setting, including 15 end classes resulting from unknown mental health phase of care or unknown HoNOS scores.

The following diagrams provide an overview of the structure of the community setting and admitted setting for the AMHCC Version 1.0.⁴⁵



44 Note: HONOS does not set targets or specify interventions. It is used to rate 'health outcomes' not 'health care outcomes' so interventions are not taken into consideration when rating progress.

45 <https://www.ihsa.gov.au/publications/amhcc-user-manual> p12



There are a total of 45 classes in the admitted setting, including 16 end classes resulting from unknown mental health phases of care or unknown HoNOS scores.

Ensuring the transparency of mental health spending

Our observations, in engaging with LHDs, were that, although funds for mental health are ostensibly quarantined, in practice they may be diverted to other areas within LHDs. The current difficult financial environment within the health sector and Government more generally has amplified the risk that mental health services may not receive their funding allocation, and this is particularly true for community mental health services. A lack of transparency in mental health funding within many LHDs makes this difficult to challenge when it occurs.

In addition, we were advised that some LHD mental health directors do not have control over their budgets and are unable to approve the recruitment of staff. Approval to recruit is not always forthcoming or is substantially delayed. This results in a workforce shortfall, especially across community-based services, and in effect also diverts funding away from mental health.

Mental health budgets can be depleted in a number of ways including:

- charging excessive or duplicated fees for corporate services
- charging excessive levies for items such as information technology, financial services and executive salaries
- requiring unreasonable efficiency or productivity savings
- imposing unreasonable revenue targets
- instituting unreasonable salary caps and position freezes, and delaying advertisement of vacancies
- using the deletion of vacant positions to divert funds to other LHD programs
- restricting spending to generate cash savings, in order to offset budget issues in other programs and in the overall LHD financial position.

The Commission believes that steps are required in some LHDs to preserve and stabilise existing mental health service and state-wide specialty mental health service budgets by eliminating any excessive extraction of overheads and levies from LHD mental health budgets.

Funding is critical to the reform agenda

This is not a new issue. There have been long-standing calls for mental health funding to be quarantined and successive commitments to ensure that this is so. Indeed, bi-partisan concern for the protection of mental health budgets was central to Parliament's support for the establishment of the Mental Health Commission of NSW.

In an environment where available funding currently falls short of the needs of reform, it is imperative that the 2013-2014 \$1.45 billion mental health services budget allocated in the Budget Papers and supported by the NSW Parliament are deployed as intended. Moreover, the thrust of current reforms is to give priority to community based services. While this will require increased funding to these services over time, it will be critical to ensure that existing mental health funding is transparent and acquitted appropriately.

The Ministry of Health has acknowledged during the consultation process that improving the transparency and governance of mental health spending is essential in order to ensure the promise of reform is fulfilled.

