ACT Government
Health

ACT Government Health Directorate

Annual Report 2011–12

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Transmittal Certificate

ACT Government
Health

Ms Katy Gallagher MLA
Minister for Health
ACT Legislative Assembly
London Circuit
CANBERRA ACT 2601

Dear Minister

This report has been prepared under section 5(1) of the *Annual Reports (Government Agencies) Act 2004* and in accordance with the requirements referred to in the Chief Minister's Annual Report Directions.

It has been prepared in conformity with other legislation applicable to the preparation of the Annual Report by the Health Directorate.

I hereby certify that the attached Annual Report is an honest and accurate account and that all material information on the operations of the Health Directorate during the period 1 July 2011 to 30 June 2012 has been included and that it complies with the Chief Minister's Annual Report Directions.

I also hereby certify that fraud prevention has been managed in accordance with Public Sector Management Standard 2, Part 2.4.

Section 13 of the *Annual Reports (Government Agencies) Act 2004* requires that you cause a copy of the report to be laid before the Legislative Assembly within three months of the end of the financial year.

Yours sincerely

Dr Peggy Brown
Director-General

13 September 2012

Aids to access

The table of contents and alphabetical index appear respectively at the beginning and end of the report.

Abbreviations and acronyms

ABA	Australian Breastfeeding Association
ABS	Australian Bureau of Statistics
ACAT	Aged Care Assessment Team
ACHS	Australian Council on Healthcare Standards
ACORN	Australian College of Operating Room Nurses
ACTALS	ACT Artificial Limb Scheme
ACTG	ACT Government Solicitor
ACTGHS	ACT General Health Survey
ACTPS	ACT Public Service
AHA	Allied Health Assistant
AHPRA	Australian Health Practitioner Regulation Agency
AIDS	Acquired Immune Deficiency Syndrome
AIHW	Australian Institute of Health and Welfare
AMAP	Aboriginal Midwifery Access Program
AMC	Alexander Maconochie Centre
ANU	Australian National University
ASSAD	Australian Secondary Students Alcohol and Drug
ATODA	Alcohol, Tobacco and Other Drug Association ACT
AVA	Australian Veterinary Association
AVBC	Australasian Veterinary Boards Council
AWA	Australian Workplace Agreement
AYAMHIU	Adolescent and Young Adult Mental Health Inpatient Unit
BISC	Breastfeeding Initiative Steering Committee
BJOG	National Breastfeeding Jurisdictional Senior Officials Group
CADP	Capital Asset Development Plan
CALD	Culturally and Linguistically Diverse
CAHMA	Canberra Alliance for Harm Minimisation and Advocacy
CAMHS	Child and Adolescent Mental Health Service
CatCH Program	Continuity at the Canberra Hospital
CCP	Chronic Care Program
CHO	Chief Health Officer
CDN/Ms	Clinical Development Nurses and Midwivaes
CeRAPH	Centre for Research and Action in Public Health
CFACT	Clinical Forensics ACT
CFET	Consumer Feedback and Engagement Team
CFMS	Clinical Forensic Medical Services
CFR	Community Funding Round
CHF	Chronic heart failure
CHC ACT	Calvary Health Care ACT
CH&HS	Canberra Hospital & Health Services
CIMS	Cancer Information Management System
CIT	Canberra Institute of Technology
COAG	Council of Australian Governments
CMP	Canberra Midwifery Program
COPD	Chronic Obstructive Pulmonary Disease
CPD	Continuing Professional Development
CPOE	Computerised Physician Order Entry
CPP	Community Partners Program
CRCS	Capital Region Cancer Service
CRT	Community Rehabilitation Team
CSS	Commonwealth Superannuation Scheme
CVAD	Central Venous Access Devices
DARS	Driver Assessment and Rehabilitation Service
DDG	Deputy Director-General
DG	Director-General
DHP	Dental Health Program

DMFT	Decayed, missing or filled teeth
ECCHO	Effective Communication in Clinical Handover
ECT	Electro-convulsive therapy
ED	Emergency Department
EDSU	Extended Day Surgery Unit
EIPP	ACT Early Intervention Pilot Project
EISGP	Education Infrastructure Support Grant Payment
ELS	Equipment Loan Service
EMR	Electronic Medical Record
EN	Enrolled Nurse
ESA	ACT Emergency Services Agency
ESAP	Elective Surgery Access Project
ESD	Ecologically Sustainable Development/ Environmentally Sustainable Design
FAMSAC	Forensic and Medical Sexual Assault Care
FMA	Financial Management Act 1996
FOI	Freedom of Information
FPFR	Falls Prevention Funding Round
FTE	Full-time equivalent
GAAP	Generally Accepted Accounting Principles
GM	Genetically modified
GP	General practitioner/general practice
GPADS	GP Aged Day Service
GPO	Government Payments for Outputs/ General Post Office
GPWWG	GP Workforce Working Group
GST	Goods and Services Tax
HACC	Home and Community Care
HASI	Housing Assistance Support Initiative
HCCA	Health Care Consumers' Association of the ACT
HCI	Healthy Communities Initiative
HDR	High dose rate
HEAL	Healthy Eating and Active Lifestyles
HIP	Health Infrastructure Program
HITH	Hospital in the Home
HIV	Human Immunodeficiency Virus
HPS	Health Protection Service
HREC	Human Research Ethics Committee
HTAC	Health Technology Advisory Committee
HWA	Health Workforce Australia
HYPP	Housing for Young People Program
ICU	Intensive care unit
IGRT	Image-guided radiation therapy
IHPA	Independent Hospital Pricing Authority
IM&IT	Information management and information technology
IMPACT	Integrated Multi-agencies for Parents and Children Together
IMRT	Intensity-modulated radiation therapy
IRCTN	Integrated Regional Clinical Training Network
JACSD	Justice and Community Services Directorate
JBI	Joanna Briggs Institute
LCMHC	Little Company of Mary Health Care
LHN	Local hospital network
MACH	Maternal and Child Health
MARSS	Migrant and Refugee Settlement Services of the ACT Inc.
MET	Medical Emergency Team
MEWS	Modified Early Warning Score
MOU	Memorandum of understanding
MUD	Mandatory Update Day
NBHF	Ngunnawal Bush Healing Farm
NCPH	National Capital Private Hospital
NEAT	National Emergency Access Target
NEST	National Elective Surgery Target
NETS	Newborn Emergency Transport Service
NGO	Non-government organisation
NHMRC	National Health & Medical Research Council
NHRA	National Health Reform Agreement
NICU	Neonatal Intensive Care Unit
NPAPH	National Partnership Agreement on Preventive Health
NPDI	National Perinatal Depression Initiative
NRAS	National Registration and Accreditation Scheme

OH&S	Occupational health and safety
OMATSIA	Office of Aboriginal and Torres Strait Islander Affairs
OOS	Occasions of service
OPMHIU	Older Persons Mental Health Inpatient Unit
OPMHS	Older persons mental health services
ORE	Occupational risk exposure
OSCAR	Online System for Comprehensive Activity Reporting
PACU	Post-Anaesthetic Care Unit
PANDSI	Pre- and Ante-Natal Depression Support and Information Service
PART	Predict, Assess and Respond to Challenging/Aggressive Behaviour
PatCH	Paediatrics at the Canberra Hospital
PBS	Pharmaceutical Benefits Scheme
PCO	Parliamentary Counsel's Office
PET/CT	Positron Emission Tomograph/ Computerised Tomography
PHAAT	Pharmacotherapy Advocacy and Action Team
PH&CDS	Primary Health and Chronic Disease Strategy Committee
PHD	Population Health Division
PICAC	Partners in Culturally Appropriate Care
PICU	Paediatric intensive care unit
PID	Public interest disclosure
PII	Professional indemnity insurance
PIN	Provisional improvement notice
PMHCS	Perinatal Mental Health Consultation Service
PMO	Project management office
PND	Perinatal depression
P&O	Prosthetics and Orthotics
PPEI	Promotion, prevention and early intervention
PPID	Positive patient identification
PSS	Public Sector Superannuation Scheme
PSSAP	Public Sector Superannuation Scheme Accumulation Plan
PSSB	People Strategy and Services Branch
PSU	Psychiatric Services Unit
PTO	Psychiatric treatment order
QSU	Quality and Safety Unit
RACC	Rehabilitation, Aged and Community Care
RACF	Residential aged care facility
RACLN	Residential Aged Care Liaison Nurse
RACS	Royal Australasian College of Surgeons
RADAR	Rapid Assessment of the Deteriorating and At-Risk
RCNMP	Research Centre for Nursing and Midwifery Practice
RED	Respect, Equity, Diversity
RILU	Rehabilitation Independent Living Unit
RPC	Respecting patient choices
RTO	Registered Training Organisation
SCPU	Student Clinical Placement Unit
SEA	Special Employment Arrangement
SERBIR	Senior Executive Responsible for Business Integrity Risk
SHAHRD	ACT Ministerial Advisory Council on Sexual Health, HIV/AIDS, Hepatitis C and Related Diseases
SHFPACT	Sexual Health and Family Planning ACT
SOG	Strategic Oversight Group
SPIEWG	ACT Suicide Prevention Implementation and Evaluation Working Group
SRS	Stereotactic radiosurgery
TCH	(the) Canberra Hospital
TRIM	Total Records Information Management
TTCP	Transitional Therapy and Care Program
UC	University of Canberra
VMO	Visiting medical officer
WHO	World Health Organisation
WHS	Women's Health Service
WiC	Walk-in Centre
WYC	Women, Youth & Children Division
YDAP	Youth Alcohol and Drug Program

Glossary of technical terms

Access Improvement Program	A major change program initiated in early 2005 aimed at redesigning the way we provide health services by focusing on patient journeys through our health system.
Acute care	An episode of acute care for an admitted patient is one in which the principal clinical intent is to provide short-term hospital admission focused on the treatment of emergency conditions or the conduct of an elective procedure.
Ambulatory care	Care provided in a non-inpatient setting such as outpatients, home-based care, office-based care or community health centre-based care.
Benchmarking	The process of assessing the performance of an organisation of entity within an organisation by comparing it to the performance of a similar entity, a national average, or the best performing entity within the same field in order to assess performance and determine opportunities for improvement.
Chlamydia	Chlamydia is Australia's most common sexually transmitted disease. It is caused by the bacteria Chlamydia trachomatis.
Community-based organisations	Not-for-profit organisations within the community that have specialist skills in the management of certain health issues. These organisations provide services such as health services for disadvantaged young people, drug and alcohol rehabilitation, Aboriginal and Torres Strait Islander health services and supported accommodation for people with mental illness.
Cost weight	A cost weight is a form of measurement for the use of health services that provides an indication of the relative resource use. It provides an indication as to the complexity of an admission or an occasion of service.
Decant	To rehouse people while their buildings are being refurbished or rebuilt.
Differential diagnosis	Diagnosis of a condition whose symptoms and signs are shared by other conditions, which must be ruled out to arrive at the correct diagnosis.
Hepatitis C	Hepatitis is inflammation of the liver. Hepatitis C is a viral form that is transferred by blood-to-blood contact.
Length of stay	The number of days (or part thereof) that each admitted patient stays in hospital. Patients who are admitted and discharged on the same day have a length of stay of one day.
Patient-centred care	Refocusing the delivery of health care around the needs of the patient rather than other stakeholders such as providers.
Patient journey	A patient's experience of travelling or moving through the health system at pre-hospital to hospital and to community care.
Primary healthcare service	Primary healthcare services are those which focus on first contact health services provided predominantly by GPs, but also by practice nurses, primary/ community health care nurses, early childhood nurses and community pharmacists, allied health professionals and other health workers such as multicultural health workers and Indigenous health workers, health education/promotion and community development workers.

Public health officers	Public health officers provide a range of services to the community, including communicable disease control, pharmaceutical services, environmental health and scientific services, and have certain powers enshrined in legislation.
Occasion of service	A measure of services provided to patients—usually used in the outpatient or community health setting.
Sub-acute	Intermediate care provided between acute care and community-based care. Sub-acute care includes services such as rehabilitation that can be provided in a less invasive environment than an acute hospital environment.
Tertiary services	Tertiary services are generally those provided in a complex, highly specialised hospital environment.

Other sources of information

ACT Health publications are available at ACT government community libraries, the Health Directorate library located at The Canberra Hospital, Garran, and from Community Health Centres.

Information can also be accessed through the Health Directorate website at www.health.act.gov.au, Canberra Connect's website at www.canberraconnect.act.gov.au or the ACT Government website at www.act.gov.au.

Information can also be obtained by contacting the Health Directorate through the following contact points:

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General inquiries:	132 281
Annual report contact:	(02) 6205 0837
Fax:	(02) 6207 5775
Web:	www.health.act.gov.au
Email:	HealthACT@act.gov.au

Additional publications relating to health status and health services in the ACT are:
ACT Chief Health Officer's Report 2012
ACT Human Rights Commission Annual Report 2011–12
Australian hospital statistics 2010–11, Australian Institute of Health and Welfare
Australia's health 2012, Australian Institute of Health and Welfare

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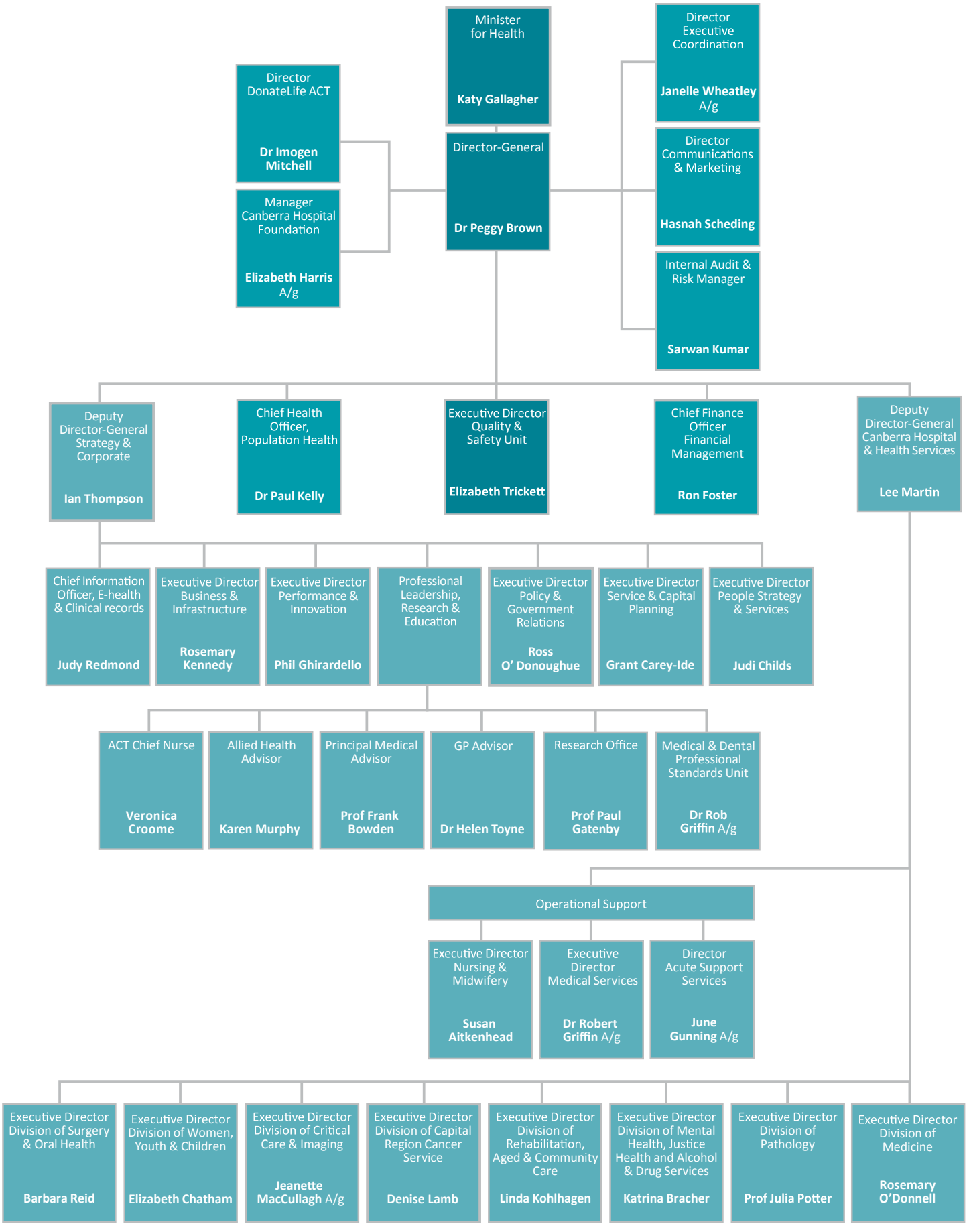
* As in previous years, the Care Coordinator annual report has been published as part of the *Public Advocate of the ACT Annual Report 2011–12*, by arrangement with the Chief Minister's Directorate.

Section A

Performance and financial reporting

ACT Government Health Directorate Organisational Chart



A.1 The organisation

Vision and values

The Health Directorate's vision is 'Your health—our priority', and our values are:

- Care
- Excellence
- Collaboration
- Integrity.

Developed by staff of the Health Directorate, our vision and values represent what we believe is important and worthwhile.

Our values underpin the way we work and how we treat others. We seek to actively demonstrate these when working with consumers, the community and our colleagues and, by doing so, aim to provide the best possible health care and health-related services throughout all areas of the Health Directorate.

Objectives

The Health Directorate's objectives are grouped under the following seven key performance areas:

- Consumer experience
- Sustainability
- Hospital and related care
- Prevention
- Social inclusion and Indigenous health
- Community-based health
- Aged care.

These seven performance areas build upon the seven overarching objectives of the National Health Care Agreement and form the basis of the Health Directorate Corporate Plan 2010–12. The plan emphasises consumer experience and sustainability. Our objectives support the achievement of our vision, and embed our values in the strategic planning and delivery of services.

The Corporate Plan informs all related business plans and annual performance agreements within the organisation.

Organisational structure

The organisation chart on page 2 provides an overview of the Health Directorate on 30 June 2012.

The Health Directorate is structured into groups and operational areas which report directly to the Director-General. The two groups—Canberra Hospital and Health Services and Strategy and Corporate—are led by Deputy Directors-General and are divided into clinical service divisions and strategic and corporate support branches.

Canberra Hospital and Health Services (CH&HS) employs the majority of staff working within the Health Directorate and provides acute, sub-acute, primary and community-based health services to the ACT and surrounding region. The Little Company of Mary provides public hospital services (Calvary Public Hospital) under a contractual agreement with the Health Directorate.

The Strategy and Corporate group employs a smaller number of staff. These staff provide infrastructure, policy, funding and strategic planning support to clinical service areas as well as plan for workforce and health service needs into the future.

Operational areas which report directly to the Director-General provide a range of corporate support and organisation-wide services such as quality and safety initiatives and financial management.

Population Health Division provides a range of public and environmental health services as well as health protection and promotion services. Through 2011–12 the division prepared for a restructure to come into effect on 1 July 2012. The main changes in the new Population Health Division structure were:

- the creation of a new Health Improvement Branch, which has brought together Epidemiology and Health Promotion
- the creation of the new Office of the Chief Health Officer, which will support the CHO on important population health initiatives and in responding to emerging issues
- the Health Protection Service remaining largely unchanged, except for the transfer of responsibility for health care facilities and needle exchange approvals
- the blood and blood product team moving to ACT Pathology; and sexual health and blood-borne virus policy being transferred to the Policy and Government Relations Branch.

The Health Directorate, other agencies and external stakeholders

The Health Directorate works closely with other ACT Government agencies such as the Community Services Directorate, the Justice and Community Safety Directorate, the Chief Minister and Cabinet Directorate and emergency services providers such as the ACT Ambulance Service and the Australian Federal Police.

Formalised consultative arrangements exist with a range of agencies, such as the Health Care Consumers' Association (ACT), the ACT Medicare Local and mental health, alcohol and drug and other community service providers in the sector.

The tertiary and training sectors remain key partners in the planning, development and delivery of health care services. Partnership arrangements with the Australian National University Medical School, University of Canberra, Australian Catholic University and Canberra Institute of Technology are well established and continue to serve the future supply of skilled workers for the health sector, as well as the development of a growing base of collaborative research.

A.2 & A.3 Overview & highlights for 2011–12

The Health Directorate faced a challenging year in 2011–12, including consolidating the Directorate's organisational restructure of 2010–11, implementing commitments under the National Health Reform Agreement and delivering on the Health Infrastructure Program, while continuing to provide high-quality health care to the people Canberra and the surrounding region.

It is pleasing that to note that while engaging with these complex issues the organisation maintained a focus on its service objectives and can report a significant number of achievements against them.

The Health Infrastructure Program, formerly called the Capital Asset Development Plan, continued to gain momentum in 2011–12, with the Adult Mental Health Unit opening in March 2012. The Centenary Hospital for Women and Children and the Gungahlin Community Health Centre are both scheduled to open early in the next reporting period.

Construction of the Canberra Region Cancer Centre and the Belconnen Enhanced Community Health Centre is progressing well and both are expected to be completed in 2013.

Community consultation on the design of the Ngunnawal Bush Healing Farm was completed in 2011–12, and preliminary sketch plans have been developed for the Centre for Health Teaching, Training and Research.

Consultation on the framework for the Health Directorate Corporate Plan 2012–17 occurred during the reporting period.

A draft Clinical Services Plan 2012–17 has been developed for broader community consultation. The plan focuses on:

- better coordination of care between hospitals, community health services and primary care
- improving the health of vulnerable people
- improving the patient journey
- building and nurturing a sustainable health system
- ensuring that all planning is underpinned by a safety and quality framework.

The Health Directorate achieved an overall reduction in the elective surgery waiting list. The waiting list at 30 June was 3996 people—a 6 per cent reduction compared to the same period last year. This has resulted in the number of people waiting beyond the clinically recommended timeframe dropping from 1431 in June 2010–11 to 898 in June 2011–12, a drop of 37 per cent.

In 2011–12, a total of 11,261 people accessed elective surgery, 75 operations below the record 11,336 set in 2010–11, and 261 above the 2011–12 target of 11,000 operations.

In 2010–11, a strategy to utilise the capacity of the private sector to address elective surgery waiting lists saw 171 operations performed by the private sector. In 2011–12, a further 353 accessed elective surgery under these arrangements.

Hospital bed capacity continued to increase in 2012, from 926 beds in 2010–11 to 939 in 2011–12. For 2012–13, the ACT Government has proposed the funding of a further 40 beds.

The bed occupancy rate decreased by 1 per cent to 88 per cent in 2011–12. The additional 40 beds funded in the 2012–13 Budget should help reduce the bed occupancy rate to the target of 85 per cent.

There were 118,389 presentations to ACT hospital emergency departments in 2011–12, an increase of 6 per cent on 2010–11 figures, and admissions to hospital through the emergency departments increased by 16 per cent to 31,062 admissions.

Waiting times for emergency treatment were at or above national benchmarks for categories 1 and 5.

Challenges were again experienced in meeting the national target for categories 2, 3 and 4. Increases in demand for emergency treatment have contributed to the challenges in meeting the targets for categories 2, 3 and 4. Category 2 presentations increased by 16 per cent while category 3 and 4 presentations increased by 7 per cent on 2010–11 figures.

Both public hospitals are undergoing process redesigns for their emergency departments, including the commencement of a redesign project focusing on the national four-hour target.

Australia's first public, nurse-led Walk-in Centre saw 17,450 presentations in 2011–12, an increase of 15 per cent on 2010–11. Of these, 9 per cent were redirected to their GP and 5 per cent to the emergency department.

A fourth linear accelerator was purchased and delivered to the Radiation Oncology Department in August 2011 and was commissioned and released for clinical use in January 2012. The Radiation Oncology Department also recruited an additional 12 full-time staff—including radiation therapists, radiation oncology medical physicists, a radiation oncologist and a registered nurse—who will provide a workforce to operate the increased treatment resources and help meet the growing demand for radiotherapy services.

Canberra Hospital-based rehabilitation services achieved a number of outcomes significantly higher than national benchmarks for the calendar year 2011. Average length of stay for patients requiring rehabilitation after a spinal cord injury was 29.0 days against a benchmark of 63.0 days, for those requiring rehabilitation after amputation it was 28.9 days against a benchmark of 36.1 days and for those requiring rehabilitation after brain dysfunction it was 20.1 days against a benchmark of 36.1 days.

The Aged Care Assessment Team undertook a redesign project to improve its responsiveness and capacity to process aged care assessments. As a result, the backlog of people awaiting assessment was reduced from 406 in September 2011 to 122 at 30 June 2012.

The Falls Injury Service conducted 466 falls clinic assessments in 2011–12, 11 per cent above the target of 420.

The NICUCAM website, which provides a video streaming service for parents of up to eight infants in the Centre for Newborn Care Neonatal Intensive Care Unit (NICU) at any one time, has helped parents who may not be able to visit the centre as regularly as they would like to stay in touch with the care and wellbeing of their child. With a secure password and login provided to families, this service promotes access to and bonding with the baby. The website has received over 100,000 hits, and been accessed from 80 countries. The project was awarded the 2012 International Oceania–Pacific Project Management Award in the category Organisation/Change Management.

In 2011, a joint initiative between Mental Health and Ward Services to reduce aggression and consumer distress saw the introduction of an Early Support and Intervention Team at the Canberra Hospital Psychiatric Services Unit. By training staff, the initiative focuses on engagement and de-escalation. The first ever formal mental health consumer-led research at Canberra Hospital has examined this project and its effect on staff, consumers and carers, and a report is being prepared for publication in late 2012.

Unauthorised changes to performance data on waiting times in the Canberra Hospital came to light in April 2012. Following an internal assessment by the Health Directorate, two independent audits were conducted: a forensic data audit by PricewaterhouseCoopers and a performance audit by the ACT Auditor-General. The Health Directorate will publish corrected data from 2008–09 onwards and provide corrected data to the Australian Institute of Health and Welfare to amend national performance measurement collections, including MyHospitals, Australian Hospital Statistics and the Report on Government Services.

In consequence:

- new validation processes were developed to increase the level of checking of data that is used for reporting of ED performance
- additional audit processes were put in place
- a review of data integrity is being undertaken across the Health Directorate
- a Director of Data Integrity position will be established
- a review of KPI governance will complement this work.

It is important to note that the unauthorised changes did not impact on patient care and that the changes to data to improve waiting time figures were made after ED episodes were finished. No patients had their care altered as a result of the changes in the data for waiting times.

On the legislative front, the F*ood Amendment Act 2012* came into effect in March 2012, introducing measures to increase regulatory transparency. Key measures are:

- a public register of recent findings of guilt regarding food-handling offences
- the mandatory display of a closure notice when a business is temporarily closed by a prohibition order
- the mandatory display of a business's certificate of registration
- a requirement for all food businesses to appoint a food safety supervisor by August 2013.

Our staff have displayed a continued commitment to the delivery of high-quality services and the active demonstration of the values of the organisation in their day-to-day work. Formal recognition of their high-quality performance has come from both internal and external sources. Several staff were recognised for their significant contribution to the organisation through a range of internal recognition programs throughout the reporting year. The awards included recognition of outstanding clinical performance, contributions to the organisation through excellence in administrative work practices, safety initiatives and specific quality projects aimed at improving work practice. These internal award programs are highly regarded within the organisation and, as a result, very competitive. Nominees and award winners are to be congratulated.

As well as these internal processes, a number of our staff were recognised at the territory and national level:

- The Deputy Director-General, Strategy and Corporate, Ian Thompson, won the ACT Public Service Award in the category of Excellence in Public Administration while Ms Bernadette Brady, Director for Patient and Family Centred Care, received the award in the Leadership and High Performance category.
- The Executive Director for the Division of Surgery & Oral Health, Ms Barbara Reid, won the 2011 Telstra ACT Business Women's Innovation Award.
- Yvette Gully of the Dental Health Program was named Dental Assistant of the Year for 2011 by the NSW Branch of the Dental Assistants Association of Australia for her contribution to her profession.
- The Health Directorate's NICUcam web camera project and the Elective Surgery Access Project (ESAP) won both ACT and national awards in the Australian Institute of Project Management Awards. The NICUcam project received its awards in the Organisational Change Management category, and ESAP won awards in the Community Benefit and Community Service or Development categories.
- Judy Rafferty of the Capital Region Cancer Service won the 2011 Joan Frances Stowe Prize from Royal Marsden Hospital in the United Kingdom for her work with lung cancer sufferers.
- The Health Directorate won the 2011 CRS Australia NSW/ACT Employer Award in the Government and Higher Education category for outstanding commitment to employing people with a disability.

- The Alcohol Tobacco and Other Drug Association ACT presented a Lifetime Achievement Award to Kate Gardner and an Outstanding Contribution Award to Helene Delany for her contribution to the sector.
- Dr Michael Levy, Medical Director of Justice Health, received the Australian Medical Association ACT President's Award for his initiatives to reduce the incidence of blood-borne diseases within the prisoner community.
- Canberra Hospital won the Public Service category in the Defence Reservists Support Awards.

A.4 Outlook for 2012–13

The 2012–13 reporting period promises to be another complex year for the Health Directorate as it seeks to consolidate and build on the work of the past few years, including in its Health Infrastructure Program and commitments under the National Health Reform Agenda, including the National Elective Surgery Target and National Emergency Access Target.

Areas of focus for 2012–13 include:

- continuing to embed the Health Directorate values of care, excellence, collaboration and integrity within all aspects of our operations as an organisation, and delivering against the key performance areas outlined in the Corporate Plan
- continuing to implement work arising from the National Health Reform Agreement, including strategies to meet performance targets for the emergency department and elective and emergency surgery
- progressing the work of the ACT Local Hospital Network
- progressing new models of care for traditionally hospital-based services to enable provision of these within the community, improving the timeliness, access to and experience of these services
- continuing the roll-out of the Health Infrastructure Program, with the progressing of design plans and the model of care for a new sub-acute hospital on the north side of Canberra, a major new clinical services block at the Canberra Hospital, and the Canberra Region Cancer Centre
- implementing a number of e-health projects, including e-referrals from GPs to community-based services, a community-based clinical record system, integration of the clinical portal to the national Personally Controlled Electronic Health Record and a centralised rostering system.

A.5 Management discussion and analysis

General overview

Operations and principal activities

The Health Directorate (the Directorate) aims to achieve good health for all residents of the Territory by planning, purchasing and providing quality community-based health services, hospital and extended care services, managing public health risks and promoting health and early care interventions.

The Directorate's objectives are grouped around the following seven key performance areas:

- consumer experience
- sustainability
- hospital and related care
- prevention
- social inclusion and indigenous health
- community based health, and
- aged care.

Changes in administrative structure

The Directorate did not gain or lose any functions in the 2011–12 financial year.

Risk management

The Directorate's management has identified the following potential risks that may influence the future financial position of the Directorate:

- abnormal rates of staff separation
- the cost of medical malpractice indemnity
- ability to attract and retain health professionals
- rising costs of pharmaceuticals, medical and surgical supplies
- demands on replacing systems and equipment, and
- growth in demand for services.

The Government and the Directorate have responded to these risks in a number of ways, including:

- implementation of strategies for the retention and recruitment of doctors, nurses, midwives and allied health professionals
- strengthening our patient safety and clinical practice review framework
- establishing the Medical School in cooperation with the Australian National University
- enhancement of procurement processes to maximise benefits from contracting
- a significant investment in infrastructure replacement and growth
- a significant investment in clinical systems and recording systems, and
- the Government introduced growth funding into the Health Budget in 2006–07. This was based on activity projected through clinical services planning.

The above risks are monitored regularly throughout the year.

Financial performance

The following financial information is based on audited financial statements for 2010–11 and 2011–12, and the forward estimates contained in the 2012–13 Budget Paper Number 4.

Total net cost of services

	Actual 2010–11 $m	Budget 2011–12 $m	Actual 2011–12 $m	Forward Estimate 2012–13 $m	Forward Estimate 2013–14 $m	Forward Estimate 2014–15 $m
Total Expenses	1,093.4	1,146.3	1,177.8	1,063.3	1,125.8	1,191.9
Total Own Source Revenue	241.1	222.1	255.9	666.8	706.5	756.0
Net Cost of Services	852.3	924.2	921.9	396.5	419.3	435.9

Comparison to budget

The Directorate's net cost of services for 2011–12 of $921.9 million was $2.3 million or 0.25 per cent lower than the 2011–12 budget (refer to Attachment A). However, this reflects a combination of factors, comprising:

- higher than budgeted expenses ($31.4 million), largely in employee expenses and superannuation ($25.9 million) and payments for grants and purchased services ($18.3 million) offset by lower than budgeted other expenses ($6.5 million) and lower than budgeted supplies and services ($6.1 million). The higher employee expenses mainly relate to pay rises for all employee categories of 1 per cent more than planned, workforce growth due to increased services, a change to the long service leave present value factor (from 92.2 per cent to 106.6 per cent) and resultant increase in superannuation costs. The higher payments for grants and purchased services represent the cost of treating ACT residents in public hospitals interstate that had previously been offset against cross-border revenue. Supplies and services decreased, largely due to the rollover of Commonwealth-funded programs to 2012–13, reduced expense for visiting medical officers due to engagement of additional salaried specialists and the effect of savings measures implemented across the Directorate, and
- offset by higher than budgeted own source revenue ($33.8 million), mainly due to user charges ($22.9 million) for cross-border revenue due to inpatient activity and a change to methodology for accounting for cross-border revenue, offset by a decline in Department of Veterans' Affairs patients revenue, and Other Revenue ($11.3 million) relating to Health Workforce Australia, Home and Community Care, Transition Care, Special Purpose Account grants, and insurance recoveries. The budget for cross-border revenue was formulated on a net basis, where cross-border revenue was shown net of expenses. The actual is accounted for on a gross basis.

Comparison to 2010–11 actual expenses

Total net cost of services was $69.6 million or 8.2 per cent higher than the 2010–11 actual cost due to increased expenses ($84.4 million), offset by increased non-appropriated revenue ($14.8 million).

Future trends

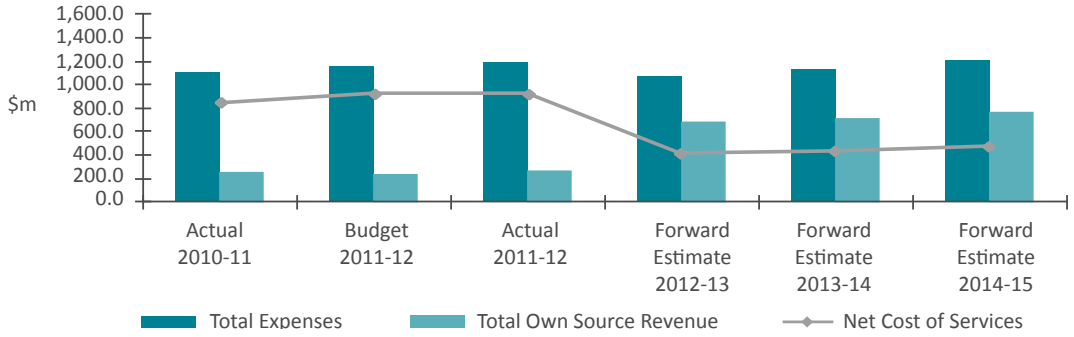


Figure 1: Net cost of services

The reason for net cost of services decreasing is the change in funding from government appropriation to own source revenue as a result of implementing the National Health Reform Agreement from 2012–13.

Total expenditure

Components of expenditure

Figure 2 below indicates the components of the Directorate's expenses for 2011–12 with the largest components of expense being employee expenses (excluding superannuation), which represents 44.8 per cent or $527.9 million, supplies and services, which represents 24.2 per cent or $285.4 million, and grants and purchased services, which represents 21 per cent or $247.5 million.

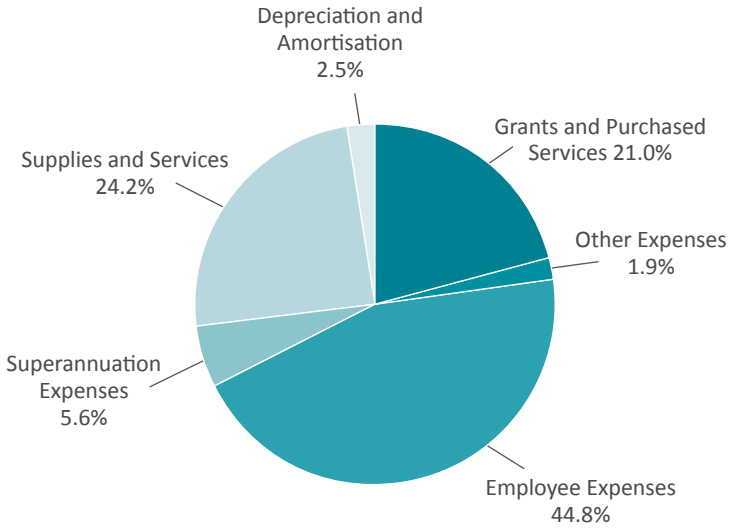


Figure 2: Components of expenditure

Comparison to budget

Total expenses of $1,177.8 million were ($31.5 million), or 2.7 per cent higher than the original 2011–12 budget of $1,146.3 million.

This variation was predominantly due to higher:

- Employee Expenses (excluding superannuation) ($21.7 million)—due to the impact of the change in the long service leave present value factor (from 92.2 per cent to 106.6 per cent), an extra 1 per cent pay rise for all staff through the enterprise bargaining agreements, and a greater increase in the overall workforce than originally planned
- Superannuation ($4.2 million)—as a result of the outcome of the enterprise bargaining agreements, a larger workforce and a slower decline in the number of employees leaving the higher cost CSS, PSS and PSSAP schemes than had been anticipated and
- Grants and Purchased Services ($18.3 million)—for increased elective surgery activity delivered through the non-government sector and inclusion of the cost of treating ACT residents in New South Wales previously offset against revenue.

The higher expenses were partially offset by lower than expected:

- Supplies & Services ($6.1 million)—largely due to the rollover of Commonwealth-funded programs to 2012–13, lower expenses for visiting medical officers due to engagement of additional salaried specialists and the effect of savings measures implemented across the Directorate, and
- Other Expenses ($6.5 million)—mainly due to reclassification of Blood Products to supplies and services.

Comparison to 2010–11 actual expenses

Total expenses were ($84.4 million) or 7.7 per cent higher than the 2010–11 actual result. The increase reflects a combination of factors, including increased expenditure in:

- Employee Expenses (excluding superannuation) ($53.5 million)—due to salary and wage increases, the impact of the change in long service leave present value factor (from 92.2 per cent to 106.6 per cent), and growth in a wide range of services including critical care, acute services, surgical services, cancer services and mental health
- Superannuation ($3.0 million)—due to the increased number of contributors as the workforce grew at a faster rate than planned, the impact of payrises, and the number of contributors in the CSS and PSS remained at similar levels to previous years
- Supplies and Services ($8.1 million)—resulting from price escalation and growth in services
- Grants and Purchased Services ($20.6 million)—mainly resulting from increased payments to Calvary Public Hospital for salary increases, other indexation, and additional activity and payments to non-government organisations for growth and indexation and workforce and healthy futures initiatives, and
- Depreciation and Amortisation ($3.7 million)—mainly resulting from the revaluation of buildings and leasehold improvements at 30 June 2011 and the commissioning of the Adult Mental Health Inpatient Facility.

This was offset by a decrease in other expenses of $4.4 million, which was due largely to the transfer of property in 2011.

Future trends

Expenses are budgeted to decrease in 2012–13 by $114.5 million, mainly as a result of payments to Calvary Public Hospital for hospital services now being met by the ACT Local Hospital Network Directorate. This reduction is partially offset by the cost of pay rises, indexation and the cost of new initiatives. It will then trend upwards across the two forward years.

Total own source revenue

Components of own source revenue

Figure 3 below indicates that for the financial year ended 30 June 2012, the Directorate received 89.5 per cent of its total own source revenue of $255.9 million from user charges.

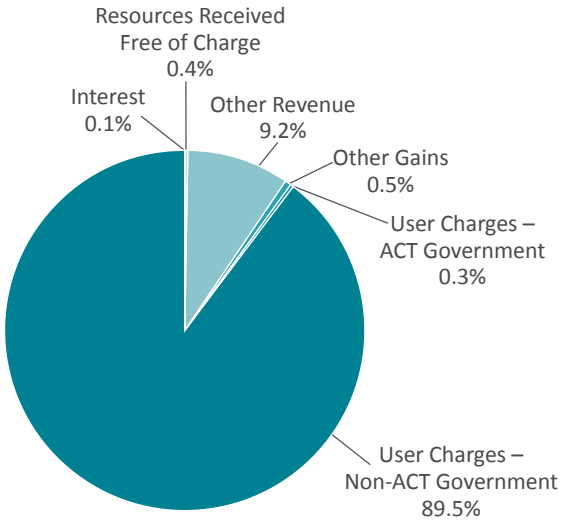


Figure 3: Components of own source revenue

Comparison to budget

Own source revenue for the year ending 30 June 2012 was $255.9 million, which was $33.8 million or 15.2 per cent higher than the 2011–12 budget of $222.1 million. This favourable variance is due to higher other revenue ($11.3 million) and user charges ($22.9 million).

Comparison to 2010–11 actual income

Own source revenue was $14.8 million or 6.1 per cent higher than the 2010–11 actual result of $241.1 million. The result reflects an increase in user charges ($16.8 million), partially offset by a reduction in other revenue ($0.8 million) and other gains ($1.4 million). User charges revenue was higher due largely to price escalation, growth in chargeable services and finalisation of three years of cross-border acquittals, offset by a decline in activity funded by the Department of Veterans' Affairs.

Future trends

Total own source revenue is expected to increase by $410.9 million in 2012–13, mainly due to the changed funding arrangements following the implementation of the National Health Reform Agreement, under which the funding for hospital services, which was previously paid as Government Payment for Outputs, will now be paid as user charges by the new ACT Local Hospital Network Directorate. It will then trend upwards across the two forward years.

Financial position

Total assets

Components of total assets

Figure 4 below indicates that, for the financial year ended 30 June 2012, the Directorate held 63 per cent of its assets in property, plant and equipment.

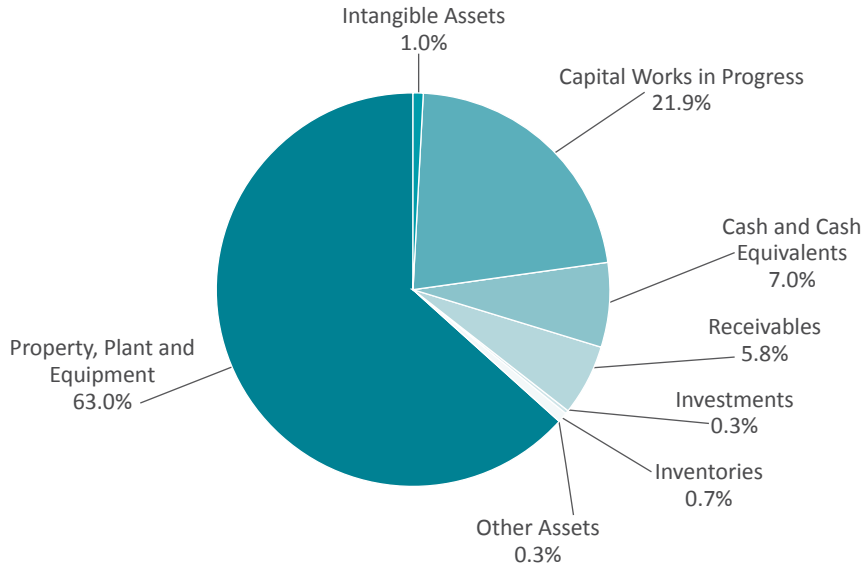


Figure 4: Total assets as at 30 June 2012

Comparison to budget

The total asset position as at 30 June 2012 is $996.2 million, $74.3 million lower than the 2011–12 budget of $1,070.5 million.

The variance reflects the timing associated with the acquisition and completion of various assets over the 2011–12 financial year, including intangibles ($53.1 million), capital works in progress ($76.7 million), and property, plant and equipment ($17.6 million), partially offset by higher cash and cash equivalents ($68.6 million), partly due to receipt, on 29 June 2012, of monies from NSW Health for prior years' cross-border activity, including the cost of blood and blood products and capital injection for capital works invoices, receivables ($3.8 million), and inventories ($1.3 million).

Comparison to 2010–11 actual

The Directorate's total asset position is $189.6 million higher than the 2010–11 actual result of $806.6 million, largely due to increases in:

- Cash and Cash Equivalents ($38.8 million)—partly due to receipt on 29 June 2012 of monies from NSW Health for prior years' cross-border activity and capital injection for capital works invoices
- Receivables (9.1 million)—due largely to cross-border activity due for acquittal in 2013
- Property, Plant and Equipment including Assets Held for Sale ($35.2 million)—as a result of buildings completed as part of the Health Infrastructure Program (HIP), including the Adult Mental Health Inpatient Facility, and

- Capital Works in Progress ($109.7 million)—as a result of works progressing on the new facilities, including the Integrated Cancer Centre, Enhanced Belconnen Health Centre, Gungahlin Health Centre and a number of e-Healthy projects.

The above increases were partially offset by a reduction in intangibles ($3.0 million).

Total liabilities

Components of total liabilities

Figure 5 below indicates that the majority of the Directorate's liabilities relate to employee benefits (67.3 per cent) and payables (30.0 per cent).

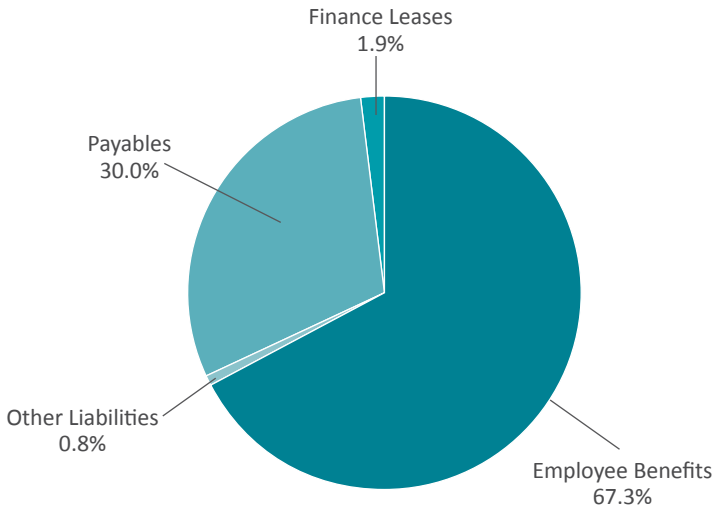


Figure 5: Total liabilities as at 30 June 2012

Comparison to budget

The Directorate's liabilities for the year ended 30 June 2012, of $266.5 million, is $48.8 million higher than the 2011–12 budget of $217.7 million. This was due to higher employee benefits ($24.8 million), payables ($39.7 million), and other provisions ($1.5 million), offset by lower finance leases ($0.8 million) and other liabilities ($16.4 million). The higher employee benefits is due largely to the increase in the long service leave present value factor (from 92.2 per cent to 106.6 per cent), the impact of the pay outcome that was more than budgeted and increased workforce. The higher payables relates to the timing of capital works invoices, and the reduction in other liabilities relates to the reduced level of AASB 1004: Contributions.

Comparison to 2010–11 actual

Total liabilities are $45.4 million higher than the actual results for the same period last year of $221.1 million, largely due to increases in payables ($22.8 million) and employee benefits ($28.1 million), offset by a reduction in other liabilities ($4.6 million).

Territorial statement of revenues and expenses

The activities whose funds flow through the Directorate's Territorial accounts are:

- the receipt of regulatory licence fees, and
- the receipt and on-passing of monies for capital works at Calvary Public Hospital.

Total income

Figure 6 below indicates that 44.6 per cent of Territorial income is regulatory licence fees, with the balance being the receipt, for on-passing, of monies for capital works at Calvary Public Hospital (expenses on behalf of the Territory).

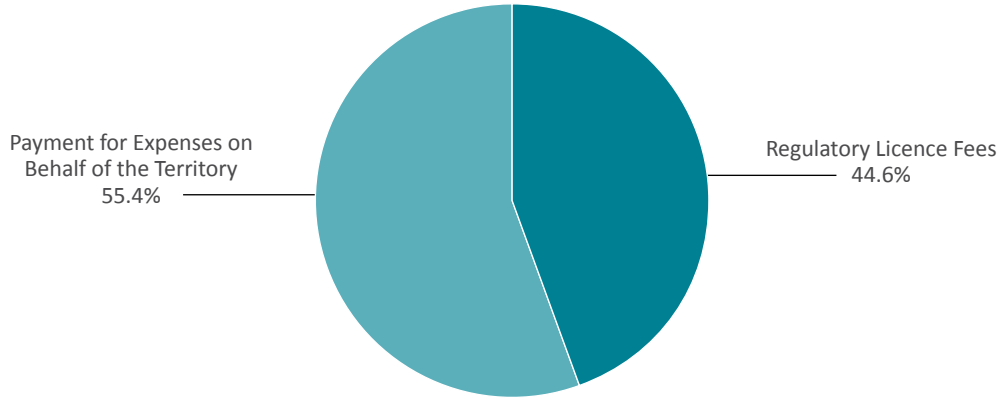


Figure 6: Sources of Territorial revenue

Total Territorial income for the year ending 30 June 2012 was $1.8 million, which was $0.4 million higher than the budget figure of $1.4 million. The variance was due to higher regulatory licence fees ($0.1 million) and a higher level of monies for on-passing for capital works at Calvary Public Hospital ($0.3 million).

Total Territorial income was $0.6 million higher than the same period last year, due to higher regulatory licence fees ($0.1 million) and an increase in the monies for on-passing for capital works at Calvary Public Hospital ($0.5 million).

Total expenses

Figure 7 below indicates that 47.8 per cent of expenses incurred on behalf of the Territory relate to the on-passing of monies for capital works to Calvary Public Hospital, with the other 52.2 per cent being the transfer, to Government, of regulatory licence fees.

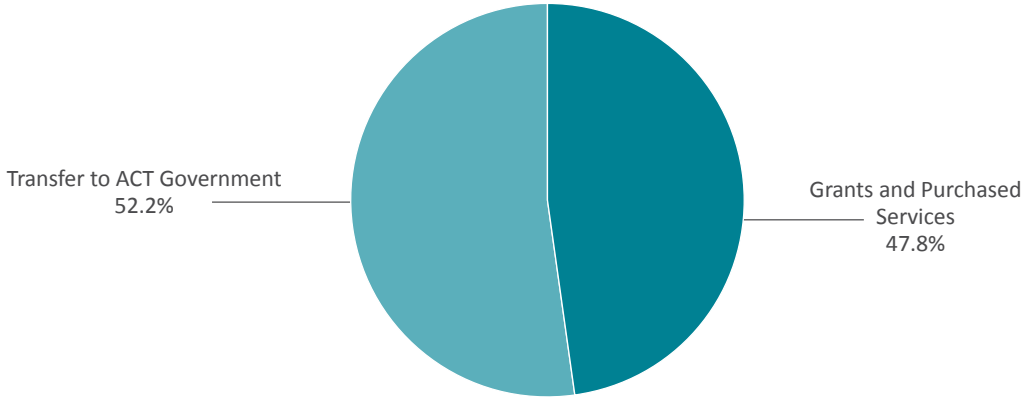


Figure 7: Sources of Territorial expenses

Total expenses were $1.5 million, which was within $0.1 million of the budget of $1.4 million for the period.

Total expenses were within $0.1 million of the same period last year.

Other disclosures

Audit qualification/matters of emphasis

In September 2012, the Auditor-General completed the financial audit of the Directorate and provided an opinion. The Auditor-General's opinion of the Directorate's financial statements concluded that the statements were prepared in accordance with the *Financial Management Act 1996* and fairly represented the financial performance of the Directorate for the year ended 30 June 2012.

Attachment A—Comparison of net cost of services to budget 2011–12

Description	Original Budget $'000	Plus AAO Transfers $'000	Total Funding $'000	Less Actual $'000	Variance to be explained $'000	Variance to be explained %
Expenses						
Employee and Superannuation	568,110	–	568,110	593,999	–25,889	–4.56%
Supplies and Services	291,564	–	291,564	285,428	6,136	2.10%
Depreciation and Amortisation	29,018	–	29,018	28,929	89	0.31%
Grants and Purchased Services	229,256	–	229,256	247,512	–18,256	–7.96%
Other Expenses	28,383	–	28,383	21,894	6,489	22.86%
Total Expenses	**1,146,331**	**–**	**1,146,331**	**1,177,762**	**–31,431**	**–2.74%**
Own Source Revenue						
User Charges	207,036	–	207,036	229,927	–22,891	–11.06%
Interest	278	–	278	254	24	8.63%
Resources Free of Charge	986	–	986	954	32	3.25%
Gains	1,496	–	1,496	1,185	311	20.76%
Other Revenue	12,289	–	12,289	23,542	–11,253	–91.57%
Total Own Source Revenue	222,085	–	222,085	255,862	–33,777	–15.21%
Total Net Cost of Services	**924,246**	**–**	**924,246**	**921,900**	**2,346**	**0.25%**

A.6 Financial Report

ACT AUDITOR-GENERAL'S OFFICE

ACT Government

INDEPENDENT AUDIT REPORT

HEALTH DIRECTORATE

To the Members of the ACT Legislative Assembly

Report on the financial statements

The financial statements of the Health Directorate (the Directorate) for the year ended 30 June 2012 have been audited. These comprise the following financial statements and accompanying notes:

- Controlled financial statements – operating statement, balance sheet, cash flow statement, statement of changes in equity and statement of appropriation.
- Territorial financial statements – statement of income and expenses on behalf of the Territory, statement of assets and liabilities on behalf of the Territory, cash flow statement on behalf of the Territory, statement of changes in equity on behalf of the Territory and Territorial statement of appropriation.

Responsibility for the financial statements

The Director-General of the Directorate is responsible for the preparation and fair presentation of the financial statements in accordance with the *Financial Management Act 1996*. This includes responsibility for maintaining adequate accounting records and internal controls that are designed to prevent and detect fraud and error, and the accounting policies and estimates used in the preparation of the financial statements.

Under the *Financial Management Act 1996,* I am responsible for expressing an independent audit opinion on the financial statements.

The audit was conducted in accordance with Australian Auditing Standards to provide reasonable assurance that the financial statements are free of material misstatement.

I formed the audit opinion following the use of audit procedures to obtain evidence about the amounts and disclosures in the financial statements. As these procedures are influenced by the use of professional judgement, selective testing of evidence supporting the amounts and other disclosures in the financial statements, inherent limitations of internal control and the availability of persuasive rather than

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Telephone: 02 6207 0833 | Facsimile: 02 6207 0826 | Email: actauditorgeneral@act.gov.au

conclusive evidence, an audit cannot guarantee that all material misstatements have been detected.

Although the effectiveness of internal controls is considered when determining the nature and extent of audit procedures, the audit was not designed to provide assurance on internal controls.

The audit is not designed to provide assurance on the appropriateness of budget information included in the financial statements or to evaluate the prudence of decisions made by the Directorate.

Electronic presentation of the audited financial statements

Those viewing an electronic presentation of the financial statements should note that the audit does not provide assurance on the integrity of information presented electronically, and does not provide an opinion on any other information which may have been hyperlinked to or from the financial statements. If users of the financial statements are concerned with the inherent risks arising from the electronic presentation of information, they are advised to refer to the printed copy of the audited financial statements to confirm the accuracy of this electronically presented information.

Independence

Applicable independence requirements of Australian professional ethical pronouncements were followed in conducting the audit.

Audit opinion

In my opinion, the financial statements of the Directorate for the year ended 30 June 2012:

(i) are presented in accordance with the *Financial Management Act 1996*, Accounting Standards and other mandatory financial reporting requirements in Australia; and

(ii) present fairly the financial position of the Directorate as at 30 June 2012 and the results of its operations and cash flows for the year then ended.

This audit opinion should be read in conjunction with the other information disclosed in this report.

M. Cooper.

Dr Maxine Cooper
Auditor-General
14 September 2012

Health Directorate
Financial Statements
For the Year Ended 30 June 2012

Statement of Responsibility

In my opinion, the financial statements are in agreement with the Directorate's accounts and records and fairly reflect the financial operations of the Directorate for the year ended 30 June 2012 and the financial position of the Directorate on that date.

Dr Peggy Brown
Director – General
Health Directorate

6 / 9 / 2012

Health Directorate
Financial Statements
For the Year Ended 30 June 2012

Statement by the Chief Finance Officer

In my opinion, the financial statements have been prepared in accordance with generally accepted accounting principles, and are in agreement with the Directorate's accounts and records and fairly reflect the financial operations of the Directorate for the year ended 30 June 2012 and the financial position of the Directorate on that date.

Mr Ron Foster
Chief Finance Officer
Health Directorate

6/9/ 2012

Health Directorate Departmental Financial Statement for the Year Ended 30 June 2012

Health Directorate Operating Statement For the Year Ended 30 June 2012

	Note No.	Actual 2012 $'000	Original Budget 2012 $'000	Actual 2011 $'000
Income				
Revenue				
Government Payment for Outputs	4	904,281	896,185	834,520
User Charges – ACT Government	5	825	885	788
User Charges – Non-ACT Government	5	229,102	206,151	212,344
Interest	6	97	100	87
Distribution from Investments with the Territory Banking Account	7	157	178	160
Resources Received Free of Charge	8	954	986	709
Other Revenue	9	23,542	12,289	24,373
Total Revenue		1,158,958	1,116,774	1,072,981
Gains				
Other Gains	10	1,185	1,496	2,608
Total Gains		1,185	1,496	2,608
Total Income		1,160,143	1,118,270	1,075,589
Expenses				
Employee Expenses	11	527,932	506,241	474,457
Superannuation Expenses	12	66,067	61,869	63,036
Supplies and Services	13	285,428	291,564	277,352
Depreciation and Amortisation	14	28,929	29,018	25,271
Grants and Purchased Services	15	247,512	229,256	226,921
Borrowing Costs	16	415	401	441
Other Expenses	17	21,479	27,982	25,918
Total Expenses		**1,177,762**	**1,146,331**	**1,093,396**

Health Directorate Operating Statement For the Year Ended 30 June 2012 (continued)

	Note No.	Actual 2012 $'000	Original Budget 2012 $'000	Actual 2011 $'000
Operating (Deficit)		(17,619)	(28,061)	(17,807)
Other Comprehensive Income				
(Decrease)/Increase in the Asset Revaluation Surplus	35	(994)	–	9,607
Total Comprehensive (Deficit)		**(18,613)**	**(28,061)**	**(8,200)**

The above Operating Statement should be read in conjunction with the accompanying notes. The Directorate only has one output class and as such the above Operating Statement is also the Directorate's Operating Statement for the Health and Community Care Output Class. A separate disaggregated disclosure note has therefore not been included in these Financial Statements.

Health Directorate Balance Sheet as at 30 June 2012

	Note No.	Actual 2012 $'000	Original Budget 2012 $'000	Actual 2011 $'000
Current Assets				
Cash and Cash Equivalents	21	69,379	744	30,598
Receivables	22	57,730	53,977	46,469
Inventories	23	7,553	6,242	7,866
Assets Held for Sale	24	169	234	127
Other Assets	29	2,515	2,986	2,414
Total Current Assets		137,347	64,183	87,474
Non-Current Assets				
Receivables	22	–	–	2,135
Investments	25	2,990	3,000	3,000
Property, Plant and Equipment	26	627,749	645,350	592,600
Intangible Assets	27	9,870	63,005	12,827
Capital Works in Progress	28	218,235	294,979	108,578
Total Non-Current Assets		858,844	1,006,334	719,141
Total Assets		996,190	1,070,517	806,615
Current Liabilities				
Payables	30	79,960	40,223	57,197
Finance Leases	31	3,288	1,471	2,423
Employee Benefits	32	164,307	138,685	136,193
Other Liabilities	34	656	17,066	5,262
Total Current Liabilities		248,211	197,445	201,075
Non-Current Liabilities				
Finance Leases	31	1,802	4,401	3,575
Employee Benefits	32	14,984	15,833	14,962
Other Provisions	33	1,503	–	1,503
Total Non-Current Liabilities		18,289	20,234	20,040
Total Liabilities		266,500	217,679	221,115
Net Assets		**729,690**	**852,838**	**585,500**

Health Directorate Balance Sheet as at 30 June 2012 (continued)

	Note No.	Actual 2012 $'000	Original Budget 2012 $'000	Actual 2011 $'000
Equity				
Accumulated Funds		585,683	717,444	440,499
Asset Revaluation Surplus	35	144,007	135,394	145,001
Total Equity		**729,690**	**852,838**	**585,500**

The above Balance Sheet should be read in conjunction with the accompanying notes. The Directorate only has one output class and as such the above Balance Sheet is also the Directorate's Balance Sheet for the Health and Community Care Output Class. A separate disaggregated disclosure note has therefore not been included in these Financial Statements.

Health Directorate Statement of Changes in Equity For the Year Ended 30 June 2012

	Accumulated Funds Actual 2012 $'000	Asset Revaluation Surplus Actual 2012 $'000	Total Equity Actual 2012 $'000	Original Budget 2012 $'000
Balance at the Beginning of the Reporting Period	**440,499**	**145,001**	**585,500**	**598,160**
Comprehensive Income				
Operating (Deficit)	(17,619)	–	(17,619)	(28,061)
(Decrease) in Asset Revaluation Surplus	–	(994)	(994)	–
Total Comprehensive (Deficit)	(17,619)	(994)	(18,613)	(28,061)
Transactions Involving Owners Affecting Accumulated Funds				
Capital Injections	162,803	–	162,803	282,739
Total Transactions Involving Owners Affecting Accumulated Funds	162,803	–	162,803	282,739
Balance at the End of the Reporting Period	**585,683**	**144,007**	**729,690**	**852,838**

	Accumulated Funds Actual 2011 $'000	Asset Revaluation Surplus Actual 2011 $'000	Total Equity Actual 2011 $'000	Original Budget 2011 $'000
Balance at the Beginning of the Reporting Period	**347,849**	**135,394**	**483,243**	**513,535**
Comprehensive Income				
Operating (Deficit)	(17,807)	–	(17,807)	(25,619)
Increase in the Asset Revaluation Surplus	–	13,780	13,780	–
Total Comprehensive (Deficit)	(17,807)	13,780	(4,027)	(25,619)
Transfers to/(from) reserves	4,173	(4,173)	–	–
Transactions Involving Owners Affecting Accumulated Funds				
Capital Injections	106,284	–	106,284	196,981
Total Transactions Involving Owners Affecting Accumulated Funds	110,457	(4,173)	106,284	196,981
Balance at the End of the Reporting Period	**440,499**	**145,001**	**585,500**	**684,897**

The above Statement of Changes in Equity should be read in conjunction with the accompanying notes.

Health Directorate Cash Flow Statement For the Year Ended 30 June 2012

	Note No.	Actual 2012 $'000	Original Budget 2012 $'000	Actual 2011 $'000
Cash Flows from Operating Activities				
Receipts				
Government Payment for Outputs		904,170	896,185	831,953
User Charges – ACT Government		822	885	800
User Charges – Non-ACT Government		215,328	206,092	221,663
Interest Received		97	100	88
Distribution from Investments with the Territory Banking Account		151	178	162
Goods and Services Tax Input Tax Credits from the Australian Taxation Office		59,616	45,997	55,202
Goods and Services Tax Collected from Customers		5,028	4,200	4,248
Other		19,882	13,785	18,188
Total Receipts from Operating Activities		1,205,094	1,167,422	1,132,304
Payments				
Employee		497,483	497,814	461,434
Superannuation		65,740	61,869	62,722
Supplies and Services		254,897	291,420	256,130
Grants and Purchased Services		243,608	229,256	224,224
Goods and Services Tax Paid to Suppliers		63,973	50,197	60,562
Borrowing Costs		415	401	441
Other		25,789	27,756	27,356
Total Payments from Operating Activities		1,151,905	1,158,713	1,092,869
Net Cash Inflows from Operating Activities	39	53,189	8,709	39,435

Health Directorate Cash Flow Statement For the Year Ended 30 June 2012 (continued)

	Note No.	Actual 2012 $'000	Original Budget 2012 $'000	Actual 2011 $'000
Cash Flows from Investing Activities				
Receipts				
Proceeds from Sale of Property, Plant and Equipment		1,397	–	679
Total Receipts from Investing Activities		1,397	–	679
Payments				
Purchase of Property, Plant and Equipment		64,548	–	29,090
Payments for Capital Works		111,634	290,034	90,034
Total Payments from Investing Activities		176,182	290,034	119,124
Net Cash (Outflows) from Investing Activities		(174,785)	(290,034)	(118,445)
Cash Flows from Financing Activities				
Receipts				
Capital Injections		162,803	282,739	106,284
Total Receipts from Financing Activities		162,803	282,739	106,284
Payments				
Repayment of Finance Leases		2,426	1,452	1,948
Total Payments from Financing Activities		2,426	1,452	1,948
Net Cash Inflows from Financing Activities		160,377	281,287	104,336
Net Increase / (Decrease) in Cash and Cash Equivalents Held		38,781	(38)	25,326
Cash and Cash Equivalents at the Beginning of the Reporting Period		30,598	782	5,272
Cash and Cash Equivalents at the End of the Reporting Period	**39**	**69,379**	**744**	**30,598**

The above Cash Flow Statement should be read in conjunction with the accompanying notes.

Health Directorate Controlled Statement of Appropriation For the Year Ended 30 June 2012

	Original Budget 2012 $'000	Total Appropriated 2012 $'000	Appropriation Drawn 2012 $'000	Appropriation Drawn 2011 $'000
Controlled				
Government Payment for Outputs	896,185	921,049	904,170	831,953
Capital Injections	282,739	313,488	162,803	106,284
Total Controlled Appropriation	**1,178,924**	**1,234,537**	**1,066,973**	**938,237**

The above Controlled Statement of Appropriation should be read in conjunction with the accompanying notes.

Column Heading Explanations

The *Original Budget* column shows the amounts that appear in the Cash Flow Statement in the Budget Papers. This amount also appears in the Cash Flow Statement.

The *Total Appropriated* column is inclusive of all appropriation variations occurring after the Original Budget.

The *Appropriation Drawn* is the total amount of appropriation received by the Directorate during the year. This amount appears in the Cash Flow Statement.

Variances between 'Original Budget' and 'Total Appropriated'

Government Payment for Outputs

The difference between the Original Budget and the Total Appropriated to the Directorate was the provision of appropriation for increased activity at Calvary Hospital, Commonwealth funding for elective surgery, essential vaccines and Preventative Health projects, and increased salaries and wages following finalisation of certified agreements.

Capital Injections

The difference between the Original Budget and Total Appropriated in 2011–12 is due to the deferral of capital works projects in 2010–11. The main reasons for the deferral of capital works projects from 2010–11 into 2011–12 were site selection issues and planning delays.

Variances between 'Total Appropriated' and 'Appropriation Drawn'

Government Payment for Outputs

The difference between the Total Appropriated and the Appropriation Drawn is due to the deferral of funding for Commonwealth programs into 2012–13. Commonwealth funding phasing was determined by the Commonwealth initially and the deferral more adequately reflects the timing of implementation of National Reform projects and the National Partnership Payments for the Preventative Health and Essential Vaccine programs.

Capital Injections

The difference between the Total Appropriated to the Directorate and the Appropriation drawn is largely due to rollover of delayed capital works projects. The delays mainly relate to geophysics issues encountered upon commencement of construction. In addition, there were tender release delays due to revisions to contract forms, several project scope reviews and inclement weather.

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Note 1 Objectives of the Health Directorate

Operations and Principal Activities

The Health Directorate (the Directorate) aims to achieve good health for all residents of the Territory by planning, purchasing and providing quality community based health services, hospital and extended care services, managing public health risks and promoting health and early care interventions.

The Directorate's objectives are grouped around the following seven key performance areas:

- consumer experience;
- sustainability;
- hospital and related care;
- prevention;
- social inclusion and indigenous health;
- community based health; and
- aged care.

Note 2 Summary of Significant Accounting Policies

(a) Basis of Accounting

The *Financial Management Act 1996 (FMA)* requires the preparation of annual financial statements for ACT Government Agencies.

The FMA and the *Financial Management Guidelines* issued under the Act, requires the Directorate's financial statements to include:

i. an Operating Statement for the year;
ii. a Balance Sheet at the end of the year;
iii. a Statement of Changes in Equity for the year;
iv. a Cash Flow Statement for the year;
v. a Statement of Appropriation for the year;
vi. an Operating Statement for each class of output for the year;
vii. a summary of the significant accounting policies adopted for the year; and
viii. such other statements as are necessary to fairly reflect the financial operations of the Directorate during the year and its financial position at the end of the year.

These general-purpose financial statements have been prepared to comply with 'Generally Accepted Accounting Principles' (GAAP) as required by the FMA. The financial statements have been prepared in accordance with:

i. Australian Accounting Standards; and
ii. ACT Accounting and Disclosure Policies.

Note 2 Summary of Significant Accounting Policies (continued)

(a) Basis of Accounting (continued)

The financial statements have been prepared using the accrual basis of accounting, which recognises the effects of transactions and events when they occur. The financial statements have also been prepared according to the historical cost convention, except for assets which were valued in accordance with the (re)/valuation policies applicable to the Directorate during the reporting period.

As at 30 June 2012, the Directorate's current assets are insufficient to meet its current liabilities. However, this is not considered a liquidity risk as its cash needs are funded through appropriation from the ACT Government on a cash-needs basis. This is consistent with the whole-of-government cash management regime, which requires excess cash balances to be held centrally rather than within individual agency bank accounts.

These financial statements are presented in Australian dollars, which is the Directorate's functional currency.

The Directorate is an individual reporting entity.

(b) Controlled and Territorial Items

The Directorate produces Controlled and Territorial financial statements. The Controlled financial statements include income, expenses, assets and liabilities over which the Directorate has control. The Territorial financial statements include income, expenses, assets and liabilities that the Directorate administers on behalf of the ACT Government, but does not control.

The purpose of the distinction between Controlled and Territorial is to enable an assessment of the Directorate's performance against the decisions it has made in relation to the resources it controls, while maintaining accountability for all resources under its responsibility.

The basis of accounting described in Note 2(a) above applies to both Controlled and Territorial financial statements except where specified otherwise.

(c) The Reporting Period

These financial statements state the financial performance, changes in equity and cash flows of the Directorate for the year ending 30 June 2012 together with the financial position of the Directorate as at 30 June 2012.

(d) Comparative Figures

Budget Figures

To facilitate a comparison with Budget Papers, as required by the *Financial Management Act 1996,* budget information for 2011–12 has been presented in the financial statements. Budget numbers in the financial statements are the original budget numbers that appear in the Budget Papers.

Note 2 Summary of Significant Accounting Policies (continued)

(d) Comparative Figures (continued)

Prior Year Comparatives

Comparative information has been disclosed in respect of the previous period for amounts reported in the financial statements, except where an Australian Accounting Standard does not require comparative information to be disclosed.

Where the presentation or classification of items in the financial statements is amended, the comparative amounts have been reclassified where practical. Where a reclassification has occurred, the nature, amount and reason for the reclassification is provided.

(e) Rounding

All amounts in the financial statements have been rounded to the nearest thousand dollars ($'000). Use of the "–" symbol represents zero amounts or amounts rounded up or down to zero.

(f) Revenue Recognition

Revenue is recognised at the fair value of the consideration received or receivable in the Operating Statement. All revenue is recognised to the extent that it is probable that the economic benefits will flow to the Directorate and the revenue can be reliably measured. In addition, the following specific recognition criteria must also be met before revenue is recognised:

Cross Border (Interstate) Health Revenue

Revenue for cross border (interstate) health services is recognised when the number of patients and complexities of the treatments provided can be measured reliably and the contract price for such services are agreed with the States and Northern Territory. Actual patient numbers and services are settled following an acquittal process undertaken in subsequent years and variations to the revenue recognised is accounted for in the year of settlement with the States and the Northern Territory.

Service Revenue

Revenue from the rendering of services is recognised when the stage of completion of the transaction at the reporting date can be measured reliably and the costs of rendering those services can be measured reliably.

Inventory Sales

Revenue from inventory sales is recognised as revenue when the significant risks and rewards of ownership of the goods has transferred to the buyer, the Directorate retains neither continuing managerial involvement nor effective control over the goods sold and the costs incurred in respect of the transaction can be measured reliably.

Note 2 Summary of Significant Accounting Policies (continued)

(f) Revenue Recognition (continued)

Amounts Received for Highly Specialised Drugs

Revenue from the supply of highly specialised drugs is recognised as revenue when the drugs have been supplied to the patients.

Inpatient Fees

Inpatient fees are recognised as revenue when the services have been provided.

Facilities Fees

Facilities fees are generated from the provision of facilities to enable specialists and senior specialists to exercise rights of private practice in the treatment of chargeable patients at a Health Directorate facility. They are recognised as revenue when the amount of revenue can be measured reliably.

Distribution

Distribution revenue is received from investments with the Territory Banking Account. This is recognised on an accrual basis using data supplied by the Territory Banking Account.

Grants

Grants that are non-reciprocal in nature are recognised as revenue in the year in which the Directorate obtains control over them.

Where grants are reciprocal in nature, the revenue is recognised over the term of the funding arrangements.

Interest

Interest revenue is recognised using the effective interest method.

(g) Revenue Received in Advance

Revenue received in advance relating to contributions, grants and donations are recognised only where there is a present obligation to repay a grant, contribution or donation because specific conditions attached to the grant, contributions and donations have not been met by the Directorate.

Note 2 Summary of Significant Accounting Policies (continued)

(h) Resources Received and Provided Free of Charge

Resources received free of charge are recorded as a revenue and expense in the Operating Statement at fair value. The revenue is separately disclosed under resources received free of charge, with the expense being recorded in the line item to which it relates. Goods and services received free of charge from ACT Government agencies are recorded as resources received free of charge, where as goods and services received free of charge from entities external to the ACT Government are recorded as donations. Services that are received free of charge are only recorded in the Operating Statement if they can be reliably measured and would have been purchased if not provided to the Directorate free of charge.

Resources provided free of charge are recorded at their fair value in the expense line items to which they relate.

(i) Repairs and Maintenance

The Directorate undertakes major cyclical maintenance on its assets. Where the maintenance leads to an upgrade of the asset, and increases the service potential of the existing asset, the cost is capitalised. Maintenance expenses which do not increase the service potential of the asset are expensed.

(j) Borrowing Costs

Borrowing costs are expensed in the period in which they are incurred.

(k) Waivers of Debt

Debts that are waived during the year under Section 131 of the *Financial Management Act 1996* are expensed during the year in which the right to payment was waived. Further details of waivers are disclosed at Note 18: Waivers, Impairment Losses and Write-offs.

(l) Current and Non-Current Items

Assets and liabilities are classified as current or non-current in the Balance Sheet and in the relevant notes. Assets are classified as current where they are expected to be realised within 12 months after the reporting date. Liabilities are classified as current when they are due to be settled within 12 months after the reporting date or when the Directorate does not have an unconditional right to defer settlement of the liability for at least 12 months after the reporting date.

Assets or liabilities which do not fall within the current classification are classified as non-current.

Note 2 Summary of Significant Accounting Policies (continued)

(m) Impairment of Assets

The Directorate assesses, at each reporting date, whether there is any indication that an asset may be impaired. Assets are also reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount may not be recoverable. However, intangible assets that are not yet available for use are tested annually for impairment regardless of whether there is an indication of impairment, or more frequently if events or circumstances indicate they might be impaired.

Any resulting impairment losses, for land, buildings, and leasehold improvements, are recognised as a decrease in the Asset Revaluation Surplus relating to these classes of assets. Where the impairment loss is greater than the balance in the Asset Revaluation Surplus for the relevant class of asset, the difference is expensed in the Operating Statement. Impairment losses for plant and equipment and intangible assets are expensed in the Operating Statement, as plant and equipment and intangibles are carried at cost. Also, the carrying amount of the asset is reduced to its recoverable amount.

An impairment loss is the amount by which the carrying amount of an asset exceeds its recoverable amount. The recoverable amount is the higher of the asset's 'fair value less cost to sell' and its 'value in use'. An asset's 'value in use' is its depreciated replacement cost, where the asset would be replaced if the Directorate were deprived of it.

Non-financial assets that have previously been impaired are reviewed for possible reversal of impairment at each reporting date.

(n) Cash and Cash Equivalents

For the purposes of the Cash Flow Statement and the Balance Sheet, cash includes cash at bank and cash on hand. Cash equivalents are short-term, highly liquid investments that are readily convertible to known amounts of cash and which are subject to an insignificant risk of changes in value. Bank overdrafts are included in cash and cash equivalents in the Cash Flow Statement but not in the cash and cash equivalents line on the Balance Sheet.

(o) Receivables

Accounts receivable (including trade receivables and other trade receivables) are initially recognised at fair value and are subsequently measured at amortised cost, with any adjustments to the carrying amount being recorded in the Operating Statement.

Trade receivables arise in the normal course of selling goods and services to other agencies and to the public. Trade receivables are payable within 30 days after the issue of an invoice or the goods/services have been provided under a contractual arrangement. In some cases, the Directorate has entered into contractual arrangements with some customers allowing it to charge interest at commercial rates where payment is not received within 90 days after the amount falls due, until the whole of the debt is paid.

Note 2 Summary of Significant Accounting Policies (continued)

(o) Receivables (continued)

Other trade receivables arise outside the normal course of selling goods and services to other agencies and to the public. Other trade receivables are payable within 30 days after the issue of an invoice or the goods/services have been provided under a contractual arrangement. If payment has not been received within 90 days after the amount falls due, under the terms and conditions of the arrangement with the debtor, the Directorate is able to charge interest at commercial rates until the whole amount of the debt is paid.

Accrued cross-border revenue arises when goods and services have been provided under a contractual arrangement for which payments are not due until an acquittal process is completed in subsequent years.

The allowance for impairment losses represents the amount of trade receivables and other trade receivables the Directorate estimates will not be repaid. The allowance for impairment losses is based on objective evidence and a review of overdue balances. The Directorate considers the following is objective evidence of impairment:

- becoming aware of financial difficulties of debtors;
- default payments; or
- debts more than 90 days overdue.

The amount of the allowance is the difference between the assets carrying amount and the present value of the estimated future cash flows, discounted at the original effective interest rate. Cash flows relating to short-term receivables are not discounted if the effect of discounting is immaterial. The amount of the allowance is recognised in the Operating Statement. The allowance for impairment losses are written back against the receivables account when the Directorate ceases action to collect the debt as it considers that it will cost more to recover the debt than the debt is worth.

Receivables that have been renegotiated because they are past due or impaired are accounted for based on the renegotiated terms.

(p) Investments

The Directorate holds one long-term investment. It is held with the Territory Banking Account in a unit trust called the Fixed Interest Portfolio. Investments are measured at fair value with any adjustments to the carrying amount recorded in the Operating Statement. Fair value is based on an underlying pool of investments which have quoted market prices as at the reporting date.

(q) Inventories

Inventories are stated at the lower of cost and net realisable value. Cost comprises the purchase price of inventories as well as transport, handling and other costs directly attributable to the acquisition of inventories. Trade discounts, rebates and similar items are deducted in determining the costs of purchase. The cost of inventories is assigned using the cost weighted average method.

Net realisable value is determined using the estimated sales proceeds less costs incurred in marketing, selling and distribution to customers.

Note 2 Summary of Significant Accounting Policies (continued)

(r) Assets Held for Sale

Assets held for sale are assets that are available for immediate sale in their present condition, and their sale is highly probable.

Assets held for sale are measured at the lower of the carrying amount and fair value less costs to sell. An impairment loss is recognised for any initial or subsequent write down of the asset to fair value less cost to sell. Assets held for sale are not depreciated.

(s) Acquisition and Recognition of Property, Plant and Equipment

Property, plant and equipment is initially recorded at cost. Cost includes the purchase price, directly attributable costs and the estimated cost of dismantling and removing the item (where, upon acquisition, there is a present obligation to remove the item).

Where property, plant and equipment is acquired at no cost, or minimal cost, cost is its fair value as at the date of acquisition. However property, plant and equipment acquired at no cost or minimal cost as part of a Restructuring of Administrative Arrangements is measured at the transferor's book value.

Where payment for property, plant and equipment is deferred beyond normal credit terms, the difference between its cash price equivalent and the total payment is measured as interest over the period of credit. The discount rate used to calculate the cash price equivalent is an asset specific rate.

Property, plant and equipment with a minimum value of $5,000 is capitalised.

(t) Measurement of Property, Plant and Equipment after Initial Recognition

Property, plant and equipment is valued using the cost or revaluation model of valuation. Land, buildings and leasehold improvements are measured at fair value.

Fair value is the amount for which an asset could be exchanged between knowledgeable willing parties in an arm's length transaction. Fair value is measured using market based evidence available for that asset (or a similar asset), as this is the best evidence of an asset's fair value. Where the market price for an asset cannot be obtained because the asset is specialised and is rarely sold, depreciated replacement cost is used as fair value.

Land, buildings and leasehold improvements are revalued every 3 years. However, if at any time management considers that the carrying amount of an asset materially differs from its fair value, then the asset will be revalued regardless of when the last valuation took place. Any accumulated depreciation relating to buildings and leasehold improvements at the date of revaluation is written-back against the gross carrying amount of the asset and the net amount is restated to the revalued amount of the asset.

The Directorate measures its plant and equipment at cost.

Note 2 Summary of Significant Accounting Policies (continued)

(u) Intangible Assets

The Directorate's Intangible Assets are comprised of internally developed and externally acquired software for internal use. Externally acquired software is recognised and capitalised when:

a. it is probable that the expected future economic benefits that are attributable to the software will flow to the Directorate;
b. the cost of the software can be measured reliably; and
c. the acquisition cost is equal to or exceeds $50,000.

Internally generated software is recognised when it meets the general recognition criteria outlined above and where it also meets the specific recognition criteria relating to internally developed intangible assets. Capitalised software has a finite useful life. Software is amortised on a straight-line basis over its useful life, over a period not exceeding 5 years.

Intangible Assets are measured at cost.

(v) Depreciation and Amortisation of Non-Current Assets

Non-current assets with a limited useful life are systematically depreciated/amortised over their useful lives in a manner that reflects the consumption of their service potential. The useful life commences when an asset is ready for use. When an asset is revalued, it is depreciated/amortised over its newly assessed remaining useful life. Amortisation is used in relation to intangible assets while depreciation is applied to physical assets such as buildings and plant and equipment.

Land has an unlimited useful life and is therefore not depreciated.

Leasehold improvements and motor vehicles under a finance lease are depreciated over the estimated useful life of each asset improvement, or the unexpired period of the relevant lease, whichever is shorter.

All depreciation is calculated after first deducting any residual values which remain for each asset.

Depreciation/amortisation for non-current assets is determined as follows.

Class of Asset	Depreciation/Amortisation Method	Useful Life (Years)
Buildings	Straight Line	40-80
Leasehold Improvements	Straight Line	2-10
Plant and Equipment	Straight Line	2-20
Externally Purchased Intangibles	Straight Line	2-5
Internally Generated Intangibles	Straight Line	2-5

The useful lives of all major assets held are reassessed on an annual basis.

Note 2 Summary of Significant Accounting Policies (continued)

(w) Payables

Payables are a financial liability and are measured at the fair value of the consideration received when initially recognised and at amortised cost subsequent to initial recognition, with any adjustments to the carrying amount being recorded in the Operating Statement. All amounts are normally settled within 30 days after the invoice date.

Payables include Trade Payables, Accrued Expenses and Other Payables.

Trade Payables represent the amounts owing for goods and services received prior to the end of the reporting period and unpaid at the end of the reporting period and relating to the normal operations of the Directorate.

Accrued Expenses represent goods and services provided by other parties during the period that are unpaid at the end of the reporting period and where an invoice has not been received by period end.

Other Payables are those unpaid invoices that do not directly relate to the normal operations of the Directorate.

(x) Leases

The Directorate has entered into finance leases and operating leases.

Finance Leases

Finance leases effectively transfer to the Directorate substantially all the risks and rewards incidental to ownership of the assets under a finance lease. The title may or may not eventually be transferred. Finance leases are initially recognised as an asset and a liability at the lower of the fair value of the asset and the present value of the minimum lease payments each being determined at the inception of the lease. The discount rate used to calculate the present value of the minimum lease payments is the interest rate implicit in the lease. Assets under a finance lease are depreciated over the shorter of the asset's useful life or lease term. Assets under a finance lease are depreciated on a straight-line basis. Each lease payment is allocated between interest expense and reduction of the lease liability. Lease liabilities are classified as current and non-current.

Operating Leases

Operating leases do not effectively transfer to the Directorate substantially all the risks and rewards incidental to ownership of the asset under an operating lease. Operating lease payments are recorded as an expense in the Operating Statement on a straight-line basis over the term of the lease.

(y) Employee Benefits

Employee benefits include salaries and wages, annual leave, long service leave and applicable on-costs. On-costs include annual leave, long service leave, superannuation and other costs that are incurred when employees take annual and long service leave. These benefits accrue as a result of services provided by employees up to the reporting date that remain unpaid. They are recorded as a liability and as an expense.

Note 2 Summary of Significant Accounting Policies (continued)

(y) Employee Benefits (continued)

Salaries and Wages

Accrued salaries and wages are measured at the amount that remains unpaid to employees at the end of the reporting period.

Annual and Long Service Leave

Annual leave and long service leave that falls due wholly within the next 12 months is measured based on the estimated amount of remuneration payable when the leave is taken.

Annual and long service leave including applicable on-costs that do not fall due within the next 12 months are measured at the present value of estimated future payments to be made in respect of services provided by employees up to the reporting date. Consideration is given to the future wage and salary levels, experience of employee departures and periods of service. At each reporting period, the estimated future payments are discounted using market yields on Commonwealth Government bonds with terms to maturity that match, as closely as possible, the estimated future cash flows. In 2011–12, the discount factor used to calculate the present value of these future payments is 106.6% (92.2% in 2010–11).

The long service leave liability is estimated with reference to the minimum period of qualifying service. For employees with less than the required minimum period of 7 years qualifying service, the probability that employees will reach the required minimum period has been taken into account in estimating the provision for long service leave and the applicable on-costs.

The provision for annual leave and long service leave includes estimated on-costs. As these on-costs only become payable if the employee takes annual and long service leave while in-service, the probability that employees will take annual and long service leave while in-service has been taken into account in estimating the liability for oncosts.

Annual leave and long service leave liabilities are classified as current liabilities in the Balance Sheet where there are no unconditional rights to defer the settlement of the liability for at least 12 months. However, where there is an unconditional right to defer settlement of the liability for at least 12 months, annual leave and long service leave have been classified as a non-current liability in the Balance Sheet.

(z) Superannuation

The Directorate receives funding for superannuation payments as part of the Government Payment for Outputs. The Directorate then makes payments on a fortnightly basis to the Territory Banking Account, to cover the Directorate's superannuation liability for the Commonwealth Superannuation Scheme (CSS) and the Public Sector Superannuation Scheme (PSS). This payment covers the CSS/PSS employer contribution, but does not include the productivity component. The productivity component is paid directly to Comsuper by the Directorate. The CSS and PSS are defined benefit superannuation plans meaning that the defined benefits received by employees are based on the employee's years of service and average final salary.

Note 2 Summary of Significant Accounting Policies (continued)

(z) Superannuation (continued)

Superannuation payments have also been made directly to superannuation funds for those members of the Public Sector who are part of superannuation accumulation schemes. This includes the Public Sector Superannuation Scheme Accumulation Plan (PSSAP) and schemes of employee choice.

Superannuation employer contribution payments, for the CSS and PSS, are calculated, by taking the salary level at an employee's anniversary date and multiplying it by the actuarially assessed nominal CSS or PSS employer contribution rate for each employee. The productivity component payments are calculated by taking the salary level, at an employee's anniversary date, and multiplying it by the employer contribution rate (approximately 3%) for each employee. Superannuation payments for the PSSAP are calculated by taking the salary level, at an employee's anniversary date, and multiplying it by the appropriate employer contribution rate. Superannuation payments for fund of choice arrangements are calculated by taking an employee's salary each pay and multiplying it by the appropriate employer contribution rate.

A superannuation liability is not recognised in the Balance Sheet as the Superannuation Provision Account recognises the total Territory superannuation liability for the CSS and PSS, and Comsuper and the external schemes recognise the superannuation liability for the PSSAP and other schemes respectively.

The ACT Government is liable for the reimbursement of the emerging costs of benefits paid each year to members of the CSS and PSS in respect of the ACT Government service provided after 1 July 1989. These reimbursement payments are made from the Superannuation Provision Account.

(aa) Equity Contributed by the ACT Government

Contributions made by the ACT Government, through its role as owner of the Directorate, are treated as contributions of equity.

Increases or decreases in net assets as a result of Administrative Restructures are also recognised in equity.

(ab) Insurance

Major risks are insured through the ACT Insurance Authority. The excess payable, under this arrangement, varies depending on each class of insurance held.

(ac) Third Party Monies

The Directorate holds third party monies in a trustee capacity for the ACT Medical Radiation Scientists Board, the ACT Veterinary Surgeons Board, the Health Directorate Human Research Ethics Committee and for residents of its Mental Health facilities. The Directorate also holds third party monies in an administrative capacity which is principally derived from patients treated by salaried specialists.

Accordingly, third party transactions are excluded from the Directorate's financial statements. Details of third party monies are shown at Note 41: Third Party Monies.

Note 2 Summary of Significant Accounting Policies (continued)

(ad) Significant Accounting Judgements and Estimates

In the process of applying the accounting policies listed in this note, the Directorate has made the following judgements and estimates that have the most significant impact on the amounts recorded in the financial statements:

a. *Fair Value of Assets*: the Directorate has made a significant judgement regarding the fair value of its assets. Land and Leasehold Improvements have been recorded at market value of similar properties as determined by an independent valuer. Buildings haven been recorded at fair value based on a depreciated replacement cost as determined by an independent valuer. This valuation is determined by reference to the new cost of the buildings less depreciation for their physical, functional and economic obsolescence.

b. *Employee Benefits*: significant judgements have been applied in estimating the liability for employee benefits. The estimated liability for employee benefits requires a consideration of the future wages and salary levels, experience of employee departures and periods of service. The estimate also includes an assessment of the probability that employees will meet the minimum service period required to qualify for long service leave and that on-costs will become payable. Further information on this estimate is provided in Note 2 (y): Employee Benefits and Note 3: Change in Accounting Policy and Accounting Estimates, and Correction of a Prior Period Error.

c. *Contingent Liabilities*: contingent liabilities is an estimate provided by the ACT Government Solicitor of the likely liability for legal claims against the Directorate.

d. *Allowance for Impairment Losses*: the Directorate has made a significant estimate in calculating the allowance for impairment losses. The allowance is based on reviews of overdue receivable balances and the amount of the allowance is recognised in the Operating Statement. Further details in relation to the calculation of this estimate are outlined in Note 2 (o): Receivables.

e. *Depreciation and Amortisation*: the Directorate has made a significant estimate in the lengths of useful lives over which its assets are depreciated and amortised. This estimation is the period in which utility will be gained from the use of the asset, based on either estimates from officers of the Directorate or an independent valuer.

f. *Impairment of Assets*: the Directorate has made a significant judgement regarding its impairment of assets by undertaking a process of reviewing any likely impairment factors. Business Units across the Directorate made an assessment of any indication of impairment by assessing against an impairment checklist.

g. Cross Border (Interstate) Health Receipts: is an estimation based on estimated numbers of interstate patients and a price per cost weighted separation agreed between the ACT, the States and the Northern Territory. Actual patient numbers and services are settled following an acquittal process undertaken in subsequent years and variations to the revenue recognised are accounted for in the year of settlement with the States and the Northern Territory. The Health Directorate has accounted for patient activity that is not disputed by New South Wales. There is currently two years of final acquittals for patient activity that have not been finalised due to a lengthy process of data review.

Note 2 Summary of Significant Accounting Policies (continued)

(ae) Impact of Accounting Standards Issued but yet to be applied

The following new and revised accounting standards and interpretations have been issued by the Australian Accounting Standards Board but do not apply to the current reporting period. These standards and interpretations are applicable to future reporting periods. The Directorate does not intend to adopt these standards and interpretations early. Where applicable, these Australian Accounting Standards will be adopted from their application date. It is estimated that the effect of adopting the below financial statement pronouncements, when applicable, will have no material financial impact on the Directorate's financial statements in future reporting periods:

- AASB 9 Financial Instruments (application date 1 January 2013);
- AASB 13 Fair Value Measurement (application date 1 January 2013);
- AASB 119 Employee Benefits (application date 1 January 2013);
- AASB 2010-7 Amendments to Australian Accounting Standards arising from AASB 9 (December 2010) [AASB 1, 3, 4, 5, 7, 101, 102, 112, 118, 120, 121, 127, 128, 131, 132, 136, 137, 139, 1023 & 1038 and Interpretations 2, 5, 10, 12, 19 & 127] (application date 1 January 2013);
- AASB 2011-8 Amendments to Australian Accounting Standards arising from AASB 13 [AASB 1, 2, 3, 4, 5,7, 9, 2009–11, 101, 107, 112, 118, 119, 120, 121, 128, 131, 132, 133, 134, 136, 138, 139, 140, 141,1004, 1023 &1038 and Interpretations 2, 4, 12, 13, 14, 17, 19, 131 & 132] (application date 1 January 2013);
- AASB 2011-9 Amendments to Australian Accounting Standards – Presentation of Items of Other Comprehensive Income [AASB 1, 5, 7, 101, 112, 120, 121, 132, 133, 134, 1039 & 1049] (application date 1 July 2012);
- AASB 2011–10 Amendments to Australian Accounting Standards arising from AASB 119 (September 2011) [AASB 1, AASB 8, AASB 101, AASB 124, AASB 134, AASB 1049 & AASB 2011-8 and Interpretation 14]] (application date 1 January 2013); and
- AASB 2012-5 Amendments to Australian Accounting Standards arising from Annual Improvements 2009-2011 Cycle [AASB 1, AASB 1010, AASB 116, AASB 132 & AASB 134 and Interpretation 2] (application date 1 January 2013).

Note 3 Change in Accounting Policy and Accounting Estimates, and Correction of a Prior Period Error

Change in Accounting Policy

The Directorate had no changes in Accounting Policy during the reporting period.

Change in Accounting Estimate

Revision of the Estimation of Employee Benefit Liability.

As disclosed in Note 2 (y): Employee Benefits, Annual Leave and Long Service Leave, including applicable on-costs, which do not fall due in the next 12 months, are measured at the present value of estimated payments to be made in respect of services provided by employees up to the reporting date. The present value of future payments is estimated using the government bond rate.

Last financial year the rate used to estimate the present value of these payments was 92.2%, however, due to a change in the government bond rate the rate is now 106.6%. As such the estimate of the long service leave has changed. This change has resulted in an increase to the estimate of the long service leave liability and expense in the current reporting period of $10,768,696.

Correction of a Prior Period Error

The Directorate had no correction of material prior period errors during the reporting period.

Note 4 Government Payment for Outputs

Government Payment for Outputs is revenue received from the ACT Government to fund the costs of delivering outputs. The ACT Government pays Government Payment for Outputs appropriation on a fortnightly basis.

	2012 $'000	2011 $'000
Revenue from the ACT Government		
Government Payment for Outputs [a]	904,281	834,520
Total Government Payment for Outputs	**904,281**	**834,520**

a) The increase relates to funding for growth in services at the Canberra Hospital and Health Services and Calvary Public Hospital, including in critical care, surgery, cancer services, mental health and aged care, and salary increases and indexation for non labour expenses.

Note 5 User Charges

	2012 $'000	2011 $'000
User Charges – ACT Government		
User Charges – ACT Government	825	788
Total User Charges – ACT Government	**825**	**788**

User Charges – Non-ACT Government		
Service Revenue	13,751	13,892
Amounts Received for Highly Specialised Drugs	16,423	15,479
Cross Border (Interstate) Health Revenue [a]	129,580	112,124
Inpatient Fees [b]	25,678	27,285
Facilities Fees [c]	22,929	20,571
Non-inpatient Fees	766	615
Inventory Sales [d]	16,501	19,002
Accommodation and Meals	3,474	3,376
Total User Charges – Non-ACT Government	**229,102**	**212,344**
Total User Charges	**229,927**	**213,132**

Cross-Border revenue which was previously accounted for on a net basis is now accounted for on a gross basis. This change had the effect of increasing User Charges by $15.814 million for 2010–11 (see note 15).

a) The increase mainly relates to growth in the number of interstate patients in ACT public hospitals and payments related to acquittal of prior year activity following finalisation of a data review.

b) The reduction mainly relates to a decrease in the number of Department of Veteran's Affairs inpatients at ACT public hospitals.

c) The increase is attributable to growth in private inpatients and outpatients and the full year effect of the Positron Emission Tomography (PET)/Computerised Tomography (CT) service.

d) The reduction is mainly due to reduced demand from the private sector for the supply of consumables.

Note 6 Interest

	2012 $'000	2011 $'000
Revenue from Non – ACT Government Entities		
Interest Revenue	97	87
Total Interest Revenue from Non-ACT Government Entities	97	87
Total Interest Revenue	**97**	**87**
Total interest revenue from financial assets not at fair value through profit and loss	**97**	**87**

Note 7 Distribution from Investments with the Territory Banking Account

	2012 $'000	2011 $'000
Revenue from ACT Government Entities		
Distribution from Investments with the Territory Banking Account	157	160
Total Distribution from Investments with the Territory Banking Account	**157**	**160**

Note 8 Resources Received Free of Charge

Resources received free of charge relate to goods and/or services being provided free of charge from other agencies within the ACT Government. Goods and services received free of charge from entities external to the ACT Government are classified as donations. Donations are shown in Note 10: Other Gains.

	2012 $'000	2011 $'000
Revenue from within the ACT Government		
Legal Services [a]	954	709
Total Resources Received Free of Charge	**954**	**709**

a) The increase reflects a higher level of legal services received from the ACT Government Solicitor.

Note 9 Other Revenue

Other Revenue arises from the core activities of the Directorate. Other Revenue is distinct from Other Gains, as Other Gains tend to be unusual transactions that are not part of the core activities of the Directorate.

	2012 $'000	2011 $'000
Revenue from Non-ACT Government Entities		
Grants	**23,542**	**24,373**
Total Revenue from Non-ACT Government Entities	23,542	24,373
Total Other Revenue	**23,542**	**24,373**

Contribution Analysis		
Contributions which have conditions of expenditure still required to be met		
Grants	546	6,296

The Directorate has received grants from various entities which must be spent on specific purposes.

Note 10 Other Gains

Other Gains tend to be unusual transactions that are not part of the Directorate's core activities. Other Gains are distinct from other revenue, as other revenue arises from the core activities of the Directorate.

	2012 $'000	2011 $'000
Gains from the Sale of Assets	206	93
Donations	979	2,515
Total Other Gains	**1,185**	**2,608**

Contribution Analysis		
Contributions which have conditions of expenditure still required to be met		
Donations	282	224

The Directorate has received donations from organisations and the general public which must be spent on specific purposes.

Note 11 Employee Expenses

	2012 $'000	2011 $'000
Wages and Salaries [a]	473,758	438,687
Annual Leave Expenses [b]	11,633	8,452
Long Service Leave Expenses [c]	16,297	5,712
Worker Compensation Insurance Premium [d]	17,407	13,541
Termination Payments [e]	1,314	828
Other Employee Benefits and On-Costs	7,523	7,237
Total Employee Expenses	**527,932**	**474,457**

	No.	No.
Average Full-time equivalent staff levels during the year were:	5,296	5,039

a) The increased Wages and Salaries mainly relates to payrises under collective agreements and staff increases related to growth in services in Critical Care, Acute Care, Women's and Children's Hospital, Surgical Services, Adult Mental Health, Rehabilitation and Cancer.

b) The increase in Annual Leave largely relates to the impact of payrises and an increase in staff numbers in 2012.

c) The increase in Long Service Leave is mainly due to a change to the present value factor from 92.2% to 106.6%, that had the effect of increasing the Long Service Leave Expenses by $10.7m.

d) The increase relates to labour costs, as the Workers' Compensation Insurance Premium is affected by increased salaries and wages.

e) The increase reflects higher number of redundancies linked to a 2012 savings target.

Note 12 Superannuation Expenses

	2012 $'000	2011 $'000
Superannuation Contributions to the Territory Banking Account	35,961	36,345
Productivity Benefit	5,286	5,290
Superannuation Payment to Comsuper (for the PSSAP)	3,433	3,582
Superannuation to External Providers [a]	21,387	17,819
Total Superannuation Expenses	**66,067**	**63,036**

a) Higher fund of choice contributors due to closure of access to CSS, PSS and PSSAP, and increased number of contributors.

Note 13 Supplies and Services

	2012 $'000	2011 $'000
Audit Expenses [a]	601	486
Clinical Expenses/Medical Surgical Supplies	55,875	54,949
Communications	3,835	3,647
Computer Expenses [b]	26,871	25,110
Contractors and Consultants	6,061	6,183
Domestic Services, Food and Utilities	27,513	26,793
General Administration	15,570	15,240
Hire and Rental Charges	3,918	4,349
Operating Lease Rental Payments [c]	6,175	5,736
Insurance [d]	29,190	25,698
Minor Capital	3,265	3,595
Non-Contract Services [e]	7,301	9,019
Pharmaceuticals [f]	38,020	35,825
Printing and Stationery	2,219	2,513
Property and Rental Expenses	2,548	2,546
Public Relations [g]	1,011	878
Publications	1,110	1,231
Repairs and Maintenance [h]	12,094	9,809
Staff Development and Recruitment	5,773	6,007
Travel and Accommodation	1,308	1,561
Vehicle Expenses [i]	1,638	1,373
Visiting Medical Officers [j]	25,610	27,688
Blood Products [k]	7,922	7,116
Total Supplies and Services	**285,428**	**277,352**

Blood Products previously included with 'Other Expenses' has now been included under 'Supplies and Services'. This re-categorisation had the effect of increasing 'Supplies and Services' by $7.116 million for the year 2010–11.

a) The increase relates to an audit of emergency department data by an external auditor.

b) The increase is mainly attributable to support costs for new systems, cost escalation and IT costs related to new staff.

c) The increase is mainly attributable to new office space at North Curtin to relocate staff affected by re-development at the Canberra Hospital and price escalation.

d) The increase mainly relates to annual price escalation and the impact of increased risk exposure due to growth in births and services.

e) The decrease is mainly due to a reduction in the use of agency nursing due to the recruitment of staff and better rostering practices.

f) The increase is mainly due to price escalation, higher activity and an increase in demand for Highly Specialised Drugs.

g) This increase mainly relates to displays for workforce related new initiatives.

h) This is mainly attributable to increased expenditure on preventative and reactive maintenance of ageing infrastructure and an increase in breakdown repairs of medical equipment.

i) This is mainly due to price escalation in vehicle running costs.

j) The decrease was achieved by employing more staff specialists and using less Visiting Medical Officers services.

k) This mainly relates to increase in demand for high cost blood products.

Note 14 Depreciation and Amortisation

	2012 $'000	2011 $'000
Depreciation		
Buildings [a]	12,034	10,496
Plant and Equipment	11,291	10,183
Leasehold Improvements [a]	1,078	818
Total Depreciation	**24,403**	**21,497**
Amortisation		
Intangible Assets [b]	4,526	3,774
Total Amortisation	**4,526**	**3,774**
Total Depreciation and Amortisation	**28,929**	**25,271**

a) Current year depreciation is based on higher asset values due to revaluation of buildings and leasehold improvements in June 2011.

b) The increase is due to additional systems implemented during the year, including e-Referrals, Electronic Discharge Summary and Equipment Loan Service Application.

Note 15 Grants and Purchased Services

Grants are sums of money given to organisations or individuals for a specified purpose directed at achieving goals and objectives consistent with government policy on health promotion.

Purchased Services are amounts paid to obtain services by the Directorate from other ACT Government agencies and external parties. They may be for capital, current or recurrent purposes and they are usually subject to terms and conditions set out in a contract, agreement, or by legislation.

Non-Government Organisation Service Providers provide services in a range of areas including Home and Community Care, Alcohol and Drug, Community Mental health, Women's Health, Aged Care and Aboriginal Health.

Purchased Services from Calvary Hospital is for the provision of healthcare for the north Canberra population.

Cross-border health costs relates to cost incurred by ACT residents in interstate hospitals.

Expenditure to Other Service Providers are mainly for the provision of elective surgery procedures by private hospitals.

Grants	2012 $'000	2011 $'000
Grants	2,709	2,685
Payments to Service Providers		
Calvary Hospital [a]	151,855	141,174
Non-Government Organisations [b]	71,515	66,273
Cross-Border Health Costs [c]	16,675	15,814
Other [d]	4,758	975
Total Grants and Purchased Services	**247,512**	**226,921**

Cross-Border Health costs incurred by the Directorate, previously treated as a reduction to cross-border revenue earned by the Directorate, is now accounted for as an expense. This change has resulted in Grants and Purchased Services increasing by $15.814 million for 2010–11.

a) The increased payment to Calvary Hospital is mainly due to the provision of funding for salary increases, price rises and growth in acute hospital services.

b) The increase is due to indexation, growth in mental health services, elective surgery procedures delivered by the non-government sector, growth in General Practice Development Fund payments and increased payments for the Preventative Health Program.

c) The increase mainly relates to additional ACT residents requiring clinical treatment in other jurisdictions and indexation.

d) The increase is due to an increased number of elective procedures bought from private hospitals than in the previous year.

Note 16 Borrowing Costs

	2012 $'000	2011 $'000
Finance Charges	415	441
Total Borrowing Costs	**415**	**441**

Borrowing cost is for finance charges in respect of finance leases for the Directorate's fleet of vehicles and clinical equipment.

Note 17 Other Expenses

	2012 $'000	2011 $'000
Cost of Goods Sold [a]	13,359	15,637
Miscellaneous Expenses	1,092	1,091
Legal Settlements [b]	2,427	1,510
Waivers, Impairment Losses and Write-offs (see Note 18) [c]	2,764	2,135
Loss on Disposal of Assets [d]	1,837	5,545
Total Other Expenses	**21,479**	**25,918**

Cost of Goods sold represents hospital supplies sold to private hospitals.

Blood Products previously included with 'Miscellaneous Expenses' has now been more appropriately included under 'Supplies and Services'. This re-categorisation had the effect of reducing 'Other Expenses' by $7.116 million for the year 2010–11.

a) The reduction is due to reduced demand for consumables from private hospitals in the ACT.

b) This is as a result of more litigated matters having been finalised in 2011–12 than in 2010–11.

c) This is mainly due to re-assessment of the impairment allowance and an increase in bad debt write-offs.

d) The 2010–11 year included the transfer of the Narrabundah Health Centre to the Winnunga Nimmityjah Aboriginal Health Service. In 2011–12 the loss mainly relates to transfer of ownership of Intensive Care Unit equipment to Calvary Public Hospital.

Note 18 Waivers, Impairment Losses and Write-Offs

Under Section 131 of the *Financial Management Act 1996*, the Treasurer may, in writing, waive the right to payment of an amount payable to the Territory.

A waiver is the relinquishment of a legal claim to a debt over which the Directorate has control. The write-off of a debt is the accounting action taken to remove a debt from the books but does not relinquish the legal right of the Directorate to recover the amount. The write-off of debts may occur for reasons other than waivers.

The impairment losses and write-offs listed below have occurred during the reporting period for the Directorate.

	No.	2012 $'000	No.	2011 $'000
Waivers	–	–		–
Total Waivers	–	–	–	–

Impairment Losses				
Impairment Loss from Receivables				
Trade Receivables [a]	29	640	–	315
Total Impairment Loss from Receivables	29	640	–	315
Impairment Loss from Property, Plant and Equipment				
Property, Plant and Equipment	8	613	6	538
Total Impairment loss from Property, Plant and Equipment	8	613	6	538
Total Impairment Losses	**37**	**1,253**	**6**	**853**

Write-Offs				
Irrecoverable Debts [b]	2,045	1,511	1,879	1,281
Total Write-offs	**2,045**	**1,511**	**1,879**	**1,281**

Total Waivers, Impairment Losses and Write-offs	**2,082**	**2,764**	**1,885**	**2,135**

a) This increase mostly relates to compensable patient debt that is assessed as unlikely to be received.

b) The increase is mainly as a result of writing-off debts of separated staff.

Note 19 Auditor's Remuneration

Auditor's remuneration represents fees charged by the Auditor-General's Office for financial audit services provided to the Directorate.

	2012 $'000	2011 $'000
Audit Services		
Audit Fees Paid to the ACT Auditor-General's Office	227	215
Total Audit Fees	227	215

No other services were provided by the ACT Auditor-General's Office.

Note 20 Act of Grace Payments

Under Section 130 of the *Financial Management Act 1996*, the Treasurer may, in writing, authorise Act of Grace Payments be made by the Directorate. Act of Grace Payments are a method of providing equitable remedies to entities or individuals that may have been unfairly disadvantaged by the Government but have no legal claim to the payment.

The Health Directorate made no Act of Grace Payments during the reporting period or the prior year.

Note 21 Cash and Cash Equivalents

The Directorate holds a number of bank accounts with the Commonwealth Bank as part of the whole-of-government banking arrangements. As part of these arrangements, the Directorate received interest at the rate of 4.78% (6.71% in 2011). These funds are able to be withdrawn upon request.

	2012 $'000	2011 $'000
Cash on Hand	47	49
Cash at Bank [a]	69,332	30,549
Total Cash and Cash Equivalents	**69,379**	**30,598**

a) The increase in cash at bank is mainly due to an increase in payables associated with timing differences between cash drawn down from Treasury and the payment of capital works invoices.

Note 22 Receivables

	2012 $'000	2011 $'000
Current Receivables		
Trade Receivables	8,705	8,928
Less: Allowance for Impairment Losses	(1,697)	(1,241)
	7,008	7,687
Other Trade Receivables [a]	18,482	13,096
Less: Allowance for Impairment Losses	(538)	(360)
	17,944	12,736
Accrued Revenue [b]	6,349	9,619
Accrued Revenue – Cross Border [c]	26,429	16,427
	32,778	26,046
Total Current Receivables	**57,730**	**46,469**
Non-Current Receivables		
Accrued Revenue [d]	–	2,135
Total Non-Current Receivables	–	2,135
Total Receivables	**57,730**	**48,604**

a) The increase is mainly attributable to accrued debtors for insurance refunds, Fringe Benefit Tax and an increase in receivables for pathology services to other hospitals.

b) The reduction mainly relates to accrued Department of Veteran's Affairs patients revenue due to reduced inpatient activity.

c) The increase reflects an increase in the number of New South Wales patients treated in the ACT and price escalation. This includes services provided in prior years that have been accured following finalisation of a data review agreed with New South Wales.

d) The reduction is due to payment by New South Wales for prior year supply of blood products to New South Wales patients.

Note 22 Receivables (continued)

Ageing of Receivables					
	Not Overdue	Past Due Less Than 30 days	Past Due 30 to 60 Days	Past Due Greater Than 60 days	Total
2012	**$'000**	**$'000**	**$'000**	**$'000**	**$'000**
Not Impaired					
Receivables [e]	24,811	1,269	561	4,660	31,301
Cross-Border [f]	26,429	–	–	–	26,429
Impaired					
Receivables	–	–	–	2,235	2,235
2011					
Not Impaired					
Receivables	24,190	2,352	715	4,920	32,177
Cross-Border	16,427	–	–	–	16,427
Impared					
Receivables	–	–	–	1,601	1,601

Receivables are written-off during the year in which they are considered to become uncollectible.

e) 'Not Overdue' component of Receivables largely consist of accrued revenues for Department of Veteran's Affairs patients which are not due until an acquittal process in subsequent years, Goods and Services input Tax receivable from Australian Taxation Office and private patient fees accrued in June.

f) Cross-Border receivables are funding due from NSW for admitted and non-admitted patient services provided to residents of NSW. This is categorised as not overdue as the funding agreement does not mandate a timeframe for payment prior to final acquittal of activity numbers for each period and the final acquittals are yet to occur.

g) Most receivables in the category 'Past Due – Greater than 60 Days' are third party, worker's compensation or public liability transactions which have become the subject of legal claims as to responsibility for the payment. Substantial delays can therefore occur before liability for such debts is determined.

Note 22 Receivables (continued)

	2012 $'000	2011 $'000
Reconciliation of the Allowance for Impairment Losses		
Allowance for Impairment Losses at the Beginning of the Reporting Period	1,601	1,250
Additional Allowance and Impairment Losses Recognised	640	351
Reduction in Allowance Resulting from a Write-Back against the Receivables	(6)	–
Allowance for Impairment Losses at the End of the Reporting Period	**2,235**	**1,601**

Classification of ACT Government/Non-ACT Government Receivables		
Receivables with ACT Government Agencies		
Net Trade Receivables	42	39
Net Other Trade Receivables	1,677	1,387
Accrued Revenue	17	12
Total Receivables with Other ACT Government Agencies	**1,736**	**1,438**

Receivables with Non ACT Government Entities		
Net Trade Receivables	6,966	8,889
Net Other Trade Receivables	16,267	10,108
Accrued Revenue	32,761	28,169
Total Receivables with Non ACT Government Entities	**55,994**	**47,166**
Total Receivables	**57,730**	**48,604**

Note 23 Inventories

The Directorate's inventory consists of Pharmaceuticals, Medical and Surgical Supplies, Pathology supplies and general consumables.

	2012 $'000	2011 $'000
Current Inventory		
Purchased Items – Cost	7,553	7,866
Total Current Inventory	7,553	7,866
Total Inventory	**7,553**	**7,866**

Note 24 Assets Held for Sale

The Directorate has 10 motor vehicles which have been returned to the Fleet Manager and are expected to be sold in July 2012. The residual and all lease payments have been paid. As such these vehicles have been classified as plant and equipment held for sale.

	2012 $'000	2011 $'000
Plant and Equipment held for Sale	169	127
Total Assets Held for Sale	**169**	**127**

Note 25 Investments

	2012 $'000	2011 $'000
The total carrying amount below has been measured at fair value.		
Non-Current Investments		
Investments with the Territory Banking Account – Fixed Interest Portfolio	2,990	3,000
Total Non-Current Investments	**2,990**	**3,000**
Total Investments	**2,990**	**3,000**

Note 26 Property, Plant and Equipment

Property, plant and equipment includes the following classes of assets – land, buildings, leasehold improvements and plant and equipment. Property, plant and equipment does not include assets held for sale.

Land includes leasehold land held by the Directorate.

Buildings include hospital buildings, community health centres and a multi storey car park.

Leasehold improvements represent capital expenditure incurred in relation to leased assets. The Directorate has fit-outs in its leased buildings.

Plant and equipment includes medical equipment, motor vehicles, mobile plant, air conditioning and heating systems, office and computer equipment, furniture and fittings, and other mechanical and electronic equipment.

Note 26 Property, Plant and Equipment (continued)

	2012 $'000	2011 $'000
Land and Buildings		
Land at Fair Value	36,820	36,820
Total Land Assets	**36,820**	**36,820**
Buildings at Fair Value [a]	551,154	501,245
Less Accumulated Depreciation	(13,027)	–
Total Written Down Value of Buildings	**538,127**	**501,245**
Total Land and Written Down Value of Buildings	**574,947**	**538,065**
Leasehold Improvements		
Leasehold Improvements at Fair Value [b]	9,244	8,314
Less Accumulated Depreciation	(1,378)	(300)
Total Written Down Value of Leasehold Improvements	**7,866**	**8,014**
Plant and Equipment		
Plant and Equipment at Cost [b]	96,314	90,307
Less: Accumulated Depreciation	(50,765)	(43,248)
Less: Accumulated Impairment Losses	(613)	(538)
Total Written Down Value of Plant and Equipment	44,936	46,521
Total Written Down Value of Property, Plant and Equipment	**627,749**	**592,600**

Assets Under a Finance Lease

Assets under a finance lease are included in the asset class to which they relate in the above disclosure.

Assets under a finance lease are also required to be seperately disclosed as outlined below.

Carrying Amount of Assets Under a Finance Lease		
Plant and Equipment Under a Finance Lease	7,538	8,151
Accumulated Depreciation of Plant and Equipment under a Finance Lease	(2,485)	(2,309)
Total Written Down Value of Assets under a Finance Lease	**5,053**	**5,842**

a) The increase relates to completed capital works projects, including the Adult Acute Mental Health Inpatient Unit and various capital upgrades projects.

b) The increase reflects plant and equipment, and leasehold improvements acquired during the year.

Note 26 Property, Plant and Equipment (continued)

Reconciliation of Property, Plant and Equipment

The following table shows the movement of Property, Plant and Equipment during 2011–12.

	Land $'000	Buildings $'000	Leasehold Improvements $'000	Plant and Equipment $'000	Total $'000
Carrying Amount at the Beginning of the Reporting Period	36,820	501,245	8,014	46,521	592,600
Additions	–	49,910	930	12,378	63,218
Revaluation (Decrement)	–	(994)	–	–	(994)
Assets classified as Held for Sale	–	–	–	(169)	(169)
Disposals	–	–	–	(2,428)	(2,428)
Depreciation	–	(12,034)	(1,078)	(11,291)	(24,403)
Impairment Losses Recognised in the Operating (Deficit)	–	–	–	(613)	(613)
Reversal of Impairment Losses Recognised in the Operating (Deficit)	–	–	–	538	538
Carrying Amount at the End of the Reporting Period	**36,820**	**538,127**	**7,866**	**44,936**	**627,749**

The following table shows the movement of Property, Plant and Equipment during 2010–11.

	Land $'000	Buildings $'000	Leasehold Improvements $'000	Plant and Equipment $'000	Total $'000
Carrying Amount at the Beginning of the Reporting Period	35,580	425,876	3,411	43,349	508,216
Additions	–	82,490	1,503	15,529	99,522
Revaluation Increment	5,700	4,163	3,917	–	13,780
Assets classified as Held for Sale	–	–	–	(127)	(127)
Disposals	(4,460)	(788)	–	(1,508)	(6,756)
Depreciation	–	(10,496)	(817)	(10,184)	(21,497)
Impairment Losses Recognised in the Operating (Deficit)	–	–	–	(538)	(538)
Carrying Amount at the End of the Reporting Period	**36,820**	**501,245**	**8,014**	**46,521**	**592,600**

Note 26 Property, Plant and Equipment (continued)

Valuation of Non-Current Assets

Certified practising registered valuers AON Risks Solutions performed an independent valuation of the Directorate's Land, Buildings and Leasehold Improvements as at 30 June 2011. Names and qualifications of the valuers are:

1. Mr Heinz Lindemann AAPI – Certified Practising Valuer
2. Mr Shane Welsh ASA – Certified Practising Valuer, Plant & Machinery

The next valuation will be undertaken during 2013–14.

Note 27 Intangible Assets

The Directorate has both internally generated software and externally purchased software. The internally generated software consists mainly of the 'patient administration system software', while the externally purchased software consists mainly of the 'patient admission system software licence'.

	2012 $'000	2011 $'000
Computer Software		
Internally Generated Software [a]	33,599	29,681
Less: Accumulated Amortisation	(23,729)	(16,854)
Total Internally Generated Software	9,870	12,827
Externally Purchased Software		
Computer Software at Cost	–	2,373
Less: Accumulated Amortisation	–	(2,373)
Total Externally Purchased Software	–	–
Total Computer Software	**9,870**	**12,827**
Total Intangible Assets	**9,870**	**12,827**

a) The increase is due to additional software implemented for the e-Referrals, Equipment Loan Service Applicatiion and Electronic Discharge Summary projects.

Note 27 Intangible Assets (continued)

Reconciliation of Intangible Assets

The following table shows the movement of each class of Intangible Asset distinguishing between internally generated and externally purchased intangibles from the beginning to the end of 2011–12.

	Internally Generated Software $'000	Externally Purchased Software $'000	Total $'000
Carrying Amount at the Beginning of the Reporting Period	12,827	–	12,827
Additions	1,569	–	1,569
Amortisation	(4,526)	–	(4,526)
Carrying Amount at the End of the Reporting Period	**9,870**	**–**	**9,870**

The following table shows the movement of each class of Intangible Asset distinguishing between internally generated and externally purchased intangibles from the beginning to the end of 2010–11.

	Internally Generated Software $'000	Externally Purchased Software $'000	Total $'000
Carrying Amount at the Beginning of the Reporting Period	11,198	196	11,394
Additions	5,207	–	5,207
Amortisation	(3,578)	(196)	(3,774)
Carrying Amount at the End of the Reporting Period	**12,827**	**–**	**12,827**

Note 28 Capital Works in Progress

Capital Works in Progress are assets being constructed over periods of time in excess of the present reporting period. These assets often require extensive installation work or integration with other assets, and contrast with simpler assets that are ready for use when acquired, such as motor vehicles and equipment. Capital Works in Progress are not depreciated as the Directorate is not currently deriving any economic benefits from them.

Assets, which are under construction, include hospital buildings, community health centres and computer software.

	2012 $'000	2011 $'000
Building Works in Progress [a]	177,252	85,189
Plant and Equipment Works in Progress	154	98
Computer Software Works in Progress [b]	40,641	23,138
Other Works in Progress	188	153
Total Capital Works in Progress	**218,235**	**108,578**

a) The increase in building works in progress is for works carried out on the Women's and Children's Hospital, Clinical Services Redevelopment, Integrated Cancer Centre, New Gungahlin Health Centre, Enhanced Community Health Centre in Belconnen, Tuggeranong Health Centre, Forward Design and various capital upgrades.

b) The increase in computer software works in progress is for development of the Patient Administration System for Calvary Hospital, Intensive Care Unit Patient Monitoring project, Electronic Health Care Record project and other e-Health projects.

Reconciliation of Capital Works in Progress

The following table shows the movement of Capital Works in Progress during 2011–12.

	Building Works in Progress $'000	Plant and Equipment Works in Progress $'000	Computer Software Works in Progress $'000	Other Works in Progress $'000	Total $'000
Carrying Amount at the Beginning of the Reporting Period	85,189	98	23,138	153	108,578
Additions	143,780	56	19,138	35	163,009
Capital Works in Progress Completed and Transferred to Property, Plant and Equipment and Intangible Assets	(49,910)	–	(1,569)	–	(51,479)
Capital Works Expensed	(1,807)	–	(66)	–	(1,873)
Carrying Amount at the End of the Reporting Period	**177,252**	**154**	**40,641**	**188**	**218,235**

Note 28 Capital Works in Progress (continued)

Reconciliation of Capital Works in Progress

The following table shows the movement of Capital Works in Progress during 2010–11.

	Building Works in Progress $'000	Plant and Equipment Works in Progress $'000	Computer Software Works in Progress $'000	Other Works in Progress $'000	Total $'000
Carrying Amount at the Beginning of the Reporting Period	77,085	260	14,903	199	92,447
Additions	90,594	–	13,442	–	104,036
Capital Works in Progress Completed and Transferred to Property, Plant and Equipment and Intangible Assets	(82,490)	(162)	(5,207)	(46)	(87,905)
Carrying Amount at the End of the Reporting Period	**85,189**	**98**	**23,138**	**153**	**108,578**

Note 29 Other Assets

	2012 $'000	2011 $'000
Current Other Assets		
Prepayments	2,515	2,414
Total Current Other Assets	2,515	2,414
Total Other Assets	**2,515**	**2,414**

Note 30 Payables

	2012 $'000	2011 $'000
Current Payables		
Trade Payables [a]	11,280	19,546
Other Payables	62	50
Accrued Expenses [b]	68,203	37,123
GST Payable	415	478
Total Current Payables	**79,960**	**57,197**
Non-Current Payables		
Other Payables	–	–
Total Non-Current Payables	**–**	**–**
Total Payables	**79,960**	**57,197**
Payables are aged as follows:		
Not Overdue	79,404	43,153
Overdue for Less than 30 Days	482	9,226
Overdue for 30 to 60 Days	45	97
Overdue for More than 60 Days	29	4,721
Total Payables	**79,960**	**57,197**

a) 2011 included a large amount of capital works invoices received late in June.

b) The increase relates to a large amount of capital works accruals.

Classification of ACT Government/Non-ACT Government Payables		
Payables with ACT Government Entities		
Accrued Expenses	39,541	6,054
Total Payables with ACT Government Entities	**39,541**	**6,054**
Payables with Non-ACT Government Entities		
Trade Payables	11,680	20,022
Other Payables	62	50
Accrued Expenses	28,677	31,071
Total Payables with Non-ACT Government Entities	**40,419**	**51,143**
Total Payables	**79,960**	**57,197**

Note 31 Finance Leases

The Directorate has 293 finance leases, which have been taken up as a finance lease liability and an asset under a finance lease. These leases are for motor vehicles. The interest rate implicit in these leases vary from 4.16% to 7.99% and the terms vary from 1 year to 6 years. These leases allow for extensions, but have no terms of renewal or purchase options and escalation clauses.

	2012 $'000	2011 $'000
Current Finance Leases		
Secured		
Finance Leases [a]	3,288	2,423
Total Current Finance Leases	**3,288**	**2,423**
Non-Current Finance Leases		
Secured		
Finance Leases [b]	1,802	3,575
Total Non-Current Finance Leases	**1,802**	**3,575**
Total Finance Leases	**5,090**	**5,998**

a) The increase is mainly due to the current repayments also include residual payments for a larger number of motor vehicles for which leases are due to expire within 12 months.

b) The decrease is mainly due to a large number finance leases with large residual payments becoming current as they are due to expire within 12 months.

Secured Liability

The Directorate's finance lease liability is effectively secured because, if the Directorate defaults, the assets under a financial lease revert to the lessor.

Note 31 Finance Leases (continued)

	2012 $'000	2011 $'000
Finance lease commitments are payable as follows:		
Within one year	3,513	2,765
Later than one year but not later than five years	1,905	3,758
Minimum Lease Payments	**5,418**	**6,523**
Less: Future Finance Lease Charges	(328)	(525)
Amount Recognised as a Liability	**5,090**	**5,998**
Add: Lease incentive involved with non-cancellable operating lease	–	–
Total Present Value of Minimum Lease Payments	**5,090**	**5,998**

The present values of the minimum lease payments are as follows:		
Within one year	3,288	2,423
Later than one year but not later than five years	1,802	3,575
Total Present Value of Minimum Lease Payments	**5,090**	**5,998**

Classification on the Balance Sheet		
Finance Leases		
Current Finance Leases	3,288	2,423
Non-Current Finance Leases	1,802	3,575
Total Finance Leases	**5,090**	**5,998**

Note 32 Employee Benefits

	2012 $'000	2011 $'000
Current Employee Benefits		
Annual Leave [a]	76,428	67,924
Long Service Leave [b]	71,762	55,084
Accrued Salaries [c]	15,688	12,506
Other Benefits	429	679
Total Current Employee Benefits	**164,307**	**136,193**
Non-Current Employee Benefits		
Long Service Leave	14,984	14,962
Total Non-Current Employee Benefits	**14,984**	**14,962**
Total Employee Benefits	**179,292**	**151,155**

a) The increase is mainly due to the impact of collective agreement payrises and an increase in staff numbers for growth in services and new initiatives.

b) The increase is mainly due to the impact of a change to the present value factor from 92.2% to 106.6%, that had the effect of increasing Long Service Leave expenses by $10.7m. Collective Agreement payrises and an increase in staff numbers for growth in services and new initiatives also had the effect of increasing the long service leave liability.

c) The increase is due to an additional unpaid working day in June 2012.

Estimate of when Leave is Payable		
Estimated Amount Payable within 12 Months		
Annual Leave	76,428	67,923
Long Service Leave	7,223	6,331
Accrued Salaries	15,688	12,506
Other Benefits	429	679
Total Employee Benefits Payable within 12 Months	**99,768**	**87,439**
Estimated Amount Payable after 12 Months		
Long Service Leave	79,524	63,716
Total Employee Benefits Payable after 12 Months	**79,524**	**63,716**
Total Employee Benefits	**179,292**	**151,155**

Note 33 Other Provisions

Provision for Make Good

The Directorate entered into lease agreements for some office space in Civic and Belconnen. There are clauses within the lease agreements which require the Directorate, upon cessation of the tenancy, to return the office space to the condition it was in before it was leased (this is referred to as 'make good'). The tenancies run for 5 years.

	2012 $'000	2011 $'000
Non-Current Other Provisions		
Provision for Make Good	1,503	1,503
Total Other Provisions	**1,503**	**1,503**

Note 34 Other Liabilities

	2012 $'000	2011 $'000
Current Other Liabilities		
Revenue Received in Advance [a]	656	5,262
Total Current Other Liabilities	656	5,262
Total Other Liabilities	**656**	**5,262**

a) The reduction is mainly due to a lower number of grants and donations that are reciprocal in nature than in 2011.

Note 35 Equity

Asset Revaluation Surplus

The Asset Revaluation Reserve is used to record the increments and decrements in the value of property, plant and equipment.

	2012 $'000	2011 $'000
Balance at the Beginning of the Reporting Period	**145,001**	**135,394**
Increment in Land due to Revaluation	–	5,700
Decrement in Land due to Disposal	–	(4,040)
Increment in Building due to Revaluation	–	4,163
Increment in Leasehold Improvements due to Revaluation	–	3,917
Decrement in Building due to Impairment Loss	–	(133)
Other Decrements [a]	(994)	–
Total (Decrease)/ Increase in the Asset Revaluation Surplus	(994)	9,607
Balance at the End of the Reporting Period	**144,007**	**145,001**

a) Other decrements relates to correction of an immaterial prior year error.

Note 36 Financial Instruments

Details of the significant policies and methods adopted, including the criteria for recognition, the basis of measurement, and the basis on which income and expenses are recognised, with respect to each class of financial asset and financial liability are disclosed in Note 2 : Summary of Significant Accounting Policies.

Interest Rate Risk

Interest rate risk is the risk that the fair value or future cash flows of a financial instrument will fluctuate because of changes in market interest rates.

The Directorate does not hold any financial liabilities with floating interest rates, the Directorate is therefore not exposed to movements in interest payable. The Directorate is, however, exposed to movements in interest rates on amounts held in Cash at Bank.

Interest rate risk for financial assets is managed by the Directorate by only investing in floating interest rate investments that are low risk. There have been no changes in risk exposure or processes for managing the risk since the last financial reporting period.

A sensitivity analysis has not been undertaken as it is considered that the Directorate's exposure to this risk is insignificant and would have an insignificant impact on its financial results.

Note 36 Financial Instruments (continued)

Credit Risk

Credit risk is the risk that one party to a financial instrument will fail to discharge an obligation and cause the other party to incur a financial loss.

Credit risk is managed by the Directorate for Cash at Bank by holding bank balances with the ACT Government's banker (the Commonwealth Bank). The Bank holds a AA issuer credit rating with Standard and Poors who considers that its traditional retail and commercial banking model supports its income stability. Credit risk is managed by the Directorate for investments by only investing surplus funds with the Territory Banking Account, which has appropriate investment criteria for the external fund manager engaged to manage the Territory's surplus funds.

The Directorate's receivables are predominantly from insurance companies, ACT Government and State (mainly NSW) and the Federal Governments. As both the Federal Government and the NSW Government have a AAA credit rating it is considered that there is a very low risk of default for those receivables. Credit risk for receivables with the NSW Government, which are for provision of services to patients who reside in NSW is managed by having an agreement in place, providing required activity data in a timely manner and requiring provisional payments for these activities.

There has been no change in credit risk exposure since last reporting period.

Liquidity Risk

Liquidity risk is the risk that the Directorate will be unable to meet its financial obligations as they fall due. The Directorate's financial obligations relate to the payment of grants and the purchase of supplies and services. Grants are paid on a quarterly basis and purchases of supplies and services are paid within 30 days of receiving the goods or services.

The main source of cash to pay these obligations is appropriation from the ACT Government which is paid on a fortnightly basis during the year. The Directorate manages its liquidity risk through forecasting appropriation drawdown requirements to enable payment of anticipated obligations. See the maturity analysis provided later in this note for further details of when financial assets and liabilities mature.

The Directorate's exposure to liquidity risk is considered insignificant based on experience from prior years and the current assessment of risk.

Price Risk

Price risk is the risk that the fair value or future cash flows of a financial instrument will fluctuate because of changes in market prices (other than those arising from interest rate risk or currency risk), whether these changes are caused by factors specific to the individual financial instrument or its issuer, or factors affecting all similar financial instruments traded into the market. The only price risk the Directorate is exposed to results from its investment in the Fixed Interest Portfolio. The Directorate has units in the Fixed Interest Portfolio that fluctuate in value. The price fluctuation in the units of the portfolio is caused by movements in the underlying investments of the portfolio. The underlying investments are managed by an external fund manager who invests in a variety of different securities, including bonds issued by the Commonwealth Government, the State Government guaranteed treasury corporations and semi-government authorities, as well as investment-grade corporate issues.

Note 36 Financial Instruments (continued)

The Directorate's exposure to price risk and the management of this risk has not changed since last reporting period.

A sensitivity analysis has not been undertaken for the price risk of the Directorate as it has been determined that the possible impact on profit and loss or total equity from fluctuations in price is immaterial.

Fair Value of Financial Assets and Liabilities

The carrying amounts and fair values of financial assets and liabilities at the end of the reporting period are:

	Carrying Amount 2012 $'000	Fair Value 2012 $'000	Carrying Amount 2011 $'000	Fair Value 2011 $'000
Financial Assets				
Cash and Cash Equivalents	69,379	69,379	30,598	30,598
Receivables	57,730	57,730	48,604	48,604
Investments with the Territory Banking Account	2,990	2,990	3,000	3,000
Total Financial Assets	**130,100**	**130,100**	**82,202**	**82,202**
Financial Liabilities				
Payables	79,960	79,960	57,197	57,197
Finance Leases	5,090	5,090	5,998	5,998
Total Financial Liabilities	**85,050**	**85,050**	**63,195**	**63,195**

Note 36 Financial Instruments (continued)

Fair Value Hierarchy

The Directorate is required to classify financial assets and financial liabilities into a fair value hierarchy that reflects the significance of the inputs used in determining their fair value. The fair value hierarchy is made up of the following three levels:

- Level 1 – quoted prices (unadjusted) in active markets for identical assets or liabilities;
- Level 2 – inputs other than quoted prices included within Level 1 that are observable for the asset or liability, either directly (i.e. prices) or indirectly (i.e. derived from prices); and
- Level 3 – inputs for the asset or liability that are not based on observable market data (unobservable inputs).

The carrying amount of financial assets measured at fair value, as well as the methods used to estimate the fair value are summarised in the table below. All other financial assets and liabilities are measured, subsequent to initial recognition, at amortised cost and as such are not included in the table below.

2012	Classification According to Fair Value Hierarchy			
	Level 1 $'000	Level 2 $'000	Level 3 $'000	Total $'000
Financial Assets				
Investment with the Territory Banking Account Fixed Interest Portfolio Account	–	2,990	–	2,990
	–	**2,990**	**–**	**2,990**

Transfer Between Categories
There have been no transfers of financial assets or liabilities between Level 1 and Level 2 during the reporting period.

2011	Classification According to Fair Value Hierarchy			
	Level 1 $'000	Level 2 $'000	Level 3 $'000	Total $'000
Financial Assets				
Investment with the Territory Banking Account Fixed Interest Portfolio Account	–	3,000	–	3,000
	–	**3,000**	**–**	**3,000**

Transfer Between Categories
There have been no transfers of financial assets or liabilities between Level 1 and Level 2 during the reporting period.

Note 36 Financial Instruments (continued)

The following table sets out the Directorate 's maturity analysis for financial assets and liabilities as well as the exposure to interest rates, including average weighted interest rates by maturity period as at 30 June 2012. All financial assets and liabilities which have a floating interest rate or are non-interest bearing will mature in 1 year or less. All amounts appearing in the following maturity analysis are shown on an undiscounted cash flow basis.

				Fixed Interest Maturing in:				
		Weighted Averaged Interest Rate	Floating Interest Rate	1 Year or Less	Over 1 to 5 Years	Over 5 Years	Non-Interest Bearing	Total
	Note No.		$'000	$'000	$'000	$'000	$'000	$'000
Financial Instruments								
Financial Assets								
Cash and Cash Equivalents	21	4.87%	69,332	–	–	–	47	69,379
Receivables	22		–	–	–	–	57,730	57,730
Investments with the Territory Banking Account	25		–	–	–	–	2,990	2,990
Total Financial Assets			**69,332**	**–**	**–**	**–**	**60,767**	**130,100**
Financial Liabilities								
Payables	30		–	–	–	–	79,960	79,960
Finance Leases	31	7.18%	–	3,513	1,905	–	–	5,418
Total Financial Liabilities			**–**	**3,513**	**1,905**	**–**	**79,960**	**85,378**
Net Financial Assets/(Liabilities)			**69,332**	**(3,513)**	**(1,905)**	**–**	**(19,193)**	**44,721**

Note 36 Financial Instruments (continued)

The following table sets out the Directorate's maturity analysis for financial assets and liabilities as well as the exposure to interest rates, including average weighted interest rates by maturity period as at 30 June 2011. All financial assets and liabilities which have a floating interest rate or are non-interest bearing will mature in 1 year or less. All amounts appearing in the following maturity analysis are shown on an undiscounted cash flow basis.

				Fixed Interest Maturing in:				
		Weighted Averaged Interest Rate	Floating Interest Rate	1 Year or Less	Over 1 to 5 Years	Over 5 Years	Non-Interest Bearing	Total
	Note No.		$'000	$'000	$'000	$'000	$'000	$'000
Financial Instruments								
Financial Assets								
Cash and Cash Equivalents	21	6.71%	30,549	–	–	–	49	30,598
Receivables	22		–	–	–	–	48,604	48,604
Investments with the Territory Banking Account	25		–	–	–	–	3,000	3,000
Total Financial Assets			**30,549**	**–**	**–**	**–**	**51,653**	**82,202**
Financial Liabilities								
Payables	30		–	–	–	–	57,197	57,197
Finance Leases	31	7.35%	–	2,765	3,758	–	–	6,523
Total Financial Liabilities			**–**	**2,765**	**3,758**	**–**	**57,197**	**63,720**
Net Financial Assets/(Liabilities)			**30,549**	**(2,765)**	**(3,758)**	**–**	**(5,544)**	**18,483**

Note 36 Financial Instruments (continued)

	2012 $'000	2011 $'000
Carrying Amount of Each Specified Category of Financial Asset and Financial Liability		
Financial Assets		
Loans and Receivables	57,730	48,604
Financial assets at fair value through the Profit and Loss designated upon initial recognition	2,990	3,000
Financial Liabilities		
Financial Liabilities measured at Amortised Cost	85,050	63,195
Gains on Each Category of Financial Asset and Financial Liability		
Gains on Financial Assets		
Loans and Receivables	–	–
Financial assets at fair value through the Profit and Loss designated upon initial recognition	157	160
Gains on Financial Liabilities		
Financial Liabilities measured at Amortised Cost	–	–

Note 37 Commitments

Capital Commitments

Capital Commitments contracted at reporting date include the Adult Mental Health Acute Inpatient Unit, Clinical Services Redevelopment, Integrated Cancer Centre, Enhancing Canberra Hospital Facilities (design), Women's and Children's Hospital, An e-Healthy Future, Health Centres in Belconnen, Tuggeranong and Gungahlin, Aboriginal & Torres Strait Islander Residential Alcohol & Other Drug Rehabilitation Facility, Central Sterilising Service and other minor new works construction projects. These have not been recognised as liabilities.

	2012 $'000	2011 $'000
Capital Commitments – Property, Plant and Equipment		
Payable:		
Within one year	238,628	283,466
Later than one year and not later than five years	169,273	212,921
Later than five years	–	–
Total Capital Commitments – Property, Plant and Equipment	**407,901**	**496,387**
Total Capital Commitments	**407,901**	**496,387**

The reduction is as a result of less monies appropriated in 2012–13 budget.

Note 37 Commitments (continued)

Operating Lease Commitments

The Directorate has several non-cancellable operating leases for buildings. The operating lease agreements give the Directorate the right to renew the leases. Renegotiations of the lease terms occur on renewal of the leases. The Directorate also has non-cancellable operating leases with Shared Services for IT equipment. Contingent rental payments have not been included in the commitments below.

	2012 $'000	2011 $'000
Non-cancellable operating lease commitments are payable as follows:		
Within one year	7,290	5,006
Later than one year and not later than five years	21,135	12,523
Later than five years	–	4,366
Total Operating Lease Commitments	**28,425**	**21,895**

The increase is largely due to renewal of lease for offices on 1 Moore Street for five years from 29 June 2012, this was partially offset by the expiration of leases on some properties.

Other Commitments

Other commitments contracted at reporting date mainly relate to grants to Non-Government Organisations that have not been recognised as liabilities.

	2012 $'000	2011 $'000
Non-cancellable other commitments are payable as follows:		
Within one year	49,295	69,219
Later than one year and not later than five years	36,855	39,881
Later than five years	–	–
Total Other Commitments	**86,150**	**109,100**

The reduction mainly relates to lower number of executed contracts than in 2011.

All amounts shown in the commitment note are inclusive of GST.

Finance Lease Commitments

Finance lease commitments are disclosed in Note 31: Finance Leases.

All amounts shown in the commitment note are inclusive of GST.

Note 38 Contingent Liabilities

Contingent Liabilities

The Directorate is currently defending 142 actions (2011 – 159 actions). These actions have an estimated net liability of $5,530,000 (2011 – $11,515,000), which has not been provided for in the accounts. The estimated liability has been calculated net of the amounts covered under the Directorate's insurance policy. The reduction in the estimated net liability is due to the ACT Insurance Authority's acceptance, in 2012, of one previously declined high cost insurance claim.

Note 39 Cash Flow Reconciliation

a. Reconciliation of Cash and Cash Equivalents at the end of the reporting period in the Cash Flow Statement to the equivalent items in the Balance Sheet.

	2012 $'000	2011 $'000
Cash and Cash Equivalents Recorded in the Balance Sheet	69,379	30,598
Total Cash and Cash Equivalents at the end of the reporting period as recorded in the Cash Flow Statement	**69,379**	**30,598**

Note 39 Cash Flow Reconciliation (continued)

b. Reconciliation of Net Cash Inflows from Operating Activities to the Operating Deficit.

	2012 $'000	2011 $'000
Operating (Deficit)	(17,619)	(17,807)
Add/(Less) Non-Cash Items		
Depreciation of Property, Plant and Equipment	24,403	21,497
Amortisation of Intangibles	4,526	3,774
Bad and Doubtful Debts	2,151	1,281
Asset Book Value Written Down	1,871	6,105
Impairment Loss of Non-Current Assets	613	538
Add/(Less) Items Classified as Investing or Financing		
Net Gain on Disposal of Assets	(75)	(114)
Unrealised Gain on Investments	(10)	–
Cash Before Changes in Operating Assets and Liabilities	**15,859**	**15,274**
Changes in Operating Assets and Liabilities		
(Increase)/Decrease in Receivables	(9,127)	11,272
Decrease/(Increase) in Inventories	313	(1,624)
(Increase)/Decrease in Other Assets	(101)	567
Increase in Payables	22,715	13,583
Increase in Provisions	28,136	12,169
(Decrease) in Other Liabilities	(4,606)	(11,804)
Net Changes in Operating Assets and Liabilities	**37,330**	**24,163**
Net Cash Inflows from Operating Activities	**53,189**	**39,435**

c. Non – Cash Financing and Investing Activities

Under the Whole-of-Government motor vehicle leasing arrangements all new motor vehicle leases entered into by the Directorate are under a finance lease rather than under an operating lease.

	2012 $'000	2011 $'000
Acquisition of Motor Vehicles by means of a Finance Lease	1,235	1,528

Note 40 Events Occurring After Balance Date

From 1 July 2012, funds for public hospital services being delivered under the National Health Reform Agreement, both activity based and block funds, must flow through the National Health Funding Pool to Local Hospital Networks. To facilitate this in the ACT, a new directorate called the ACT Local Hospital Network Directorate has been established under the *ACT Financial Management Act 1996* (the FMA).

As the ACT Local Hospital Network Directorate will not have any assets or liabilities there will be no impact on the Health Directorate's balance sheet for future years ending 30 June.

The Health Directorate's Operating Statement and Cash Flow Statement for future years will however be impacted:

- Government Payment for Outputs Revenue will be lower by the amount going to the ACT Local Hospital Network Directorate ($599 million in 2012–13).
- Monies received from the ACT Local Hospital Network Directorate will be accounted for as User Charges – ACT Government (estimated in 2012–13 at $546 million), and
- Expenditure on Purchased Services to Calvary Public Hospital, Clare Holland House and Queen Elizabeth II Hospital will no longer be in the Health Directorate expenditures as these expenditures will be reported by the ACT Local Hospital Network Directorate (estimated in 2012–13 at $156 million).

Note 41 Third Party Monies

The Directorate held funds in trust relating to the activities of the ACT Medical Radiation Scientists Board, the ACT Veterinary Surgeons Board and the Health Directorate Human Research Ethics Committee.

	2012 $'000	2011 $'000
Registration Boards and Ethics Committee Trust Account		
Balance at the Beginning of the Reporting Period	438	2,430
Cash Receipts	1,079	4,628
Cash Payments	(988)	(6,620)
Balance at the End of the Reporting Period	**529**	**438**

The Directorate held funds in trust relating to residents of its Mental Health facilities.

Mental Health Trust Account		
Balance at the Beginning of the Reporting Period	22	25
Cash Receipts	127	82
Cash Payments	(122)	(85)
Balance at the end of the Reporting Period	**27**	**22**

The Directorate held funds relating to the activities of Salaried Specialists.

Private Practice Hospital Account		
Balance at the Beginning of the Reporting Period	21,702	18,960
Cash Receipts	18,954	20,688
Cash Payments	(17,389)	(17,946)
Balance at the End of the Reporting Period	**23,267**	**21,702**

Note 42 Service Concession Assets

The Directorate has entered into an agreement with Calvary Health Care ACT Ltd for the provision of hospital and associated services. The original agreement was entered into by the Commonwealth on 22 October 1971 and does not stipulate any expiry date. This was subsequently amended in 1979 to include the Directorate (named at the time as Capital Territory Health Commission) with any duties or functions of the Commonwealth being transferred to the Directorate. The Agreement was for the facility to be used for a public hospital. This was varied, in 1988, by the Calvary Private Agreement to allow Calvary Health Care Ltd to use two floors of the facility for treating private patients. The Calvary Private Agreement sets the process and mechanism for Calvary Private to reimburse Calvary Public for any costs incurred in using public hospital facilities for treating private patients. These agreements were replaced on 7 December 2011 with the Calvary Network Agreement.

Under the agreement, Calvary Health Care ACT Ltd is required to provide hospital services and make these services available to all persons irrespective of their circumstances and is to charge patients fees only in accordance with the scale of fees applicable at Health Directorate hospitals for comparable services. In the event that the agreement ceases, all land is to be returned to the Territory. The level of services that is required to be provided in a financial year, for the amount of funding provided, is stipulated in a Performance Plan agreed between the Directorate and Calvary Health Care ACT Ltd for each year.

The amount of funding provided for in the 2011–12 financial year was $151.855 million in recurrent funding, recognised in the Directorate's grants and purchased services expenditure, and $0.727 million for capital upgrades of assets subject to these service concession arrangements. This is recognised as Territorial grants expenditure.

The land, hospital buildings and other assets comprising the Calvary Public Hospital are not recognised in the Directorate's Balance Sheet.

Health Directorate Territorial Financial Statements for the year ended 30 June 2012

Health Directorate Statement of Income and Expenses on Behalf of the Territory For the Year Ended 30 June 2012

	Note	Actual 2012 $'000	Original Budget 2012 $'000	Actual 2011 $'000
Income				
Revenue				
Payment for Expenses on Behalf of the Territory	44	986	727	451
Fees	45	794	676	721
Total Revenue		**1,780**	**1,403**	**1,172**
Total Income		**1,780**	**1,403**	**1,172**
Expenses				
Grants and Purchased Services	46	727	727	710
Transfer to the ACT Government	47	794	676	721
Total Expenses		**1,521**	**1,403**	**1,431**
Operating Surplus/(Deficit)		259	–	(259)
Total Comprehensive Income/(Deficit)		**259**	**–**	**(259)**

The above Statement of Income and Expenses on Behalf of the Territory should be read in conjunction with the accompanying notes.

Health Directorate Statement of Assets and Liabilities on Behalf of the Territory as at 30 June 2012

	Note	Actual 2012 $'000	Original Budget 2012 $'000	Actual 2011 $'000
Current Assets				
Cash and Cash Equivalents	48	300	295	36
Receivables	49	–	5	5
Total Current Assets		300	300	41
Total Assets		**300**	**300**	**41**
Current Liabilities				
Non-Current Liabities				
Advance from Territory Banking Account	50	300	300	300
Total Liabilities		300	300	300
Net (Liabilities)		**–**	**–**	**(259)**
Equity				
Accumulated (Deficits)		–	–	(259)
Total Equity		**–**	**–**	**(259)**

The above Statement of Assets and Liabilities on Behalf of the Territory should be read in conjunction with the accompanying notes.

Health Directorate Statement of Changes in Equity on Behalf of the Territory For the Year Ended 30 June 2012

	Accumulated Funds 2012 $'000	Total Equity 2012 $'000	Original Budget 2012 $'000
Balance at the Beginning of the Reporting Period	(259)	(259)	–
Comprehensive Income			
Operating Surplus	259	259	–
Total Comprehensive Income	259	259	–
Transactions Involving Owners Affecting Accumulated Funds			
Total Transactions Involving Owners Affecting Accumulated Funds	–	–	–
Balance at the End of the Reporting Period	–	–	–

The above Statement of Changes in Equity on Behalf of the Territory should be read in conjunction with the accompanying notes.

	Accumulated Funds Actual 2011 $'000	Total Equity Actual 2011 $'000
Balance at the Beginning of the Reporting Period	–	–
Comprehensive Income		
Operating (Deficit)	(259)	(259)
Total Comprehensive Income	**(259)**	**(259)**
Transactions Involving Owners Affecting Accumulated Funds		
Total Transactions Involving Owners Affecting Accumulated Funds	–	–
Balance at the End of the Reporting Period	**(259)**	**(259)**

The above Statement of Changes in Equity on Behalf of the Territory should be read in conjunction with the accompanying notes.

Health Directorate Cash Flow Statement on behalf of the Territory For the Year Ended 30 June 2012

	Note	Actual 2012 $'000	Original Budget 2012 $'000	Actual 2011 $'000
Cash Flows from Operating Activities				
Receipts				
Cash from the ACT Government for Expenses on Behalf of the Territory		986	727	451
Fees		794	676	721
Other Receipts		78	73	71
Total Receipts from Operating Activities		**1,858**	**1,476**	**1,243**
Payments				
Grants and Purchased Services		727	727	710
Transfer of Territory Receipts to the ACT Government		794	676	721
Other		73	73	(47)
Total Payments from Operating Activities		**1,594**	**1,476**	**1,384**
Net Cash Inflows/(Outflows) From Operating Activities		264	–	(141)
Net Increase/(Decrease) in Cash Held	51	264	–	(141)
Cash and Cash Equivalents at the Beginning of the Reporting Period		36	295	177
Cash and Cash Equivalents at the End of the Reporting Period	**51**	**300**	**295**	**36**

The above Cash Flow Statement on Behalf of the Territory should be read in conjunction with the accompanying notes.

Health Directorate Territorial Statement of Appropriation For the Year Ended 30 June 2012

	Original Budget 2012 $'000	Total Appropriated 2012 $'000	Appropriation Drawn 2012 $'000	Appropriation Drawn 2011 $'000
Territorial				
Expenses on Behalf of the Territory	727	986	986	451
Total Territorial Appropriation	**727**	**986**	**986**	**451**

The above Territorial Statement of Appropriation should be read in conjunction with the accompanying notes.

Column Heading Explanations

The Original Budget column shows the amounts that appear in the Cash Flow Statement in the Budget Papers.

The amount also appears in the Cash Flow Statement on Behalf of the Territory.

The Total Appropriated column is inclusive of all appropriation variations occurring after the Original Budget.

The Appropriation Drawn is the total amount of appropriation received by the Directorate during the year. The amount also appears in the Cash Flow Statement on Behalf of the Territory.

Expenses on Behalf of the Territory

The difference between the Original Budget and the Total Appropriated is due to this amount being drawn on a cash needs basis for capital upgrades at Calvary Public Hospital.

The Appropriation Drawn 2011 was for capital upgrades at Calvary Hospital and was based on cash needs.

Health Directorate Territorial Note Index

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Note 43 Summary of Significant Accounting Policies – Territorial

The Directorate's accounting policies are contained in Note 2: 'Summary of Significant Accounting Policies'. The policies outlined in Note 2 apply to both the Controlled and Territorial financial statements.

Note 44 Payment for Expenses on Behalf of The Territory – Territorial

Under the *Financial Management Act 1996*, funds can be appropriated for expenses incurred on behalf of the Territory. The Directorate receives this appropriation to fund a number of expenses incurred on behalf of the Territory, being onpassing of appropriated funds for Capital Funding for Calvary Public Hospital.

(See Note 46 – Grants and Purchased Services – Territorial)

	2012 $'000	2011 $'000
Payment for Expenses on Behalf of the Territory [a]	986	451
Total Payment for Expenses on Behalf of the Territory	**986**	**451**

a) This relates to capital upgrades at Calvary Hospital. The increase reflects the payment of 2011 capital upgrades funding in 2012.

Note 45 Fees – Territorial

Fees refers to the collection of licence fees, including from food businesses, smoke free places, boarding houses and radiation equipment.

	2012 $'000	2011 $'000
Fees		
Fees for Regulatory Services	794	721
Total Fees	**794**	**721**

Note 46 Grants and Purchased Services – Territorial

Grants are amounts provided by the Directorate, to ACT Government entities and non-ACT Government entities for general assistance or for a particular purpose. Grants may be for capital, current or recurrent purposes and the name or category reflects the use of the grant. The grants given are usually subject to terms and conditions set out in a contract, correspondence, or by legislation.

	2012 $'000	2011 $'000
Capital Grants to External Parties – Calvary Hospital [a]	727	710
Total Grants and Purchased Services	**727**	**710**

a) This relates to payments for capital upgrades at Calvary Hospital.

Note 47 Transfer to Government – Territorial

'Transfer to Government' represents the transfer of money, which the Directorate has collected on behalf of the Territory, to Government. The money collected by the Directorate on behalf of the Territory includes licence fees collected.

	2012 $'000	2011 $'000
Transfer to the Territory Bank Account	794	721
Total Transfer to the ACT Government	**794**	**721**

Note 48 Cash and Cash Equivalents – Territorial

	2012 $'000	2011 $'000
Cash at Bank	300	36
Total Cash and Cash Equivalents	**300**	**36**

This increase is mainly due to a timing difference between appropriation received and amount paid to Calvary Hospital for capital upgrades.

Note 49 Receivables – Territorial

	2012 $'000	2011 $'000
Current Receivables		
Goods and Services Tax Receivable	–	5
Less: Allowance for Doubtful Debts	–	–
Total Current Receivables	–	5
Total Non-Current Receivables	–	–
Total Receivables	**–**	**5**

Ageing of Receivables					
	Not Overdue	Past Due	Past Due	Past Due	Total
	$'000	Less Than 30 days $'000	30 to 60 Days $'000	Greater Than 60 days $'000	$'000
2012					
Not Impaired Receivables	–	–	–	–	–
Impaired Receivables	–	–	–	–	–
2011					
Not Impaired Receivables	–	5	–	–	5
Impaired Receivables	–	–	–	–	–

Classification of ACT Government/Non-ACT Government Receivables	2012 $'000	2011 $'000
Receivables with Non-ACT Government Entities		
Net Goods and Services Tax Receivable	–	5
Total Receivables with Non-ACT Government Entities	–	5
Total Receivables	**–**	**5**

Note 50 Advance from Territory Banking Account – Territorial

	2012 $'000	2011 $'000
Advance from Territory Banking Account	300	300
Total Advance from Territory Banking Account	**300**	**300**

This cash advance in perpetuity is for the purpose of funding the GST (Goods and Services Tax) cash outlay due to timing difference between the GST payment and receiving of refunds from the Australian Taxation Office. Capital upgrades funds transferred to Calvary Hospital attracts GST which is not appropriated.

Note 51 Cash Flow Reconciliation – Territorial

a. Reconciliation of Cash at the end of the Reporting Period in the Cash Flow Statement on behalf of the Territory to the Related Items in the Statement of Assets and Liabilities on Behalf of the Territory.

	2012 $'000	2011 $'000
Total Cash Disclosed in the Statement of Assets and Liabilities on Behalf of the Territory	300	36
Cash at the End of the Reporting Period as recorded in the Cash Flow Statement on behalf of the Territory	300	36

b. Reconciliation of Net Cash Inflows/(Outflows) from Operating Activities to the Operating Surplus/(Deficit)

	2012 $'000	2011 $'000
Operating Surplus/(Deficit)	259	(259)
Cash before changes in Operating Assets and Liabilities	259	(259)
Changes in Operating Assets and Liabilities		
Decrease in Receivables	5	118
Net Changes in Operating Assets and Liabilities	5	118
Net Cash Inflows/(Outflows) from Operating Activities	**264**	**(141)**

Note 52 Financial Instruments – Territorial

Details of the significant policies and methods adopted, including the criteria for recognition, the basis of measurement, and the basis on which income and expenses are recognised, with respect to each class of financial asset and financial liability are disclosed in Note 43: Summary of Significant Accounting Policies – Territorial.

Interest Rate Risk

Interest rate risk is the risk that the fair value or future cash flows of a financial instrument will fluctuate because of changes in market interest rates.

The Directorate has all of it's Territorial financial assets and liabilities held in non-interest bearing arrangements. This means the Directorate is not exposed to movements in interest rates, and, as such, does not have any interest rate risk.

A sensitivity analysis has not been undertaken for the interest rate risk of the Directorate as it is not exposed to any movements in interest rates.

Credit Risk

Credit risk is the risk that one party to a financial instrument will fail to discharge an obligation and cause the other party to incur a financial loss. The Directorate's credit risk is limited to the amount of the financial assets held.

The Directorate's Territorial financial assets mostly consist of Cash and Cash Equivalents.

Credit risk is managed by the Directorate for cash at bank by holding bank balances with the ACT Government's banker the Commonwealth Bank. The Bank holds a AA issuer credit rating with Standard and Poors, which considers that its traditional retail and commercial banking model supports its income stability.

Liquidity Risk

Liquidity risk is the risk that the Directorate will be unable to meet its financial obligations as they fall due. The Directorate's only Territorial financial obligation relates to an advance received from the Territory Banking Account where there is no requirement to repay the advance within the next twelve months. The Directorate's exposure to liquidity risk is therefore insignificant.

Price Risk

Price risk is the risk that the fair value or future cash flows of a financial instrument will fluctuate because of changes in market prices, whether these changes are caused by factors specific to the individual financial instrument or its issuer, or factors affecting all similar financial instruments traded in the market.

The Directorate holds no investments on behalf of the Territory that are subject to price risk and as a result, is not considered to have any price risk. Accordingly, a sensitivity analysis has not been undertaken.

Note 52 Financial Instruments – Territorial (continued)

Fair Value of Financial Assets and Liabilities

The carrying amounts and fair values of financial assets and liabilities at balance date are:

	Carrying Amount 2012 $'000	Fair Value 2012 $'000	Carrying Amount 2011 $'000	Fair Value 2011 $'000
Financial Assets				
Cash and Cash Equivalents	300	300	36	36
Total Financial Assets	300	300	36	36
Financial Liabilities				
Advance from Treasury Banking Account	300	300	300	300
Total Financial Liabilities	300	300	300	300
Net Financial (Liabilities)	–	–	(264)	(264)

The following table sets out the Directorate's maturity analysis for financial assets and liabilities as well as the exposure to interest rates, including the weighted average interest rates by maturity period as at 30 June 2012. All financial assets and liabilities, excluding Advance from the Territory Banking Account which are non-interest bearing will mature in 1 year or less. All amounts appearing in the following maturity analysis are shown on an undiscounted cash flow basis.

			Fixed Interest Maturing in:				
	Note	Floating Interest Rate	1 Year or Less	Over 1 to 5 Years	Over 5 Years	Non-Interest Bearing	Total
		$'000	$'000	$'000	$'000	$'000	$'000
Financial Instruments							
Financial Assets							
Cash and Cash Equivalents	48	–	–	–	–	300	300
Total Financial Assets		–	–	–	–	300	300
Financial Liabilities							
Advance from Territory Banking Account	50	–	–	–	–	300	300
Total Financial Liabilities		–	–	–	–	300	300
Net Financial Assets/(Liabilities)		–	–	–	–	–	–

Note 52 Financial Instruments – Territorial (continued)

The following table sets out the Directorate's maturity analysis for financial assets and liabilities as well as the exposure to interest rates, including the weighted average interest rates by maturity period as at 30 June 2011. All financial assets and liabilities which are non-interest bearing will mature in 1 year or less. All amounts appearing in the following maturity analysis are shown on an undiscounted cash flow basis.

	Note	Floating Interest Rate	Fixed Interest Maturing in:			Non-Interest Bearing	Total
			1 Year or Less	Over 1 to 5 Years	Over 5 Years		
		$'000	$'000	$'000	$'000	$'000	$'000
Financial Instruments							
Financial Assets							
Cash and Cash Equivalents	48	–	–	–	–	36	36
Total Financial Assets		**–**	**–**	**–**	**–**	**36**	**36**
Financial Liabilities							
Advance from Treasury Banking Account	50	–	–	–	–	300	300
Total Financial Liabilities		**–**	**–**	**–**	**–**	**300**	**300**
Net Financial (Liabilities)		**–**	**–**	**–**	**–**	**(264)**	**(264)**

	2012 $'000	2011 $'000
Carrying Amount of Each Class of Financial Asset and Financial Liability		
Financial Assets		
Loans and Receivables	–	–
Financial Liabilities		
Financial Liabilities Measured at Amortised Cost	300	300

Fair Value Hierarchy

The Directorate does not have any financial assets or financial liabilities on behalf of the Territory at fair value. As such no fair value hierarchy disclosures have been made.

Note 53 Commitments – Territorial

Capital Commitments	2012 $'000	2011 $'000
Capital Commitments at reporting date that have not been recognised as liabilities are as follows:		
Capital Grant Commitments		
Within one year	746	727
Later than one year and not later than five years	–	–
Total Capital Commitments	**746**	**727**

All amounts shown in the commitment note are exclusive of Goods and Services Tax (GST).

Note 54 Contingent Liabilities and Contingent Assets – Territorial

There were no contingent liabilities or contingent assets as at 30 June 2012.

There were no indemnities as at 30 June 2012.

Note 55 Events Occuring After Balance Date – Territorial

There were no events occurring after the balance date, which would affect the financial statements as at 30 June 2012, or in the future reporting periods.

A.7 Statement of performance

ACT AUDITOR-GENERAL'S OFFICE

REPORT OF FACTUAL FINDINGS

HEALTH DIRECTORATE

To the Members of the ACT Legislative Assembly

Report on the statement of performance

The statement of performance of the Health Directorate (the Directorate) has been reviewed.

Responsibility for the statement of performance

The Director-General of the Directorate is responsible for the preparation and fair presentation of the statement of performance in accordance with the *Financial Management Act 1996*. This includes responsibility for maintaining adequate records and internal controls that are designed to prevent and detect fraud and error, and the systems and procedures used to measure the results of the accountability indicators reported in the statement of performance.

The auditor's responsibility

Under the *Financial Management Act 1996* and *Financial Management (Statement of Performance Scrutiny) Guidelines 2011*, I am responsible for providing a report of factual findings on the statement of performance.

This review was conducted in accordance with Australian Auditing Standards applicable to review engagements, to provide assurance that the results of the accountability indicators reported in the statement of performance have been fairly presented in accordance with the *Financial Management Act 1996*.

A review is primarily limited to making inquiries with representatives of the Directorate, performing analytical and other review procedures and examining other available evidence. These review procedures do not provide all of the evidence that would be required in an audit, therefore, the level of assurance provided is less than that given in an audit. An audit has not been performed and no audit opinion is being expressed on the statement of performance.

The review did not include an assessment of the relevance or appropriateness of the accountability indicators reported in the statement of performance or the related performance targets.

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No opinion is expressed on the accuracy of explanations provided for variations between actual and targeted performance due to the often subjective nature of such explanations.

Electronic presentation of the statement of performance

Those viewing an electronic presentation of this statement of performance should note that the review does not provide assurance on the integrity of information presented electronically, and does not provide an opinion on any other information which may have been hyperlinked to or from this statement. If users of the statement of performance are concerned with the inherent risks arising from the electronic presentation of information, they are advised to refer to the printed copy of the reviewed statement of performance to confirm the accuracy of this electronically presented information.

Independence

Applicable independence requirements of Australian professional ethical pronouncements were followed in conducting the review.

Review opinion

Based on the review procedures, no matters have come to my attention which indicate that the results of the accountability indicators, reported in the statement of performance of the Directorate for the year ended 30 June 2012, are not fairly presented in accordance with the *Financial Management Act 1996*.

This review opinion should be read in conjunction with the other information disclosed in this report.

Dr Maxine Cooper
Auditor-General
5 September 2012

Health Directorate
Statement of Performance
For the Year Ended 30 June 2012

Statement of Responsibility

In my opinion, the Statement of Performance is in agreement with the Directorate's records and fairly reflects the service performance of the Directorate for the year ended 30 June 2012 and also fairly reflects the judgements exercised in preparing it.

Dr Peggy Brown
Director-General
Health Directorate
16 August 2012

Output Class 1: Health and Community Care

Output 1.1 Acute Services

Description

The Government provides public hospital services at the Canberra Hospital and Calvary Public Hospital. These public hospitals provide a comprehensive range of acute care, including inpatient, outpatient, and emergency department services. The key strategic priority for acute services is to deliver timely access to effective and safe hospital care services.

This means focussing on:

- reducing waiting times for admission to a hospital bed through emergency departments, with a specific emphasis on older patients who might otherwise experience long waits due to the complexity of their conditions;
- achieving national benchmark performance standards for waiting times for access to elective surgery for category one patients;
- ensuring timely access to public dental health care in cases of emergency need;
- achieving bed occupancy rates of approximately 85 per cent. Occupancy levels of around 85 per cent contribute positively to patient safety, reduce access block, ensure efficient workflows and minimise disruptions to elective surgery; and
- providing timely access to counselling services within the ACT Women's Health Service.

Accountability Indicators	Original Target 2011–12	Actual Result 2011–12	% Variance from Original Target	Explanation of Material Variances	Notes
Total Cost ($000's)	735,950	765,357	4%	The higher than expected total cost relates mostly to a increase in the rate used to estimate the present value of future payments for long service leave, cross-border health payments previously offset against revenue, an increase of 1 per cent to the final pay rate outcomes for all employees and cost pressures at Calvary Public Hospital. These higher than expected costs were partially offset by lower than expected Commonwealth National Health Reform expenditure.	
Government Payment for Outputs (GPO) ($000's)	527,350	532,114	1%	The higher than expected GPO relates mostly to final pay rise outcomes and cost pressures at Calvary Public Hospital. These were offset by rollovers of Commonwealth National Health Reform funding to 2012–13.	
Patient activity					
a. Cost weighted patient separations	91,600	90,692	–1%		1

Accountability Indicators	Original Target 2011–12	Actual Result 2011–12	% Variance from Original Target	Explanation of Material Variances	Notes
b. Non-admitted occasions of service	300,235	323,986	8%	There has been a higher than expected demand for range of outpatient services including ophthalmology, thoracic medicine, plastic surgery, endocrinology, paediatrics and ear, nose and throat services.	2
c. Percentage of category one elective surgery patients who receive surgery within 30 days of listing	95%	97%	2%		3
d. Number of allied health care services provided for acute care patients in ACT public hospitals	101,400	103,917	2%		4
e. Mean waiting time for clients on the dental services waiting list	12 Months	12 Months	–		5
f. Percentage of the Women's Health Service Intake Officer's clients who receive an intake and assessment service within 14 working days of their initial referral	100%	100%	–		6

The above statement of performance should be read in conjunction with the accompanying notes.

Notes

1. Cost weighted separations for all hospital episodes, excluding those reported elsewhere (Mental Health, Cancer Service and Aged Care and Rehabilitation Service) and unqualified neonates (well babies, who are counted as part of their mother's admission). Cost weighted separations differ from reporting raw separations, as they account for the relative complexity of each separation, thereby giving a more accurate picture of activity performed.
2. Non-admitted patient services provided in ACT public hospitals, excluding those services provided by Mental Health, Cancer Service, and the Aged Care and Rehabilitation Service.
3. Category one patients are those assessed by the treating medical officer as the highest priority for elective surgery requiring surgery within 30 days of being listed on the elective surgery waiting list. In line with national definitions, the 30-day recommended waiting time for category one patients commences from when the hospital accepts the patient's 'request for admission' from the treating medical officer and is placed on the hospitals elective surgery waiting list. The time does not start from the date a patient is initially assessed by the treating medical officer as the Directorate cannot control the time taken by the treating medical officer to submit complete documentation to the hospital to place them on the elective surgery waiting list.
4. The number of allied health services only relates to inpatients within the Canberra Hospital (this indicator excludes services provided to other public hospitals).
5. Client mean waiting time is defined as the mean waiting period between when a client is placed on the adult dental central waiting list and the receipt of treatment by a public dentist.
6. This accountability indicator provides an indication of the availability of services.

Output 1.2 Mental Health, Justice Health and Alcohol and Drug Services

Description

Mental Health, Justice Health and Alcohol and Drug Services provide a range of services in hospitals, community health centres, adult and youth correctional facilities and peoples' homes across the Territory. This service works with its community partners to provide integrated and responsive care to a range of services including hospital-based specialist services, supported accommodation services and community based service responses.

The key strategic priorities for Mental Health, Justice Health and Alcohol and Drug Services are ensuring that clients' needs are met in a timely fashion and that care is integrated across hospital, community and residential support services. This means focussing on:

- ensuring timely access to emergency mental health care by reducing waiting times for urgent admissions to acute psychiatric units;
- ensuring that public mental health services in the ACT provide consumers with appropriate assessment, treatment and care that result in improved mental health outcomes; and
- providing hospital and community based alcohol and drug services and health care assessments for people detained in corrective facilities.

Accountability Indicators	Original Target 2011–12	Actual Result 2011–12	% Variance from Original Target	Explanation of Material Variances	Notes
Total Cost ($000's)	111,515	111,589	–		
Government Payment for Outputs (GPO) ($000's)	104,537	105,481	1%		
Patient activity					
a. Cost weighted separations	4,030	4,109	2%		7
b. Admitted patient separations	1,380	1,435	4%		8
c. Adult services (18 to 64 years)	175,100	190,434	9%	Above target variance is attributable to growth in demand in adult services.	9
d. Children and youth services (0 to 17 years)	56,000	51,551	–8%	The variance is mainly due to the unavailability of staff.	10
e. Older persons' services (65+ years)	18,600	16,570	–11%	The variance is mainly due to the unavailability of staff.	11
f. Older persons' services bed days	6,570	5,262	–20%	The target was based on a plan that the Calvary Public Hospital Sub-acute facility would increase capacity from 15 to 20 beds, however, this did not occur in 2011–12.	12
h. Supported accommodation bed occupancy rate	95%	97%	2%		13

Accountability Indicators	Original Target 2011–12	Actual Result 2011–12	% Variance from Original Target	Explanation of Material Variances	Notes
i. Proportion of clients contacted by a Health Directorate community facility during the 7 days post discharge from the inpatient services	75%	75%	–		14
j. Percentage of clients with outcome measures completed	65%	61%	-6%	The target was based on a different method of calculation. By applying the method of calculation used in setting the target, the result would have been 66%.	15
k. Proportion of offenders and detainees at the Alexander Maconachie Centre with a completed health care assessment within 24 hours of detention	100%	100%	–		16
l. Proportion of offenders and detainees in Bimberi Youth Detention Centre with a completed health care assessment within 24 hours of detention	100%	91%	-9%	Roster issues and staff vacancies contributed to underperformance early in the reporting period.	16
m. Percentage of current clients on opioid treatment with management plans	98%	99%	1%		17

The above statement of performance should be read in conjunction with the accompanying notes.

Notes

7. Cost weighted separations for mental health relate to the Psychiatric Services Unit (PSU) at the Canberra Hospital, Ward 2N and the Older Person's Mental Health Inpatient Unit (OPMHIU) at Calvary Public Hospital. Cost weighted separations differ from reporting raw separations, as they account for the relative complexity of each separation.
8. Raw separations from the Psychiatric Services Unit (PSU) and Calvary Public Hospital Ward 2N. Raw separations count the number of inpatient hospital episodes.
9. Mental Health ACT Adult community occasions of service (Age group 18 to 64).
10. Mental Health ACT Children and Adolescents community occasions of service (Age group 0 to 17).
11. Mental Health ACT older person's community occasions of service (Age group 65+).
12. The actual number of Occupied Bed Days at the Calvary Public Hospital older persons' mental health inpatient unit.
13. Actual occupancy expressed as a percentage of the total supported accommodation places provided by the following Community Service providers: Richmond Fellowship, Centacare, ACT Mental Health Foundation and Inanna.
14. The proportion of clients admitted to a mental health inpatient unit and contacted by Mental Health ACT Community Services during the 7 days post discharge from the Mental Health Inpatient Units (not all inpatients are referred to Mental Health ACT community mental health but may be seen by their general practitioner or private psychiatrist). The name of this indicator was amended in 2011–12 by a Section 19D Instrument under the *Financial Management Act 1996*. Previous indicator description: The proportion of clients seen at an ACT Health community facility during the 7 days post discharge from the inpatient services.
15. Percentage of Mental Health ACT registered clients with mandatory outcome measures completed each three months. The purpose of measuring clinical outcomes is to see whether consumers of public mental health services are getting better as a result of the services they receive.
16. Percentage of detainees inducted into Bimberi and Alexander Maconachie Centre who are assessed within 24 hours of arrival at the facility. In respect of Bimberi, young detainees who are detained for a period of less than 24 hours will be excluded from this measure.
17. On presentation for opioid replacement treatment, a management plan is developed. This indicator represents the percentage of clients with management plans.

Output 1.3 Public Health Services

Description

Public Health Services provides high quality health and community services to the ACT and surrounding region. The key strategic priorities for Public Health Services include monitoring the health of the ACT population; promoting health; preventing disease; improving health equity; protecting the health of the public; and supporting workforce excellence (Population Health Division).

Accountability Indicators	Original Target 2011–12	Actual Result 2011–12	% Variance from Original Target	Explanation of Material Variances	Notes
Total Cost ($000's)	38,794	39,210	1%		
Government Payment for Outputs (GPO) ($000's)	**36,159**	**36,486**	**1%**		
a. Samples analysed	7,600	8,282	9%	More than expected samples were received for analysis in the areas of Food, Water, Environment (Asbestos), Illicit Drugs, Road Traffic, Oral Fluid and Coronial cases.	18
b. Inspection compliance of licensable, registrable and non-licensable activities	85%	75%	–12%	The lower than expected compliance rate is due to targeted inspections of identified problem businesses, complaint based inspections and re-inspections of non-compliant businesses.	19
c. Response time to environmental health hazards, communicable disease hazards relating to measles and meningococcal infections and food poisoning outbreaks is less than 24 hours	100%	100%	–		20

The above statement of performance should be read in conjunction with the accompanying notes.

Notes

18. Number of samples analysed during the period by the ACT Government Analytical Laboratory.

19. Percentage of inspected premises found to be in compliance with relevant legislation, licence or registration. The data is drawn from records of inspection carried out under provisions of all ACT Health administered legislation. The relevant Acts are: *Food Act 2001, Public Health Act 1997, Radiation Protection Act 2006* and *Medicines, Poisons and Therapeutic Goods Act 2008*.

20. Response time is defined as the elapsed time between notification and commencement of investigation. The reported percentage is derived from the combined data sets across the three classes of quick response categories: environmental health hazards, communicable disease control hazards and food poisoning outbreaks.

Output 1.4 Cancer Services

Description

Capital Region Cancer Services provides a comprehensive range of screening, assessment, diagnostic, treatment, and palliative care services. Services are provided in inpatient, outpatient, and community settings.

The key strategic priorities for cancer care services are early detection and timely access to diagnostic and treatment services. These include ensuring that population screening rates for breast and cervical cancer meet targets; waiting time for access to essential services such as radiotherapy are consistent with agreed benchmarks; and increasing the proportion of females screened through the BreastScreen Australia program for the target population (aged 50 to 69 years) to 70 per cent over time.

Accountability Indicators	Original Target 2011–12	Actual Result 2011–12	% Variance from Original Target	Explanation of Material Variances	Notes
Total Cost ($000's)	66,586	68,549	3%		
Government Payment for Outputs (GPO) ($000's)	56,794	57,307	1%		
Patient activity					
a. Cost weighted admitted patient separations	5,040	5,199	3%		21
b. Non-admitted occasions of service	57,288	60,852	6%	There has been a higher than expected demand for a range of outpatient services provided by medical oncology, haematology and radiation oncology.	22
Breast Screening					
a. Total breast screens	11,400	15,019	32%	The cessation of services provided on behalf of NSW Health, combined with the engagement of locum radiographers and the recruitment of two permanent radiographers, resulted in a significant increase in screening capacity.	23
b. Number of breast screens for women aged 50 to 69	9,975	12,475	25%	Higher performance is primarily due to the cessation of services provided on behalf of NSW Health and recruitment of two permanent radiographers resulting in increased screening capacity. Promotional activity directed towards this target age group has commenced and resulted in increased participation.	24
c. Percentage of women who receive results of screen within 28 days	100%	100%	–		25
d. Percentage of screened who are assessed within 28 days	90%	88%	–2%		26

The above statement of performance should be read in conjunction with the accompanying notes.

Notes:

21. Inpatient cost weighted activity for patients of the Capital Region Cancer Service. Cost weighted separations differ from reporting raw separations, as they account for the relative complexity of each separation, thereby giving a more accurate picture of activity performed.
22. Medical oncology (including chemotherapy), radiation oncology and haematology outpatient services.
23. Total number of women screened in the period.
24. Number of women aged between 50 to 69 years screened in the period. This age group is the target population for the breast screen program.
25. The percentage of women with a 'normal' result who receive notice of this outcome within 28 days of their screening appointment. Consistent with national methodologies, the end date is the date the results are produced, as it is not possible to ascertain the date a client receives a mailed document.
26. The percentage of women seeking an appointment who wait 28 days or less from the making of an appointment to the actual appointment.

Output 1.5 Rehabilitation, Aged and Community Care

Description

The provision of an integrated, effective, and timely response to rehabilitation, aged care and community care services in inpatient, outpatient, emergency department, sub-acute and community-based settings.

The key strategic priorities for Rehabilitation, Aged and Community Care are:

- ensuring that older persons in hospital wait the least possible time for access to comprehensive assessment by the Aged Care Assessment Team. This will assist in their safe return home with appropriate support, or access to appropriately supported residential accommodation;
- improving discharge planning to minimise the likelihood of readmission or inadequate support for independent living, following completion of hospital care; and
- ensuring that access, consistent with clinical need, is timely for community-based nursing and allied health services and that community-based services are in place to better provide for the acute and post-acute health care needs of the community.

Accountability Indicators	Original Target 2011–12	Actual Result 2011–12	% Variance from Original Target	Explanation of Material Variances	Notes
Total Cost ($000's)	122,490	120,738	–1%		
Government Payment for Outputs (GPO) ($000's)	108,378	109,357	1%		
Patient activity					
a. Cost weighted admitted patient separations	5,070	4,761	–6%	The below target result is due to reduced activity at the sub-acute units based at Calvary Public Hospital (due to the inability to recruit Geriatricians to provide a service for the allocated 12 Geriatric Evaluation and Management beds) and a 4% reduction in the number of bed days at Canberra Hospital for Rehabilitation, Aged and Community Care patients in the first 10 months of 2011–12. Ward 12B was closed for 7 days due to flooding affecting 20 beds.	27
b. Non-admitted occasions of service	2,230	1,077	–52%	A reduction in geriatric non-admitted occasions of service during the reporting period due to inability to recruit to funded FTE Geriatric and Advanced Trainee Geriatric Registrar positions combined with a reduction in the hours worked by existing staff. The Directorate is moving the delivery of some outpatient service off the Canberra Hospital campus to improve efficiency and support access to services for consumers. There has also been a 22% increase in "did not attend" in comparison to last year. As a result of improved counting methodology for non-admitted occasion of service, over 700 occasions of service (OOS) are no longer counted in this activity count. These OOS relate to home visits and should no longer be included in the activity count, however they have been included in the target.	28
c. Sub-acute service — episodes of care	1,640	1,664	1%		29
d. Sub-acute service — occupied bed days	22,849	20,392	–11%	The unfavourable variation can be attributed to a reduction in the occupied bed days mainly at the Calvary campus due to temporary closure of Geriatric Medicine Beds since February 2011, and a greater proportion of day only admissions at Rehabilitation Independent Living Unit of the Canberra Hospital.	30

Accountability Indicators	Original Target 2011–12	Actual Result 2011–12	% Variance from Original Target	Explanation of Material Variances	Notes
e. Number of people assessed in falls clinics	420	465	11%	The fall Injury Prevention Services exceeded its target by 11% due to high demand early in the year and as a result of presentations to community groups to increase falls awareness, the April Falls month information stand initiative at the Canberra Hospital and involvement in the Seniors Expo.	31
f. Number of nursing (domiciliary and clinic based) occasions of service	80,000	83,905	5%	Increase in complex referrals with clients requiring more frequent visits.	32
g. Number of allied health regional services (occasions of service)	22,000	22,544	2%		33

The above statement of performance should be read in conjunction with the accompanying notes.

Notes

27. Inpatient cost weighted activity for patients of the Aged Care and Rehabilitation Service. Cost weighted separations differ from reporting raw separations, as they account for the relative complexity of each separation, thereby giving a more accurate picture of activity performed.
28. Geriatric and rehabilitation outpatient services.
29. The total number of persons separated from the sub and non-acute service at Calvary Public Hospital.
30. Total number of occupied bed days used for persons separated from the sub and non-acute service at Calvary Public Hospital.
31. Data is for the Falls Clinic taken from 'Integrated Health Care Partnership Central Regional Team'. The 'Integrated Health Care Partnership Assessors' contacts have been excluded as this relates to 'non-clinic time' intervention by staff member.
32. All occasions of service provided to community patients by Continuing Care Nurses in the following settings: home visits; ambulatory care clinics; foot care clinics; continence clinics; wound clinics; and stoma clinics.
33. All occasions of service provided to community patients by Continuing Care Allied Health Professionals and Technical Officers for Physiotherapy, Occupational Therapy, Social Work, Podiatry, and Nutrition.

Output 1.6 Early Intervention and Prevention

Description

Increasing the focus on initiatives that provide early intervention to, or prevent, health care conditions that result in major acute or chronic health care burdens on the community.

The key strategic priorities for intervention and prevention are reducing the level of youth smoking in the ACT and maintaining immunisation rates for children above 90 per cent.

Accountability Indicators	Original Target 2011–12	Actual Result 2011–12	% Variance from Original Target	Explanation of Material Variances	Notes
Total Cost ($000's)	70,996	72,319	2%		
Government Payment for Outputs (GPO) ($000's)	62,967	63,536	1%		
Immunisation					
a. Immunisation coverage for the primary immunisation schedule measured at 1 year of age, in accordance with the Australian Childhood Immunisation Register	92%	93%	1%		34
Community Health					
b. Proportion of clients attending 'Well Women's Check' within the Women's Health Service that are from culturally and linguistically diverse communities	30%	40%	33%	Increased targeting of Culturally and Linguistically Diverse women through location of services.	35
c. Proportion of children aged 0 to 14 who are entering substitute and kinship care within the ACT who attend to the Child at Risk Health Unit for a health and wellbeing screen	80%	80%	–		36

The above statement of performance should be read in conjunction with the accompanying notes.

Notes

34. Percentage of 12 month old children who have been fully immunised in accordance with the Australian Childhood Immunisation Register.

35. This indicator measures the percentage of women who are from culturally and linguistically diverse communities accessing a 'Well Women's Check'.

36. This indicator measures the percentage of children aged 0–14 placed in out of home care (substitute or kinship care) who have received a health and wellbeing screen. The Health Directorate is reliant on referrals from the Community Services Directorate in order to provide these services.

A.8 Strategic indicators

The Health Directorate's strategic indicators for 2011–12 have been aligned to relate closely to the following priorities, which are outlined in *Your health—Our priority and the ACT Health Corporate Plan 2010–12:*

- timely access to better care
- management of chronic disease
- improved care for the elderly
- comprehensive services for mental health
- supporting children and vulnerable families
- addressing gaps in Aboriginal and Torres Strait Islander health status.

Strategic indicators 2 and 6 are new indicators in 2011–12 and have been added to provide information on government increasing access to health care and investment to improve health care in the ACT. Strategic indicators 10 and 18 have also been added to provide information on how the government is working to meet its priorities.

Strategic objective 1—Timely access to better care

Strategic indicator 1—Waiting times for admission following Emergency Department care

The proportion of persons who are admitted via the Emergency Department and who wait less than eight hours from commencement of treatment to admission to a ward. This provides an indication of the effectiveness of public hospitals in meeting the need for acute care and Emergency Department care.

	2011–12 target	2011–12 result
Proportion of patients admitted to hospital who wait less than eight hours	75%	77%

This strategic indicator will be deleted in 2012–13, as it is no longer consistent with national reporting or reporting under the national health reforms.

Strategic objective 2—Removals from the waiting list for elective surgery

Strategic indicator 2—Number of people removed from waiting list

The number of people removed from the ACT elective surgery waiting lists managed by ACT public acute hospitals. This may include public patients treated in private hospitals.

	2011–12 target	2011–12 result
People removed from the ACT elective surgery waiting list for surgery	11,000	11,300

In order to improve access to elective surgery, Commonwealth, state and territory governments have entered into a partnership to significantly increase the number of elective surgery operations provided in our public hospitals each year and reduce the number of people waiting more than clinically recommended times for that surgery.

As part of this program, the Australian and ACT Governments have committed funds specifically to increase access to surgery from 2009–10 to 2012–13.

Strategic objective 3—No waiting for access to emergency dental health services

Strategic indicator 3—Percentage of assessed emergency clients seen within 24 hours

This provides an indication of the responsiveness of the dental service to emergency clients.

	2011–12 target	2011–12 result
Percentage of emergency clients seen within 24 hours	100%	100%

Strategic objective 4—Reaching the optimum occupancy rate for acute adult overnight hospital beds

Strategic indicator 4—Mean percentage of adult overnight acute medical and surgical beds in use

This provides an indication of the efficient use of resources available for hospital services.

	2011–12 target	2011–12 result
Percentage of adult overnight acute medical and surgical beds in use	85%	88%

Strategic objective 5—Access to radiotherapy services

Strategic indicator 5—Percentage of radiotherapy patients who commence treatment within standard time frames

This provides an indication of the effectiveness of public hospitals in meeting the need for cancer treatment services.

Category	2011–12 target	2011–12 result
Urgent—treatment starts within 48 hours	100%	100%
Semi-urgent—treatment starts within four weeks	95%	99.8%
Non-urgent—treatment starts within six weeks	95%	99.2%

Strategic objective 6—Government capital expenditure on healthcare infrastructure

Strategic indicator 6—Capital consumption

This indicator provides information on government investment to improve healthcare infrastructure. Information on the level of funding allocated for health infrastructure as a proportion of overall expenditure provides an indication of investment towards developing sustainable and improved models of care. The ACT's aim is to exceed the national rate.

Government[1] capital expenditure as a proportion of government[2] capital consumption expenditure by healthcare facilities	ACT rate	National rate
2007–08	1.89	1.51
2008–09	2.76	1.90
2009–10	2.67	1.57

Source: Health Expenditure Australia 2009–10 (Australian Institute of Health and Welfare)

1. Excludes local government.
2. Expenditure on publicly owned healthcare facilities.

Strategic objective 7—Management of chronic disease

Strategic indicator 7—Maintenance of the highest life expectancy at birth in Australia

Maintenance of the highest life expectancy at birth in Australia	ACT rate	National rate
Females	84.7	84
Males	80.5	79.5

Source: ABS 2011, Deaths, Australia, 2010, cat. no. 3302.0, ABS, Canberra

Life expectancy at birth provides an indication of the general health of the population and reflects a range of issues other than the provision of health services, such as economic and environmental factors. The ACT has the highest life expectancy of any jurisdiction in Australia, and the government aims to maintain this result.

Strategic objective 8—Lower than national average prevalence of circulatory disease

Strategic indicator 8—Proportion of the ACT population with some form of circulatory disease

Cardiovascular disease	ACT rate	National rate
Proportion of the ACT population diagnosed with some form of cardiovascular disease	15.2%	16.4%

Source: National Health Survey 2007–08 updates. No updated data for this indicator has been published.

Population projections suggest that the ACT population is ageing faster than that of other jurisdictions. The median age of the ACT population (34.5 years in 2005) has increased 6.4 years since 1985. While people of all ages can present with a chronic disease, the ageing of population and longer lifespans mean that chronic diseases will place major demands on the health system for workforce and financial resources. The ACT continues to have a lower prevalence of cardiovascular disease than the national rate.

Strategic objective 9—Lower than national average prevalence of diabetes

Strategic indicator 9—Proportion of the ACT population diagnosed with some form of diabetes

This provides an indication of the success of prevention and early intervention initiatives. The self-reported prevalence of diabetes in Australia has more than doubled over the past 25 years. Prevalence rates may increase in the short term of a result of early intervention and detection campaigns. This would be a positive result, as experts predict that only half of those with diabetes are aware of their condition. This can have significant impacts on their long-term health.

Diabetes	ACT rate	National rate
Prevalence of diabetes in the ACT	3.1%	3.6%

Source: National Health Survey 2007–08 updates

Strategic objective 10—Higher than national average proportion of government recurrent health funding expenditure on public health activities

Strategic indicator 10—Proportion of government recurrent health funding expenditure on public health activities

Improvements in prevention of diseases can reduce longer-term impacts on the health system, particularly for people with chronic diseases. The aim for the ACT is to better the Australian average.

Estimated total government expenditure on public health activities as a proportion of total current health expenditure—Proportion of government recurrent health funding	ACT rate	National rate
2009–10	3.7%	3.2%

Source: Health Expenditure Australia 2009–10 (AIHW)

Previously, public health expenditure has been reported from the Australian Institute of Health and Welfare Public Health Expenditure Project. However, in 2011, the project was halted pending a review of the scope and content of the collection. Consequently, breakdowns by specific types of public health activities are not available for 2009–10.

The information provided here has been sourced from *Health Expenditure Australia 2009–10*, which includes all government expenditure, not just that of jurisdictional health departments. Consequently, information provided here is not comparable to the information provided for the Select Committee on Estimates 2011–12 budget.

Public health expenditure as a percentage of total recurrent health expenditure is an important measure of the allocation of health expenditure in Australia. This expenditure ratio forms a Council of Australian Governments' (COAG) performance indicator under the National Healthcare Agreement.

Nationally, governments spent 1.6 per cent of all recurrent health expenditure on public health programs—this was down from 2.0 per cent in 2008–09 and 2.2 per cent in 2007–08.

Excluding Commonwealth expenditure, state and territory governments spent, on average, 3.2 per cent of all recurrent health expenditure in 2009–10 on public health programs—this is 0.1 percentage point more than in 2007–08. In 2009–10, 3.7 per cent of the Health Directorate's recurrent health funding was spent on public health activities.

Public health expenditure in the ACT has decreased from $50 million in 2007–08 to $46 million in 2009–10, expressed in 2009–10 prices, primarily due to a $9 million drop in Commonwealth expenditure. This drop has been partially offset by an increase in the Health Directorate public health expenditure from $23 million to $28 million over the same period.

Strategic objective 11—Improved care for the elderly

Strategic indicator 11—Improving hospital access times for persons aged over 75 years

The percentage of admissions via Emergency Department (ED) by persons 75 years or more who wait less than eight hours from commencement of treatment in ED to admission to ward. This provides an indication of the effectiveness of public hospitals in meeting the need for acute care and Emergency Department care for persons aged over 75 years.

	2011–12 target	2011–12 result
Proportion of patients aged >75 years of age admitted to hospital who wait less than eight hours	70%	68.9%

This strategic indicator will be deleted in 2012–13, as it is no longer consistent with national reporting or reporting under the national health reforms.

Strategic objective 12—Maintaining the waiting times for in-hospital assessments by the Aged Care Assessment Team

Strategic indicator 12—Mean waiting time in working days between the request for, and provision of, assessment by the Aged Care Assessment Team (ACAT) for patients in public hospitals

This provides an indication of the responsiveness of the ACAT team in assessing the needs of clients.

	2011–12 target	2011–12 result
Mean waiting time in working days	2 days	1.7 days

Strategic objective 13—Increasing the rate of discharge planning

Strategic indicator 13—Proportion of aged care clients under the management of Rehabilitation, Aged and Community Care Services discharged with a comprehensive discharge plan

This provides an indication of the effectiveness of services in planning and organising for the needs of clients following their hospital episode and the level of integration of hospital and community-based care.

	2011–12 target	2011–12 result
Proportion of aged care clients with comprehensive discharge plan	99%	100%

Strategic objective 14—Providing comprehensive services for mental health and reducing the usage of seclusion

Strategic indicator 14—Proportion of clients with episodes of seclusion of public mental health in the ACT who are subject to seclusion during an inpatient episode

This measures the effectiveness of public mental health services in the ACT over time in providing services that minimise the need for seclusion.

	2011–12 target	2011–12 result
Proportion of clients of public mental health services in the ACT subject to seclusion during an inpatient episode	3%[1]	2.1%

1. A proposed national indicator to replace the local ACT proportion percentage is a rate per 1000 bed days, for which the long-term target is zero. The rate for the ACT is currently 1.3 episodes per 1000 acute inpatient bed days; the national average is 12 episodes—National Seclusion and Restraint Forum.

Strategic objective 15—Maintaining consumer and carer participation on relevant mental health committees

Strategic indicator 15—Proportion of Mental Health ACT committees in which consumers and carers are represented

This measure ensures that the committees which monitor the delivery and planning of our mental health services have effective input from mental health consumers.

	2011–12 target	2011–12 result
Proportion of mental health services committees with consumer and carer representation	100%	100%

Strategic objective 16—Patients return rate to an ACT Public Mental Health Inpatient Unit lower than national average

Strategic indicator 16—Proportion of clients who return to hospital within 28 days of discharge from an ACT public mental health inpatient unit

	2011–12 target	2011–12 result
Proportion of clients who return to hospital within 28 days of discharge from an ACT public mental health inpatient unit	<10%[1]	9.9%[2]

1. The COAG National Action Plan for Mental Health report suggests a proportion below 10 per cent could be considered good practice.
2. Group A jurisdictions (New South Wales, Victoria, Queensland, Western Australia, Australian Capital Territory, Northern Territory) able to provide a unique patient count—COAG National Action Plan for Mental Health Report.

The 2009–10 national rate for this indicator was 12 per cent.

Strategic objective 17—Maintaining short admission waiting times for mental health clients following Emergency Department care

Strategic indicator 17—Proportion of mental health clients admitted to hospital from the Emergency Department who wait less than eight hours from the time of commencement of treatment to the time of transfer to a ward

This provides an indication of the effectiveness of public hospitals in meeting the need for acute care and Emergency Department care for mental health clients.

	2011–12 target	2011–12 result
Proportion of mental health clients admitted to hospital who wait less than eight hours	85%	66.5%

There was a 13 per cent increase in the number of mental health clients admitted to ACT public hospitals in 2011–12. There are only a small number of mental health clients admitted to hospital via the Emergency Department each month, so minor changes in access can result in large fluctuations in performance against this indicator.

This strategic indicator will be deleted in 2012–13, as it is no longer consistent with national reporting or reporting under the national health reforms.

Strategic objective 18—Addressing gaps in Aboriginal and Torres Strait Islander health status

Strategic indicator 18—Immunisation rates—ACT Indigenous population

This provides an indication of the public health services to minimise the incidence of vaccine preventable diseases, as recorded by the Australian Childhood Immunisation Register, in the ACT's Indigenous population. The ACT aims to maintain immunisation coverage rates for vulnerable groups and, in particular, minimise disparities between Indigenous and non-Indigenous Australians.

Immunisation rates for vaccines in the national schedule for the ACT Indigenous population	2011–12 target	2011–12 result[1]
12 to 15 months	≥90%	82.5%
24 to 27 months	≥90%	91.7%
60 to 63 months	≥90%	89.9%
All	≥90%	88.1%

1. The very low numbers of Aboriginal and Torres Strait Islander children in the ACT means that the ACT Aboriginal and Torres Strait Islander coverage data should be read with caution. Rate fluctuations can occur because of the small population.

Strategic objective 19—Maximising the quality of hospital services

The following three indicators are a selection of the patient safety and service quality indicators that are used to monitor ACT public hospital services. The targets provide an indication of the desired outcomes over time. Given the nature of the indicators, small fluctuations during a particular period can skew results. The success of the Health Directorate in meeting these indicators requires a consideration of performance over time rather than for any given period.

Strategic indicator 19.1—Proportion of people who undergo a surgical operation requiring an unplanned return to the operating theatre within a single episode of care due to complications of their primary condition

This provides an indication of the quality of theatre and post-operative care.

	2011–12 target	2011–12 result
Canberra Hospital	<1.0%[1]	0.8%
Calvary Public Hospital	<0.5%	0.3%

1. The Canberra Hospital target is based on similar rates for peer hospitals, based on Australian Council of Healthcare Standards.

Strategic indicator 19.2—Proportion of people separated from hospital who are re-admitted to hospital within 28 days of their separation due to complications of their condition (where the re-admission was unforeseen at the time of separation)

This provides an indication of the effectiveness of hospital-based and community services in the ACT in the treatment of persons who receive hospital-based care.

	2011–12 target	2011–12 result
Canberra Hospital	<2.0%	1.4%
Calvary Public Hospital	<1.0%	0.8%

Strategic indicator 19.3—Number of people admitted to hospitals per 10,000 occupied bed days who acquire a bacteraemial infection during their stay

This provides an indication of the safety of hospital-based services.

	2011–12 target	2011–12 result
Canberra Hospital	<7 per 10,000	8.3
Calvary Public Hospital	<3 per 10,000	1.2

In 2011–12 there was a 20 per cent increase in the number of positive episodes of bacteraemia diagnosed at Canberra Hospital.

The Health Directorate has had a program in place for continued monitoring of these infections since 1998, which is unique among Australian hospitals and in which every patient with a positive blood culture is followed up to see why their infection occurred and what might be done in the future to prevent other infections.

This program has led to a sustained 70 per cent decrease in the numbers of bloodstream infections caused by intravascular devices. However, in recent years there has been a noted increase in urinary tract infections related to urinary catheters.

A number of interventions aimed at preventing the occurrence of many of these urinary tract healthcare-acquired bloodstream infections are being initiated across the hospital.

Strategic objective 20—High participation rate in the Cervical Screening Program

Strategic indicator 20—Two-year participation rate in the Cervical Screening Program

The two-year participation rate provides an indication of the effectiveness of early intervention health messages. The ACT aims to exceed the national average for this indicator.

	ACT rate	National rate
Two-year participation rate	58.8%	57.4%

Source: Cervical Screening in Australia 2009–10 (Australian Institute of Health and Welfare, May 2012.

Strategic objective 21—Improved Emergency Department timeliness

Strategic indicator 21—Proportion of Emergency Department presentations that are treated within clinically appropriate timeframes

	2011–12 target	2011–12 result[1]
One (resuscitation, seen immediately)	100%	100%
Two (emergency, seen within 10 mins)	80%	76%
Three (urgent, seen within 30 mins)	75%	50%
Four (semi-urgent, seen within 60 mins)	70%	47%
Five (non-urgent, seen within 120 mins)	70%	81%
All presentations	70%	55%

1. The below target 2011–12 outcome is related to the continuing demand for Emergency Department services in the ACT, with presentations up by over 6 per cent compared to 2010–11. Since 2008–09, demand has increased by 16 per cent.

Strategic objective 22—Improved breast screen participation rate for women aged 50 to 69 years

Strategic indicator 22—Proportion of women in the target age group (50 to 69 years) who have a breast screen in the 24 months prior to each counting period

	2011–12 target	2011–12 result
Proportion of women aged 50 to 69	60%	54%

The ACT's performance against this indicator is consistent with that of other jurisdictions, in that no jurisdiction achieves 60 per cent on this indicator. Performance on this indicator improved in 2011–12 compared to the 2010–11 result of 52 per cent.

Strategic objective 23—High comprehensive discharge plan rate

Strategic indicator 23—Proportion of patients with a length of stay greater than 30 days who have a comprehensive discharge plan

Discharge plans

Discharge planning is the quality link between hospital, community-based services, non-government organisations and carers. Doctors, nurses and allied health professionals continually assess patients during their stay to determine their post-hospital needs. Eighty per cent of patients discharged from hospital have relatively straightforward needs. It is the 20 per cent of patients who have more complex needs who require a more robust discharge plan. This indicator reports on the provision of complex discharge planning to target those patients whose length of stay is greater than 30 days.

	2011–12 target	2011–12 result
Proportion of patients with a length of stay greater than 30 days who have a comprehensive discharge plan	90%	98%

The 2011–12 result for this indicator is based on six months of patient records.

Strategic objective 24—Achieve lower than the Australian average in the decayed, missing or filled teeth (DMFT) index

Strategic indicator 24—Mean number of decayed, missing or filled teeth at ages 6 and 12

This gives an indication of the effectiveness of prevention, early intervention and treatment services in the ACT. The aim for the ACT is to better the Australian average.

Dental health—decayed, missing or filled teeth (DMFT)	ACT rate	National rate
DMFT index at 6 years	1.37	1.95
DMFT Index at 12 years	0.80	0.95

Source: Child Dental Health Survey, 2007, 30-year trends in child oral health (AIHW), Australian Research Centre for Population Oral Health 2012, Australia's Health 2008 (2002 data)

While the table reflects the latest published national figures, ACT Health Directorate figures for 2011–12 are 1.73 at 6 years and 0.63 at 12 years.

Strategic objective 25—Reducing the risk of fractured femurs in ACT residents aged over 75 years

Strategic indicator 25—Reduction in the rate of broken hips (fractured neck of femur)

The reduction or maintenance of the rate of fractured femurs for ACT residents aged over 75 years provides an indication of the success of public and community health initiatives to prevent hip fractures. In 2010–11, the ACT rate of admissions in persons aged 75 years and over with a fractured neck of femur was 5.3 per 1000 ACT population. This is within the long-term target and follows the generally decreasing trend over the 10–year period from 2001–02.

The long-term target for this indicator has been adjusted to the rate of 5.3 per 1000 population to reflect the 2010–11 result.

Strategic objective 26—Reduction in the youth smoking rate

Strategic indicator 26—Percentage of persons aged 12 to 17 years who smoke regularly

The results from the 2008 Australian Secondary Students Alcohol and Drug (ASSAD) Survey show that 6.7 per cent of students were smokers in that year. This demonstrates a continued decline in current smoking rates, from 15.3 per cent in 2001 to 8.6 per cent in 2005 and down to 6.7 per cent in 2008. The national rate for current smoking in 2008 was 7.3 per cent.

Source: ACT Chief Health Officer's Report 2010.

No updated data for this indicator has been published.

A.9 Analysis of agency performance

Strategy and Corporate overview

Strategy and Corporate provides infrastructure, policy, funding, and strategic planning support to clinical service areas, as well as planning for workforce and health service needs for the future.

Strategy and Corporate consists of seven branches: Service and Capital Planning, Policy and Government Relations, the Professional Leadership, Education and Research branch, People Strategy and Services, E-Health and Clinical Records, Performance and Innovation and Business and Infrastructure.

Health infrastructure

The Service and Capital Planning Branch has corporate responsibility for:

- leading and facilitating the development of whole-of-government plans (as they relate to the Health Directorate and health services), the Health Directorate Corporate Plan, territory-wide strategic plans and clinical service plans that have a territory-wide impact, and
- the project direction and management of the Directorate's Health Infrastructure Program (HIP), inclusive of health planning, coordination, management and implementation.

During 2011–12, the branch has worked to implement the Health Infrastructure Program (HIP), and conduct planning activity for, or generated by, the Corporate Plan 2010–2012 and draft Clinical Services Plan 2012–2017.

A key achievement for the HIP during the year was the opening of the Adult Mental Health Unit in March 2012, with the first consumers admitted in April 2012. The planning and design of the 40-bed unit had extensive input from consumer, carer and staff groups. The resulting building supports a model of care that places strong emphasis on a flexible, consumer-centred, recovery-based therapeutic environment. A phased approach to commissioning saw 35 beds operational by the end of the reporting year.

Please see section C.14 Capital Works for a detailed description of the progress on a variety of HIP capital works, including the:

- Centenary Hospital for Women & Children
- Gungahlin Community Health Centre
- Belconnen Community Health Centre
- Canberra Region Cancer Centre.

Health workforce

Nursing

Over the past 12 months, the nursing and midwifery professions have continued to increase both in numbers and experience, with achievements in workforce development, education and research.

A key commitment of the ACT Public Service Nursing and Midwifery Enterprise Agreement 2011–2013 was to work in partnership with the ACT Branch of the Australian Nursing Federation in the development of a new and contemporary workforce through the recognition of nurses and midwives with advanced skills and knowledge with the introduction of the Advanced Practice Nurse classification and the Enrolled Nurse Level 2 personal grade classification. These roles seek to provide an interesting, challenging and

rewarding clinical pathway for nurses.

Over the past 12 months, the Directorate co-funded, with the University of Canberra, clinical professorial positions in midwifery and mental health nursing. These roles, combined with the work being undertaken by the Research Centre for Nursing and Midwifery Practice (RCNMP), place nursing and midwifery in the ACT at the forefront of developing and utilising evidence-based practice. The RCNMP has recently gained accreditation with the International Council of Nurses and is now affiliated with the Joanna Briggs Institute.

Numerous partnerships and targeted education programs have been established to support the vocational education and training needs of our existing workforce. These partnerships afford a valuable career pathway for enrolled nurses, now educated to work to their full scope of practice.

Nurse Practitioner positions continue to be developed throughout the ACT in both the public and private sector. A total of 24 Nurse Practitioners are now employed and a further eight qualified Nurse Practitioners are waiting for a position to be created. Nine nurses are currently enrolled in study to become a Nurse Practitioner. With changes to the eligibility criteria for Medicare Benefits Schedule and Pharmaceutical Benefits Schedule provider and prescriber numbers, Nurse Practitioners working in primary health care settings are able to work more collaboratively with general practitioners to improve access to care. The ACT Government Health Directorate is working with the University of Canberra to develop the first PhD program for Nurse Practitioners.

Scholarships

The allocation of scholarships to health professionals supports a range of recruitment and retention programs designed to facilitate the recruitment of new graduates to the ACT, support the training requirements of the workforce, and recognise and reward existing staff through postgraduate scholarships.

The 2012 year has shown growth in uptake of the postgraduate scholarships that are offered by the Directorate to eligible registered nurses, midwives and enrolled nurses. A total of 160 scholarships have been awarded, with 48 per cent of scholarships awarded to nurses and midwives working in disciplines identified as having workforce shortages within the ACT/NSW region. These include mental health, critical care and midwifery.

Additionally, commencing with the academic year in 2013 the Jennifer James Memorial Honours Degree Scholarship in Research will be available to support a graduate registered nurse to undertake an honours degree with a focus on clinical leadership. This scholarship will be offered in equal partnership between the University of Canberra and the ACT Government Health Directorate.

In the 2012 Allied Health Postgraduate Scholarship Scheme round, 28 applications were approved, with 79 per cent of applicants from therapeutic allied health disciplines and 21 per cent from scientific/diagnostic groups. Social work was the most represented profession, accounting for 25 per cent of all applications.

GP Development Fund

The ACT Government 2009–10 Budget initiative titled 'GP Workforce Initiatives' established the GP Development Fund. This is a four-year (2009–10 to 2012–13) biannual grants pool totalling $4 million for general practices that commit to attracting, retaining, sustaining and developing the general practice workforce. It is one of the five initiatives of the GP Workforce Program aimed at supporting and expanding our general practice workforce.

The fund has four categories of funding: infrastructure; education and training; attraction and retention; and innovation. Grants provide infrastructure to support the general practice workforce and support for teaching and learning for ideas to attract and retain staff.

To date there have been five rounds of grants. Round Five was announced by the Minister on 21 June 2012. The fund will provide an additional $1,003,387 (including GST) for 33 new projects to help Canberra GPs to boost their services and update skills.

Over the first three years of this four-year initiative there has been significant investment in local general practices, totalling almost $2.94 million (including GST).

Health Reform

In August 2011, the ACT entered into the National Health Reform Agreement (NHRA). The NHRA represents a major step forward in addressing changing and growing health care needs, nationally and for the ACT, as well as providing increases in Commonwealth funding for the ACT. Over the longer term, the Commonwealth will contribute to efficient growth funding for public hospital services, contributing 45 per cent in 2014–15, increasing to 50 per cent in 2017–18.

Establishment of local hospital networks (LHNs) and Medicare Locals are central elements of the NHRA. LHNs are being established around the country and will comprise groups of public hospitals with a geographic or functional connection. Medicare Locals are also being established nationally, and will be the general practice and primary health care partners of LHNs, responsible for supporting and enabling better integrated and responsive local GP and primary health care services. The ACT has established a single LHN and Medicare Local, both being limited to the geographical borders of the territory. The ACT has also established a skill-based Local Hospital Network Council to provide high-level strategic advice to the Director General of the LHN and government.

A National Health Performance Authority has been established to administer a new national performance and accountability framework. The framework includes a range of performance indicators relating to LHNs and Medicare Locals that will be progressively made publicly available on the My Hospitals website. It also outlines a remediation process to be implemented for underperforming LHNs and Medicare Locals. The framework has been agreed to by the Council of Australian Governments, and was publicly released in May 2012.

The Independent Hospital Pricing Authority (IHPA) has been established to set a national efficient price which will be used to calculate the Commonwealth contribution to public hospital funding. The IHPA will also implement a system to support national activity-based funding for public hospital services.,

Funds for public hospital services being delivered under the NHRA (both activity-based and block funds for the Commonwealth and activity-based funds for the territory) must flow through the National Health Funding Pool. Enabling legislation is being enacted nationally to establish the National Health Funding Pool and an Administrator of the National Health Funding Pool. To this end, the Health (National Health Funding Pool and Administration) Bill 2012, which will give effect to the funding arrangements set out in the NHRA, was introduced in the ACT Legislative Assembly on 7 June 2012.

Health Workforce Australia

The Directorate has been funded by Health Workforce Australia (HWA) to be a lead organisation to facilitate the nationally funded initiatives to meet workforce planning and clinical training programs to build the workforce of the future. This work is coordinated by People Strategy and Services Branch, specifically through the Workforce Policy and Planning Unit, where dedicated Health Workforce Australia funded roles are based.

The Integrated Regional Clinical Training Network (IRCTN) was established in September 2011 to facilitate activities associated with increasing student clinical training capacity within the ACT and Southern and Murrumbidgee regions of NSW.

Comprising representatives from cross-sectoral member organisations, including universities, health providers from the private and government sectors, the vocational education and training sector and professional bodies from the health sector, the group is governed by an Executive Management Group which meets monthly, co-chaired to date by the Director-General, Dr Peggy Brown, and Professor Nick Glasgow, Dean of the Australian National University Medical School. The broader group of network representatives meets every six months.

Calvary Health Care Limited

The Territory has been in negotiations with the Little Company of Mary Health Care (LCMHC) for many years, particularly in relation to the transfer of Calvary Public Hospital to the Territory. An in-principle agreement for the transfer was announced in October 2009. However, in February 2010, LCMHC announced that it would be withdrawing from the in-principle agreement. Negotiations have been ongoing since this time.

The Government has since announced the expansion of hospital services on the northside of Canberra as part of the Health Infrastructure Program, including delivery of a third hospital, in northern Canberra, this being a sub-acute facility.

As part of this decision, it was agreed that Calvary Public Hospital would continue to operate as the second acute care public hospital in the ACT. A new Network Agreement has now been finalised and operation is now managed within this agreement.

Canberra Hospital and Health Services overview

Canberra Hospital and Health Services (CHHS) provides acute, sub-acute, primary and community-based health services to the ACT and surrounding region.

CHHS consists of nine divisions: Surgery & Oral Health, Women, Youth & Children, Critical Care & Imaging, the Capital Region Cancer Service, Rehabilitation, Aged & Community Care, Mental Health, Justice Health & Alcohol & Drug Service, Pathology and Medicine.

A comprehensive range of services are delivered from the Canberra Hospital campus, including acute inpatient and day services, outpatient services and pathology services. Community-based services include early childhood, youth and women's health; dental services; rehabilitation and community care; mental health care; and alcohol and drug services. In addition, justice health services are provided within the territory's detention facilities. Strong links are maintained between hospital and community-based services, as many of the operational divisions deliver services across the continuum of care to ensure continuity of patient care. Community-based services are provided from various venues across the ACT, including community health centres, child and family centres, schools and in people's homes. Canberra Hospital and Health Services liaises closely with Calvary Public Hospital to ensure effective coordination of services across the territory and delivery of required outputs. A number of CHHS divisions provide services within Calvary Public Hospital facilities and many of the community-based services liaise closely to ensure that a seamless service is provided.

The performance of CHHS is monitored at organisational, branch (CHHS) and divisional levels against accountability indicators and strategic objectives. Over the past year CHHS continued to develop and implement initiatives designed to increase staff and patient safety and quality and governance. This work has included:

- continuing to embed the restructure and bringing the services and staff of CHHS together
- development of the CHHS Executive, Medical Executive and Nursing Executive teams
- establishment of the CHHS multidisciplinary Quality and Safety Committee and divisional quality and safety committees
- increasing governance and accountability through scorecard performance monitoring
- establishment of an Arts and Wellbeing Committee to promote wellness of staff and art in the patient and staff environments
- rebranding of CHHS to bring the service under one umbrella, including cosmetic changes to the foyer of Canberra Hospital to make a brighter, more inviting environment and prominently displaying the Health Directorate values across all CHHS locations
- implementation of a centralised emergency management process to ensure stronger coordination of incident management, and
- implementation of a redesign program across CHHS, including a regular redesign showcase to promote redesign activities.

Output 1.1 Acute services

Output description

The Government provides public hospital services at the Canberra Hospital and Calvary Public Hospital. These public hospitals provide a comprehensive range of acute care, including inpatient, outpatient, and emergency department services. The key strategic priority for acute services is to deliver timely access to effective and safe hospital care services.

This means focussing on:

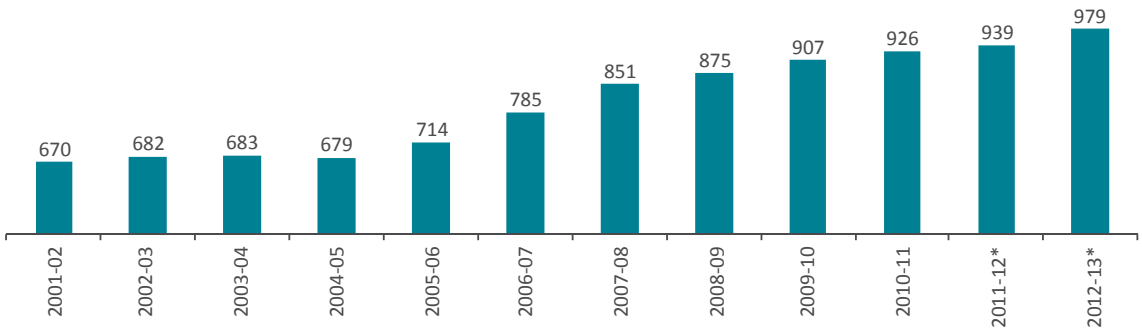
- reducing waiting times for admission to a hospital bed through emergency departments, with a specific emphasis on older patients who might otherwise experience long waits due to the complexity of their conditions;
- achieving national benchmark performance standards for waiting times for access to elective surgery for category one patients;
- ensuring timely access to public dental health care in cases of emergency need;
- achieving bed occupancy rates of approximately 85 per cent. Occupancy levels of around 85 per cent contribute positively to patient safety, reduce access block, ensure efficient workflows and minimise disruptions to elective surgery; and
- providing timely access to counselling services within the ACT Women's Health Service.

Increasing the capacity of ACT public health services—more beds to manage increasing demand for hospital services

The Australian Institute of Health and Welfare (AIHW) reported that in 2010–11 ACT public hospitals provided an average of 926 beds. In the 2011–12 Budget an additional 13 beds were funded, providing an estimated capacity of 939 beds. For 2012–13 the ACT Government has proposed funding for another 40 inpatient beds This is an extra 309 beds since 2001–02.

In addition, a considerable expansion to the hospital-in-the-home service provided another 25 bed equivalents for the service in 2010, with a further 15 bed equivalents due to be provided in 2012–13.

ACT Public Hospitals
Bed Capacity by Year

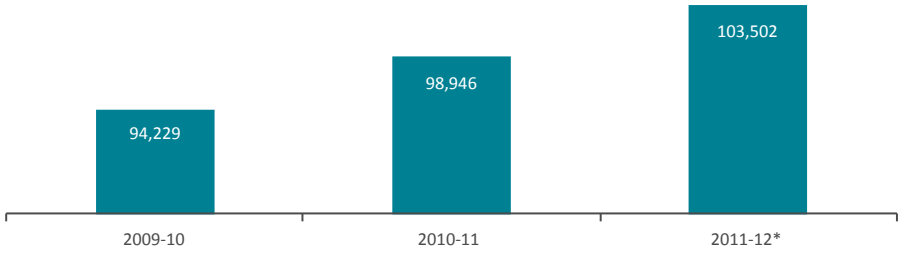


2011-12*/2012-13* figures provide estimated impact of Government investment in additional capacity
Source: Australian Hospital Statistic, AIHW, 2001-2002 to 2010-11 publications

The Government continues its commitment to adding bed capacity to the public hospital system to meet growing demand for care and to reduce bed occupancy to optimum levels.

In 2011–12, our public hospitals provided 103,502 cost-weighted separations within Acute Care Services (which includes general hospital services and private hospital contracted patients but excludes hospital services provided by Mental Health ACT, the Capital Region Cancer Service and the Aged Care and Rehabilitation Service). This represents a 4 per cent increase in cost-weighted separations in 2011–12 compared to 2010–11.

ACT Public Hospitals
Inpatient Admitted Patient CWS
(Round 13 National DRG 5.2)

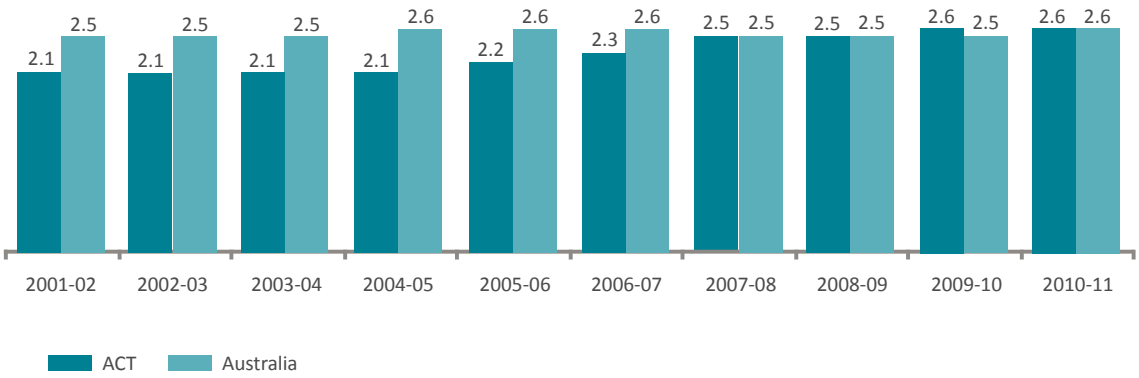


* Preliminary
Year to June
Source: Admitted patient care data set

In 2011–12, our public hospitals provided over 275,425 overnight hospital bed days of care, 4 per cent up on the total of 265,982 in 2010–11.

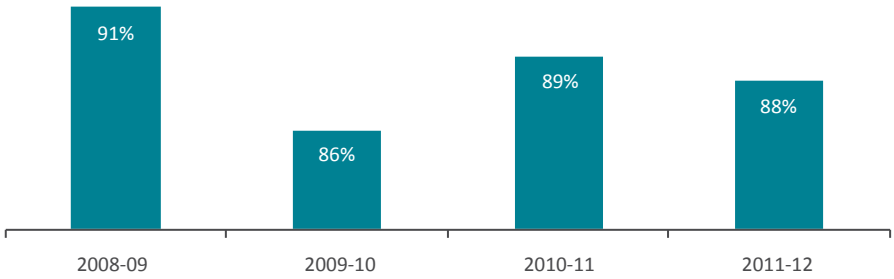
The Australian Hospital Statistics Report for 2010–11 issued by the Australian Institute of Health and Welfare in May 2012 showed that the ACT had achieved the national average in public hospital bed availability for the third time in the almost 21 years of reporting by the institute. We reached 2.6 public hospital beds per 1000 people—which is on par with the Australian national average. In 2009–10 the ACT achieved better than the national average in public hospital bed availability.

ACT Public Hospitals
Available beds per 1,000 population
ACT vs National



The bed occupancy rate for overnight adult medical and surgical beds in 2011–12 was 88 per cent. The Government's long-term target is to maintain bed occupancy levels at around 85 per cent, which is considered the best level for best patient outcomes and to achieve maximum efficiency. The additional 40 beds funded in the 2012–13 budget should help reduce the bed occupancy rate towards the 85 per cent target.

ACT Public Hospitals
Bed Occupancy Rate



Year-to-date June
Source: ACT Public Hospitals

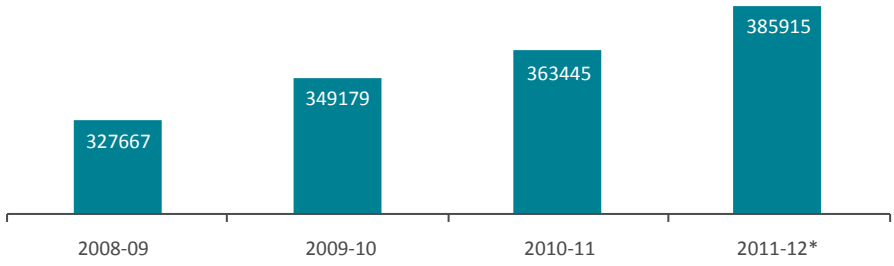
The Canberra Hospital Outpatient Services Redesign Project commenced in July 2010 with the principal objective of reviewing current business processes within the Outpatient Service and implementing changes to improve efficiency and support access to services for consumers.

In 2011–12, Outpatient Services experienced a further increase in demand—with demand since 2008–09 having grown by 18 per cent at both Canberra and Calvary hospitals. In response to this growth, resources have been committed to improve the functioning and processes of Outpatient Services.

A Redesign Steering Committee for Canberra Hospital's Outpatient Services is currently reviewing and working towards implementing changes to improve processes within Outpatient Services. The first stage of redesign is working to improve referral, booking and scheduling processes. Since the project began, the waiting time for referral registrations has been reduced and the number of patient appointments processed has increased.

An Electronic Referral (eReferral) Redesign project is also being progressed to improve communications back to GPs. Improvements will provide them with receipts for patient referrals and access to information on progress through automatic electronic software integration.

Non-admitted (outpatient) occasions of service



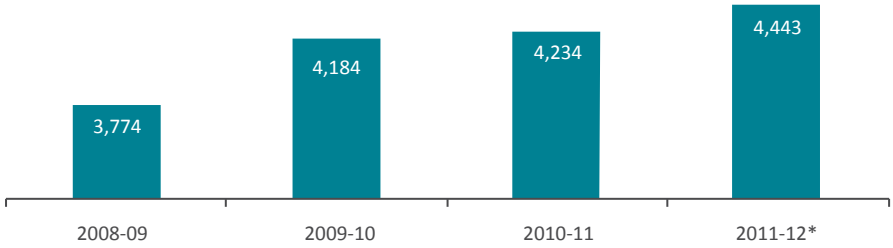
Year-to-date June
Source: ACT Public Hospitals

* As a result of improved counting methodology for non-admitted (outpatient) occasions of service (OOS) in 2011–12, some additional OOS activity is now included in the data. There have also been some minor changes where activity should not be included in the data. Some of this activity relates to delivery of some outpatient services off the hospital campus to improve efficiency and support access to services for consumers.

Births

Births in ACT public hospitals increased by 5 per cent in 2011–12, recording a result of 4433 compared with the 4234 births reported in 2010–11. The 2011–12 result is 55 per cent higher (more than 1500 babies) than the result for 2001–02.

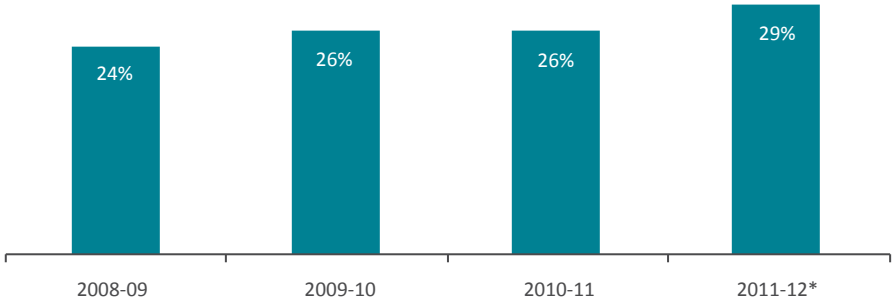
ACT Public Hospital
Births by Year



* Preliminary
Source: Admitted patient care data set

Births by Caesarean section increased to 29 per cent of all births in 2011–12, up from the 26 per cent reported in 2010–11.

% Caesarean by procedures by year



* Preliminary
Year-to-date June
Source: Admitted patient care data set

Caesarean rates have been steadily rising since 2001, both in the ACT and nationally. The ACT rate of 26 per cent in 2010–11 is lower than the most recent national figures published by the Australian Institute of Health and Welfare, for 2007–08. ACT public hospitals continue to have a low caesarean rate compared to benchmarking hospitals.

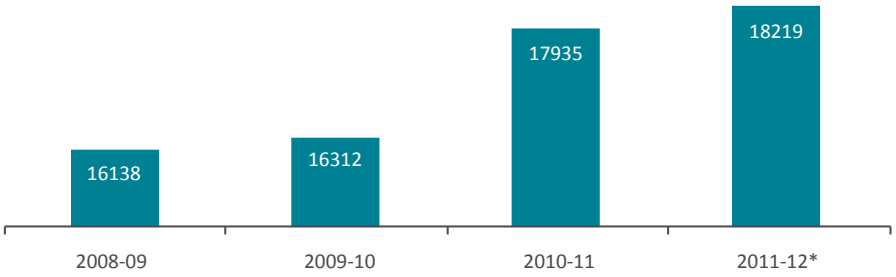
The most recent Australian hospitals data on women, for 2009–10, shows that the Canberra Hospital's caesarean rate is below those of peer hospitals. There are a number of measures in place to help reduce, and reverse the trend of increased caesarean rates in ACT public hospitals. These include actively promoting vaginal birth after Caesarean as an option for women and increasing the availability in continuity of midwifery care models.

The ACT Government has also provided an additional $2 million in 2010–11 and $1.5 million in 2011–12 to enhance obstetric and gynaecological services and neonatal services. The Continuity at the Canberra Hospital (CatCH) Program began in 2011 as a second continuity of care model at the Canberra Hospital. In 2012–13 a Community Midwifery Program at Calvary Public Hospital will be established to further enhance the obstetrics service at Calvary.

Operations in ACT public hospitals

Over the past three years, the number of surgical operations performed at our public hospitals has jumped by 13 per cent, from 16,138 in 2008–09 to 18,219 (preliminary) reported for 2011–12. Around 30 per cent of the emergency and elective surgical operations are performed on people from New South Wales.

ACT Public Hospitals
Total Surgical Operations
(Emergency & Elective)



* Preliminary
Source: Admitted patient care data set

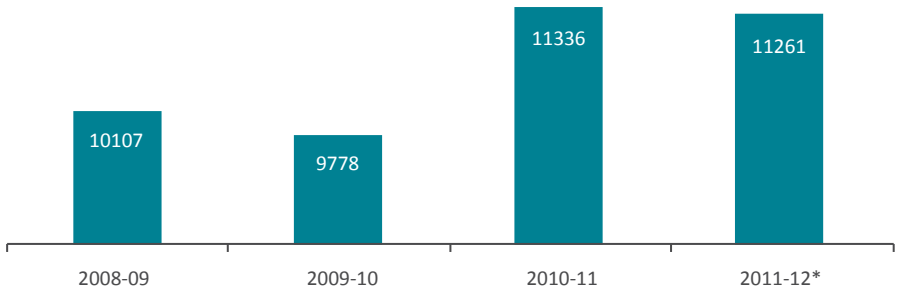
A Surgical Assessment Planning Unit was opened in December 2010. This unit is designed to streamline the admission process for non-critically ill surgical patients, allowing for increased throughput and rapid turnaround for short-stay surgical patients.

Access to elective surgery

A total of 11,261 people accessed elective surgery in 2011–12, 261 above the target of 11,000. This was achieved by utilising the private sector, and was part of the strategy to maintain the high level of throughput for elective surgery in the ACT, particularly in the specialties of ear, nose and throat surgery, urology surgery and orthopaedic surgery.

In 2010–11, approximately 171 patients accessed elective surgery under these arrangements. An additional 353 people accessed elective surgery under this agreement in 2011–12, which makes a total of 524 patients since this initiative was first established.

ACT Public Hospitals
Elective surgery waiting list
Number of people removed from the list for surgery



* Preliminary
Source: Elective surgery data set

As a result of the increased access to elective surgery, the number of people waiting to access elective surgery was reduced to 3996 people at 30 June 2012. This is a 6 per cent reduction compared with the same period last year, and a 25 per cent decrease compared with 2009–10.

The increased access to elective surgery has also meant the number of people waiting beyond the clinically recommended timeframe has been significantly reduced, with the number of long-wait patients falling by 37 per cent in 2011–12, from 1431 in June 2010–11 to 898 in June 2011–12.

The ACT Government will provide more than $12 million over the next four years to meet the growing demand for surgical services in ACT public hospitals.

Number of people waiting against standard recommended waiting times by clinical urgency

	Category 1		Category 2		Category 3		All Patients		
	Urgent—admission within 30 days		Semi-urgent—admission within 90 days		Non-urgent—admission at some time (365 day maximum desirable)				
	Long Wait	Not Long Wait	Long Wait	Not Long Wait	Long Wait	Not Long Wait	Long Wait	Not Long Wait	Total
At June 08	9	136	1422	1251	422	1553	1853	2940	4793
At June 09	0	111	1405	1367	332	1691	1737	3169	4906
At June 10	10	149	1721	1226	489	1733	2220	3108	5328
At June 11	2	173	1173	1169	256	1495	1431	2837	4268
At June 12	0	161	782	1126	116	1811	898	3098	3996

The ACT Government also reports surgeon waiting times and operating sessions for the ACT's public hospitals by reference to average waiting times for elective surgery for either a particular doctor or a clinical speciality. The data shows the number of operating sessions a doctor has at either of the two public hospitals in the ACT. This information can be found at the Health Directorate's website at www.health.act.gov.au/waitinglists.

Median waiting time to surgery for ACT public hospitals

	2008–09	2009–10	2010–11	2011–12
Category one	14 days	13 days	15 days	14 days
Category two	101 days	106 days	103 days	89 days
Category three	172 days	200 days	225 days	198 days
Total ACT	**75 days**	**73 days**	**77 days**	**64 days**

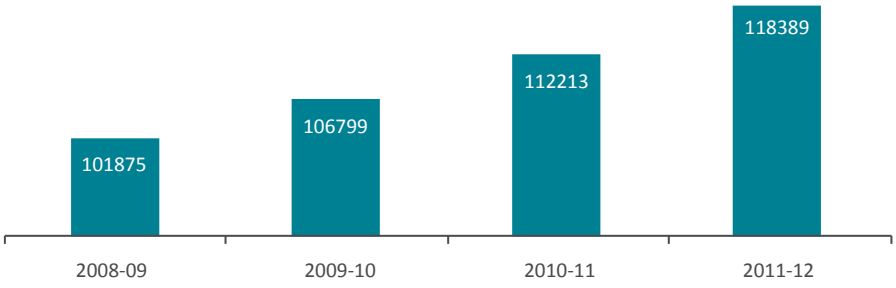
The ACT median wait time for all elective surgery was 64 days at June 2012. This represents a significant reduction on previous years.

Additional information on the ACT elective surgery waiting list and other surgery can be found in the ACT Public Health Services Quarterly Performance Report and the ACT Surgery Report Card. These reports can be found at http://health.act.gov.au/publications/reports/act-public-health-services-quarterly-performance-report and http://health.act.gov.au/publications/reports/act-surgery-report-card.

Access to acute services

The proportion of patients admitted through the emergency department who wait less than eight hours from commencement of treatment for admission to a ward during 2011–12 was 77 per cent. This result is above the target of 75 per cent, and an improvement on the 73 per cent recorded for 2010–11.

ACT Public Hospitals
All presentations to Emergency Department



Year-to-date June
Source: ACT Public Hospitals

In 2011–12, ACT hospital emergency departments saw 118,389 presentations, a 6 per cent increase in presentations compared to 2010–11. Admissions to hospital through the emergency department have also grown, with 31,062 admissions (16 per cent growth) reported for 2011–12 compared to the 26,704 recorded in 2010–11.

Waiting time for emergency treatment

Waiting times for category 1 and 5 patients either met or exceeded national standard waiting time targets during 2011–12. The below-target results for category 3 and 4 patients are related to continuing increases in demand for emergency department services in the ACT for these categories of presentations, with presentations up for category 3 and 4 by 7 per cent compared to the same period last year. Category 2 presentations (emergency) increased by 16 per cent in 2011–12.

Triage category	2011–12 target	2011–12 result
One (resuscitation—seen immediately)	100%	100%
Two (emergency—seen within 10 mins)	80%	75%
Three (urgent—seen within 30 mins)	75%	49%
Four (semi-urgent—seen within 60 mins)	70%	47%
Five (non-urgent—seen within 120 mins)	70%	81%
All presentations	**70%**	**55%**

Both our public hospital emergency departments are undergoing internal process redesigns to improve patient flow through them. These include:

- incorporating clinical streaming. This approach is becoming adopted in a number of leading emergency departments across the country. The basic premise of clinical streaming is to separate those patients who should not wait for treatment (triage category 1, 2 and some 3 patients) and those who can safely wait (triage category 5, and some category 3 patients). Each clinical stream is then seen in order of presentation within the clinical stream, regardless of triage score. The aim of clinical streaming is that overall waiting times are reduced
- early consultant-led review, with strong clinical leadership on the floor
- conversion of two emergency department beds to create four treatment chairs to increase treatment options

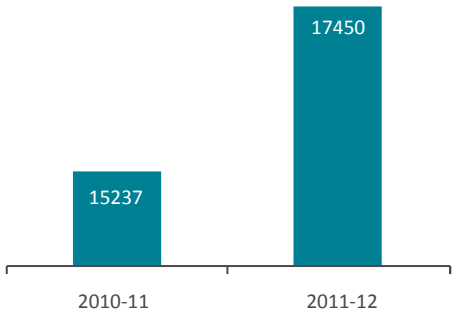
- the allocation of a paediatric registrar to provide services in the evening (previously there has been no paediatric cover out of business hours)
- the creation of discharge chairs to free up treatment space within the emergency department
- displaying the ED weekly report for all staff to see progress
- reviewing extended scope of roles, particularly in the nursing and allied health disciplines
- improving strategies to maximise diversion and referral systems
- the commencement of an emergency department redesign project focusing on the national four-hour target.

Australia's first Walk-in-Centre

The Walk-in Centre, located on the campus of the Canberra Hospital at Garran, provides free treatment for people with minor illnesses or injuries. It has been funded by the ACT and Commonwealth governments.

The Walk-in Centre is designed to help people get fast, free, one-off treatment for minor illnesses and injuries. The people of Canberra will be able to see a specialist nurse for advice, assessment and treatment for conditions such as cuts and bruises, minor infections, strains, sprains, skin complaints, and coughs and colds.

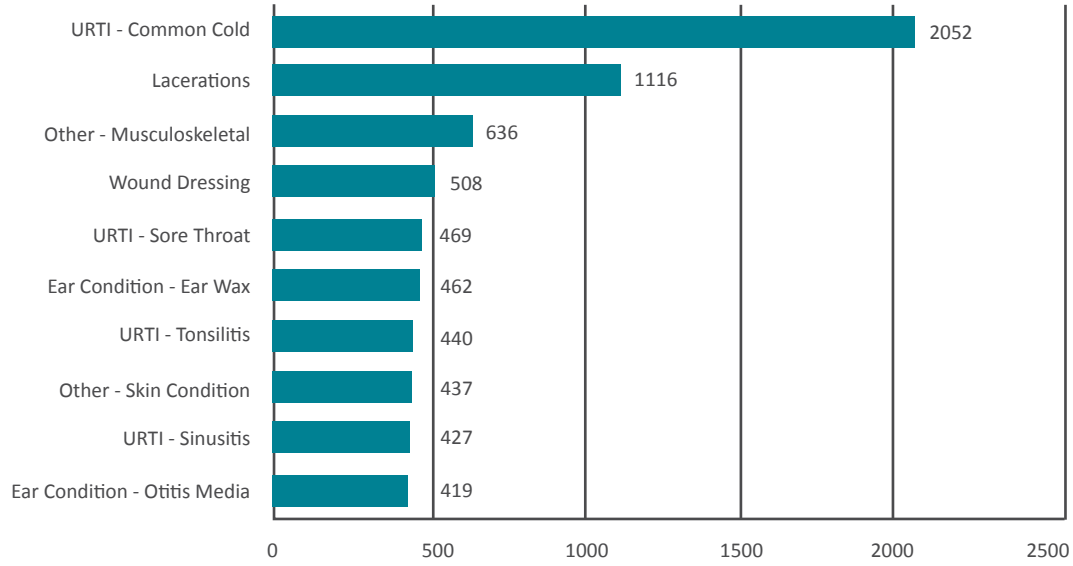
Walk-in Centre Total Presentations



Presentations to the Walk-in Centre increased by 15 per cent in 2011–12 compared with 2010–11. This increase reflects the value that the service provides to the community.

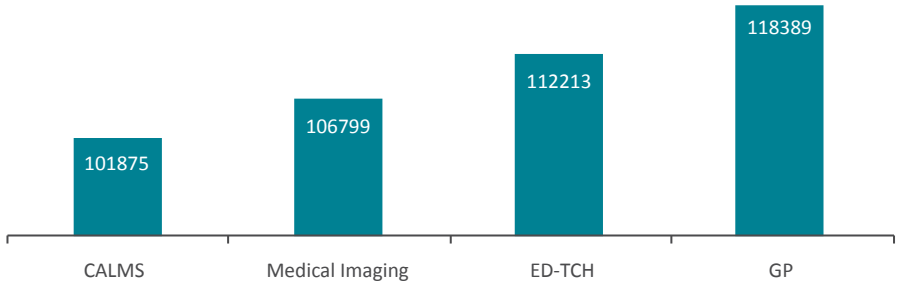
The Walk-in Centre nurses treat a wide range of conditions. There has been no significant change since last year in the top 10 conditions treated.

Top 10 Conditions Treated
Year to June 2012



If necessary, people are redirected to more appropriate services, such as their GP or the Emergency Department. Of the 17,450 presentations in 2011–12, 11,734 received a completed treatment episode from the nurse. A total of 9 per cent of patients assessed were subsequently redirected to their GP (compared with 18 per cent last year) and 5 per cent were told to present to the Canberra Hospital Emergency Department (on par with 2010–11).

Walk-in Centre
Patient Redirection following Nurse Assessment
Year to June 2012



The Walk-in Centre does not provide ongoing care for patients and will not treat people with chronic conditions or children less than two years of age. These patients should seek treatment and advice from their GP or the Emergency Department.

The Walk-in Centre is not designed to provide the range of services that a GP can provide, including comprehensive medical management, referral to specialist services or general health checks. The nurses who work in the Walk-in Centre have all completed additional training and the care they provide is guided by established protocols that have been endorsed by the appropriate clinical approvals processes. A visit report is sent to the patient's general practitioner with consent.

People in our community now have access to a wide range of primary health services, including their GPs, emergency departments, community health services, pharmacists and the Walk-in Centre.

The operation of the Walk-in Centre was externally evaluated after its first year of operation. The ACT Government Health Directorate is responding to aspects of the review that will enhance the centre's efficiency, such as staffing profile and hours of operation, as well as the effectiveness of its service delivery. Options are being considered for additional walk-in centres, particularly in relation to location, collaborative practice models and functionality. Patient attendances have increased consistently since the centre opened and consumer feedback remains positive.

National Partnership Agreement on Improving Public Hospital Services

The Commonwealth will deliver an additional $67 million to the ACT under the National Partnership Agreement on Improving Public Hospital Services for emergency department, elective surgery and sub-acute services. This agreement commenced on 1 January 2012. It provides for National Emergency Access Targets (NEAT), National Elective Surgery Targets (NEST) and sub-acute care reform.

National Emergency Access Targets

The main objective of NEAT is that 90 per cent of all patients presenting to a public hospital emergency department (ED) will be admitted, transferred or discharged within four hours. The targets will be staged in increments over the next four years to achieve the final target of 90 per cent. The first target—set at 64 per cent—is to be achieved by December 2012.

In the calendar year to June 2012, ACT public hospitals reported 57 per cent of all patients having a length of stay less than four hours. This is 7 per cent below the target of 64 per cent. Both public hospitals are undergoing continual redesign and process improvement initiatives to improve the way patients move into, through and out of the emergency departments.

National Elective Surgery Targets

There are three components to the NEST. They aim to ensure timely access to surgery while reducing the number of patients waiting beyond clinically recommended time frames.

Part 1 refers to the proportion of patients who access their elective surgery procedure within clinically recommended timeframes. Currently, ACT public hospitals are meeting Part 1 of the NEST in urgency categories 1 and 3. Category 2 remains a concern, with a result for the first six months of calendar year 2012 of 51 per cent against the target of 55 per cent to be achieved by December 2012. However, recent monthly performance has shown some notable improvements. The Health Directorate continues to work with the public hospitals to increase internal capacity to achieve these targets by December 2012.

Part 2A of the NEST targets refers to a reduction in the number of people waiting beyond the clinically recommended timeframes for each category of patients. The Health Directorate is to ensure that the top 10 per cent longest waiting category 2 and 3 patients have their surgery in each calendar year to 2016.

In the calendar year to June 2012, ACT public hospitals have already removed 79 per cent of the longest waiting patients from the list established at 31 December 2011, and remain on track to meet the target for the end of 2012.

Part 2B of the NEST is based on the requirement to reduce the average overdue wailing times for each category of patients so that there are no overdue patients by the conclusion of the agreement. In the calendar year to June 2012, ACT public hospitals are meeting all the required targets for all clinical urgencies in component 2B of the NEST.

Sub-acute care reform

The sub-acute component is aimed at improving patient health outcomes, functional capacity and quality of life by increasing access to sub-acute care services including rehabilitation, palliative care, sub-acute mental health and geriatric evaluation and management, and psycho-geriatric services in both hospitals and the community.

The ACT was required to build capacity for 11 sub-acute bed equivalents before 1 July 2012. Because of a lack of appropriate tender applications in relation to the ACT's sub-acute projects, the ACT added only 6.9 bed equivalents to the system by the end of June 2012. There is no financial reward or penalty associated with this target.

The ACT Government Health Directorate has established a National Health Reform Steering Committee. This committee is working on alternative models that may attract additional service providers, as well as contingency plans in relation to this project to ensure that 21 bed equivalents are delivered by July 2014.

Division of Critical Care

Since its formation in January 2011, the Division of Critical Care has supported the wider community by providing a tertiary referral service, which includes emergency medicine, intensive care, medical emergency teams in support of the deteriorating patient, an accredited aeromedical retrieval service, and assessment and planning units for both medical and surgical patients. Consumer representation is an integral part of this focus with advisory input and conciliation from services related to mental health and chronic care clients.

The division is represented at national and international levels, with senior medical and nursing staff participating in research studies and education programs related to acute and critical care. This supports the strong focus across the division to ensure that care is delivered to a high standard of safety and quality.

There will continue to be a strong emphasis on accessible and timely care, with redesign in the areas of access and patient flow, changes to existing models of care and a planned expansion in capacity in 2012–13.

Achievements

Emergency Department

- The Emergency Department Redesign Group has introduced a change to existing models of care that has the ED Consultant at the front line to undertake initial assessment of patients and initiate a treatment plan, which is implemented by junior medical staff. The aim of this initiative is to provide timely quality care to meet the National Emergency Access Target requirements. The results of this redesign have proved successful and have been presented to an international audience of emergency physicians.
- Despite a 6 per cent year-on-year increase in presentations to the Emergency Department, initiatives to reduce the waiting times have resulted in the number of patients who did not wait to be treated decreasing to an average of 9 per cent per month.
- The Emergency Department continued to meet the national target for category 1 patients.
- To meet the comfort needs of patients in the waiting room, the Emergency Department Management Group obtained funding from the Canberra Hospital Foundation to provide new seating for the waiting room. The comfort provided by the new seating is demonstrated by the dramatic decline in negative consumer feedback.
- The implementation of the Emergency Department Volunteer Program has seen the successful inclusion of volunteers within the department's multidisciplinary team to provide practical and/or emotional support to patients, families and carers.
- The relationship between the Emergency Department and the Walk-in Centre continues to support the referral of patients to the most appropriate service. This has been strengthened further by the introduction of informative posters in the Emergency Department waiting room promoting the self-referral of eligible patients to the Walk-in Centre.
- The ACT Ambulance Service target to transfer patients from the ambulance stretcher in the Emergency Department is 20 minutes. Of the 16,000 transports to the hospital from 1 July 2011 to 31 March 2012, 90 per cent of patients were offloaded within 20 minutes of arrival, 9 per cent within 20 to 40 minutes and 1 per cent in more than 40 minutes.
- The Emergency Planning and Disaster Preparedness Improvement Plan identified areas that would benefit from a redesign of processes in order to provide an improved, safer response in an emergency or disaster situation. The key improvements under the plan are a streamlined Emergency Management Committee, clearly identified roles and responsibilities in emergency planning and disaster response, training for staff in the new processes, resources matched appropriately with services provided, and standardised and implemented business continuity plans.

- A refresh of all Emergency Management Code documentation has been undertaken, including distribution of new code handbooks to all areas of the Canberra Hospital campus.
- The division implemented a four-week emergency care communication campaign to 'Keep Emergency for Emergency Patients' on regional television and radio stations with the aim of helping to direct patients to the most appropriate care for their needs and raise community awareness of our priority in providing treatment to those people who are seriously ill, in pain or suffering. This has continued on the ACT Health Directorate website, providing information to the community indicating that those persons who present with serious illness will be seen as a priority.

Access Unit

- The Access Unit has been relocated on Level 3 of Building 2. This dedicated area is designed to provide a central point for divisional reporting on patient flow activity and to provide visibility of all available bed resources. The unit is designed as a control centre, with resources available for other divisional liaison officers to update their available capacity. IT provisions within the unit will promote visibility of live information in regard to ED activity and elective requirements. In stage 1 of a tiered redesign for the Access Unit, changes have been implemented to:
  - improve the patient journey and promote the movement of patients, resulting in improved outcomes and quality services
  - provide improved processes that will engage and support staff involved with patient flow and access
  - create a dedicated environment that has a primary focus on patient flow, activity and available capacity.

Intensive Care Unit

- The Intensive Care Unit (ICU) has implemented an electronic patient record system, called MetaVision. MetaVision is a real-time comprehensive bedside record-keeping tool for use by the entire multidisciplinary team. Metavision continues to support the provision of quality care with timely and accurate reporting of clinical records and medication management and eliminates repetitive documentation for the bedside nurse.
- Following the implementation of a dedicated Medical Emergency Team (MET) service at Canberra Hospital in March 2011, there has been a significant escalation in the number of MET reviews. By having the dedicated MET service, deteriorating patients on the ward can be provided with medical emergency care in a timely fashion. More recently, MET nurses have provided a 24-hour post-MET review, and this service along with the MET reviews has seen a reduction in the number of patients being readmitted to the Intensive Care Unit.
- Following the successful implementation of the Emergency Department Volunteer Program, volunteers have been introduced into the Intensive Care Unit to provide support for relatives of patients admitted to the Intensive Care Unit. This has received positive feedback from both family and staff.

Capital Region Retrieval Service

- The Capital Region Retrieval Service has gained accreditation and is the only retrieval service in Australia to gain accreditation from three colleges: the College of Intensive Care Medicine of Australian and New Zealand, the Australian College of Rural and Remote Medicine and the Australian College of Emergency Medicine.
- A remote digital web-based application has been introduced to enhance decision making and provide consultation advice to regional NSW hospitals.

- A portable ultrasound device has been introduced to the Retrieval Service to assist doctors dealing with differential diagnosis, allowing them to make a more informed decision about the patient's management and improve patient care.
- The SkyTrac system has recently been installed on the Snowy Hydro SouthCare helicopter. This brings SouthCare in line with other aeromedical services. The device has proven to be very useful in increasing safety during flight training and retrieval operations because it allows the SouthCare helicopter to be tracked during aeromedical retrieval missions, search and rescue missions and training exercises. The landscape and environmental challenges in this region add an increased complexity to aviation missions, and this system allows for flight operations to be analysed and for the information to be used during debrief sessions to improve mission tasking and future operations.

Issues and challenges

- The reporting of data manipulation of Emergency Department performance information resulted in investigations being undertaken by the Auditor-General and PriceWaterhouseCoopers. This resulted in several recommendations to the Health Directorate with regard to Emergency Department data security and integrity and a review of all user requirements. This will be an ongoing body of work.
- The National Emergency Access Targets will continue to be a challenge that will require active resolution from all services within Canberra Hospital in consultation with the ED. Senior ED staff continue to develop initiatives directed at internal departmental issues with a view to achieving triage targets for all categories and streamlining the discharge pathway.
- Increased demand with the number of presentations year on year will challenge the physical capacity of the ED, though this should be relieved in mid-September with the planned opening of four new treatment spaces and an additional seven spaces in mid-2013.

Future directions

- Additional planned ED capacity (4 treatment spaces) and ICU capacity (2 beds) is nearing completion for mid-September 2012. This will support the capacity requirements for ED to provide quality safe care and assist with meeting activity targets.
- Plans have been developed for extending the Emergency Department and Intensive Care Unit to provide additional capacity and storage space. Plans have been finalised and completion is projected for mid-2013, dependent on budget appropriation.
- An additional six beds for the Medical Assessment and Planning Unit are planned for occupation in September 2012.
- The Discharge Lounge is being relocated to provide additional capacity, ease of access to support services such as Pharmacy, and make pick-up easier for relatives and transport services.
- In conjunction with the Division of Women, Youth and Children, and supported by the Canberra Hospital Foundation, the ED paediatric treatment area will undergo refurbishment to provide a brighter, more child-friendly environment.

Division of Medicine

The Division of Medicine provides a wide range of adult medicine services to the Canberra community in inpatient, outpatient and outreach settings. It also provides chronic disease management, infection control and pharmacy services. A strong emphasis is placed on accessible, timely and integrated care being delivered to a high standard of safety and quality.

The division has a strong commitment to teaching and research. Health students from several universities do practical placements in the division. Most of the senior medical staff also hold academic appointments in the Australian National University Medical School and there are many active research programs in operation. Many members of the Division also participate in the development of national professional guidelines and quality initiatives. Many units of the division work actively with community groups, other services and the private sector to improve the care of patients across the whole health system. Consumer representatives play a crucial role on the division's internal advisory committees.

In the coming year, the division's services will expand to include more inpatient beds, an increase in Hospital in the Home provision and greater access to medical procedures, including endoscopies. We will continue to develop innovative ways to provide the care that people need, and ensure our patients have access to leading edge medical treatment.

Achievements

Endocrinology and Diabetes Service—The *ACT Diabetes Services Strategic Plan 2008–2012* recognises the increasing incidence of diabetes in the ACT, with an estimated 25,000 people affected. Diabetes services received $232,000 of recurrent funding in the 2011–12 Budget to assist with implementing the plan as part of the Chronic Disease Management Initiative. The key objectives of the plan are to:

- prevent and delay the onset of diabetes
- prevent and slow progression of diabetes complications, and
- enhance the quality of life of people with diabetes.

The ACT Diabetes Services Reference Group was established in 2012 to enhance links and collaboration among all groups involved in diabetes care in the ACT. This group has very broad representation, including that of consumers, the primary care sector and non-government organisations. The group will provide input to the development of both prevention and management strategies for diabetes. In 2011–12, progress was made in restructuring the ACT Health Diabetes Service. This service provides care to children, youth, pregnant women and adults with diabetes in the ambulatory care setting and the acute care setting. The restructure is intended to improve the quality and efficiency of care in all these areas.

Cardiology Services—The Department of Cardiology is the tertiary diagnostic and therapeutic centre for acute and chronic cardiac diseases for the people of the ACT and the surrounding NSW region. It provides a comprehensive suite of diagnostic and treatment facilities, including non-invasive diagnostic facilities, cardiac catheterisation and angiography and a wide range of interventional cardiac and vascular procedures. The cardiac catheterisation service is available around the clock for emergency response.

Renal Services—All the achievements outlined for Renal Services are consistent with stated objectives in the Renal Services Plan 2010 – 2015, which was developed in consultation with clinical and community stakeholders in 2010–11. Achievements this year include:

- customisation and implementation of the Renal Specific Electronic Medical Record (EMR) system, with an expected go-live date of September 2012
- establishment of self-care community dialysis centres, including a centre in the ACT at Weston and another at Young, New South Wales

- co-location of self-care dialysis training facilities at Gaunt Place, with handover of the new area estimated to occur in September 2012
- governance of a newly established dialysis service at Queanbeyan
- establishment of a vasculitis clinic in collaboration with the Department of Immunology. This clinic provides multidisciplinary care for patients with vasculitis and also enables the creation of a space for clinical and case-based research in this group of patients
- establishment of transplant service clinics conducted by visiting transplant physician/surgeons from Royal Prince Alfred Hospital
- upgrade of water treatment units for home dialysis patients in the ACT and surrounding NSW
- continued operation of a high-throughput ambulatory service without a waiting list.

Chronic Disease Management—Chronic Disease Management is a multidisciplinary team within the Division of Medicine of Canberra Hospital and Health Services. The focus is on improving the management of patients with chronic disease, particularly Chronic obstructive pulmonary disease (COPD), chronic heart failure (CHF) and obesity. The unit also undertakes management consulting, clinical audits, continuous quality improvement, research activities and evaluations to improve the management of chronic disease across the ACT.

The Chronic Care Program is a service that sits within Chronic Disease Management. It is delivered by clinical nurse consultants and clinical care coordinators who provide clinical support, education and care coordination in the acute care sector for patients with COPD, CHF and Parkinson's disease. The program's achievements this year were:

- the Chronic Care Program being awarded 'Team of the Year' at the 2012 Nursing and Midwifery Excellence Awards
- a COPD patient resource booklet winning a 'Better Practice Achievement' award at the 2012 Health Directorate Practice Awards
- development, implementation and official media launch of the 12-week multidisciplinary Heart Failure Rehabilitation Course, which aims to educate, improve quality of life through exercise, improve confidence and self-management skills and reduce frequency of hospitalisations for patients with chronic heart failure
- development and implementation of the Parkinson's and Movement Disorders Service, including the employment of a Parkinson's disease clinical nurse consultant and an additional care coordinator to provide clinical support, education and care coordination for patients with Parkinson's disease and other movement disorders
- the evaluation of the Home Telemonitoring program, which is gradually increasing its patient load. Referrals are now accepted from general practitioners as well as hospital specialists
- development and implementation of the mobile 'Respecting Patient Choices' clinic to increase the number of patient advanced care plans
- using the Chronic Disease Management Register, completion of audits of HbA1c levels, eGFR and care planning for groups of Canberra Hospital and Health Services patients
- obtaining $184,000 for new bariatric equipment at the Canberra Hospital through the Obesity Service Redesign Project.

Neurology—A neuro-ophthalmology service opened in November 2011 in conjunction with the Ophthalmology Department. The Neurology Department will work closely with the Chronic Disease Management Unit in providing a service for people with Parkinson's disease funded in the 2011–12 Budget and included the appointment of a registered nurse to coordinate the care of this group of clients. A review of stroke services is well underway in the Neurology Department.

Clinical and Forensic & Medical Service—Clinical Forensic Medical Services (CFMS) encompasses two services: Forensic and Medical Sexual Assault Care (FAMSAC) and Clinical Forensics ACT (CFACT). CFMS started as a forensic-based sexual assault service and it has grown to encompass all facets of clinical forensic medical services required by the Australian Federal Police. In 2011 and 2012 the service has further developed to meet the requirements of other Australian police forces, as well as delivering training in clinical forensic medicine internationally.

Major achievements over the past year have included the CFMS 24-hour, seven days a week provision of clinical forensic nursing. This provides an improved service to the Australian Federal Police, more appropriate medical practitioner call-outs, improved job satisfaction for the medical staff and cost savings. FAMSAC has initiated a domestic violence documentation service, with a signed stakeholder agreement between FAMSAC and the Domestic Violence Crisis Service. Increasingly the medical specialists are providing reviews and expert evidence for interstate cases. Delivery of training programs by the medical specialists locally, nationally and internationally is also increasing.

Pharmacy—The Antimicrobial Stewardship Program was fully implemented under the governance of the Healthcare Associated Infections Standards group and a part-time antimicrobial stewardship pharmacist was recruited. An infectious diseases approval system for the prescribing of broad-spectrum antimicrobials has been established, two point prevalence surveys completed and an education program commenced. There has been a major review of Oncology Pharmacy Services and the recruitment of a lead cancer services pharmacist. An integrated electronic chemotherapy prescribing, dispensing and administration system (CHARM) was fully implemented. Also completed was the tender process for the procurement of closed system transfer devices to improve safety in the compounding and administration of chemotherapeutic agents.

New pharmacist positions established in 2011–12 under the Quality Use of Medicines framework included a drug utilisation evaluation pharmacist and a clinical information systems pharmacist.

Gastroenterology and Hepatology Unit—The Gastroenterology and Hepatology Unit at Canberra Hospital provides services to patients in the ACT and surrounding region in all areas of gastrointestinal diseases, with a particular focus on inflammatory bowel diseases, gastrointestinal cancer, chronic hepatitis, chronic liver disease, and gastrointestinal endoscopy. The unit has well-developed multidisciplinary teams, including consultant medical staff, senior registrars and nursing staff with special expertise. The unit also plays a significant role in undergraduate teaching at the Australian National University Medical School and in the postgraduate education and training of medical and nursing staff. The unit has active research programs that achieve recognition at national and international levels. In 2011–12, 28 peer-reviewed scientific articles from members of the unit were published, not including abstracts of presentations at scientific meetings. Members of the unit also contribute to many community and professional organisations.

In 2011–12 members of the unit provided 4419 endoscopy procedures (elective and acute), 6413 outpatient attendances, and 1212 episodes of care to admitted inpatients (excluding Hospital in the Home—HITH). Over a five-year period endoscopy services have grown by 25 per cent, inpatient care episodes (excluding HITH) by 39 per cent, and outpatient attendances by 82 per cent. The unit also provided outreach services in the community and at the Alexander Maconochie Centre.

Issues and challenges

Waiting lists for both endoscopy and outpatient services continue to grow, but are being addressed with the appointment of more medical and nursing staff, refurbishment of the unit and acquisition of more endoscopy equipment in 2012–13.

Some services will be reconfigured to better manage the chronic conditions associated with bariatric patients. There will be better management of patients who present with undifferentiated diagnosis to the Emergency Department.

Future directions

Endocrinology and Diabetes Service—In 2012, the clinical space available to the Diabetes Service in Canberra Hospital is being expanded by relocation of the endocrinology offices. Two new consulting rooms and a second high-risk foot clinic room will soon be available.

The ACT Health Directorate Diabetes Service will increase its support to the Winnunga Aboriginal Health Service in 2013 with visits by an endocrinologist. The directorate also provides diabetes nursing, nutrition and podiatry support to the Winnunga Aboriginal Health Service.

In September 2012, the ACT Health Diabetes Service will commence a new clinic for women with gestational diabetes in Gungahlin. This will save women from this area having to cross the city to Canberra Hospital for this service. In 2013, transfer of more ACT Health Diabetes Service activities to the northern parts of Canberra will occur when the new Belconnen Enhanced Community Health Centre opens.

In 2013 programs to enhance engagement between the ACT Health Diabetes Service and primary care services will be developed with assistance from the ACT Medicare Local. As well as establishing improved referral patterns, joint professional education and staff development programs will be established.

Cardiology Services—Work has commenced on scoping and developing a cardiac centre model for cardiac services. This will include the clinical model of service delivery and integration of health promotion and prevention through Canberra Hospital and Health Services, with strong links to the Heart Foundation.

Work is underway to facilitate access to interventional cardiology by clinicians working at Calvary Health Care ACT. This will allow for ease of access and continuity for patients who present at Calvary Hospital requiring cardiology intervention. A Chest Pain Evaluation Unit will be developed in 2012–13 to further manage patients who present to the Emergency Department. Patients will be managed in a dedicated unit and be triaged in a timely manner.

Chronic Disease Management—Chronic Disease Management will focus on expanding the Heart Failure Rehabilitation Course, which is a 2012–13 Chronic Disease Management budget initiative. We also aim to maintain the quality and increase the productivity of our clinical services. We will look to strengthen our links with other units within the Division of Medicine. We plan to engage more deeply with the Aboriginal and Torres Strait Islander community and to develop a strategy for our Chronic Disease Management services to integrate more closely with the work of general practice in this field.

***Renal Service**s—*

- Go live with the Renal Electronic Medical Record in September 2012.
- Increase capacity at Belconnen and Tuggeranong for renal service delivery as part of the Health Infrastructure Program.
- Provision for Tele-health services for consumers in remote areas.
- Environmentally friendly health service delivery—reuse of dialysis water.
- Establish a care-coordinator network with other partners (diabetes service, cardiology, chronic disease management, palliative care) to provide a more holistic and integrated service to patients with kidney disease.
- Develop an education network to better support care providers in the community.

Pharmacy—The Pharmacy Department has been closely involved in the evaluation and procurement of a hospital-wide electronic medication management system and has developed an electronic system for medication reconciliation. These systems will be implemented in 2012–13, with the Pharmacy Department closely involved with project management and rollout.

The clinical pharmacy service will be redesigned as a unit-based service to improve access to and rates of medication review and medication reconciliation. Three new senior pharmacist positions have been established to lead the unit-based teams and recruitment has commenced. The pharmacists have developed the drug library for the new infusion pumps which will be rolled out in 2012–13. The drug library contains 450 entries and will improve safety associated with the infusion of intravenous medications.

A redesign of the dispensary operations has commenced to improve customer focus and workflows and the introduction of ward-based pharmacy technicians will improve timely access to medications for inpatients.

Gastroenterology & Hepatology Unit—Waiting lists for both endoscopy and outpatient services continue to grow, but these are being addressed with the appointment of more medical and nursing staff and refurbishment of the unit in 2012–13. The unit will also be commencing endoscopic ultrasound to enhance the diagnosis and treatment of gastrointestinal cancer.

Hospital in the Home (HITH)—We will expand the number of Hospital in the Home beds as part of our commitment to meet the growth in demand for acute services through innovative, patient-centred models of care. Work has commenced on discussions with the Chronic Disease Management Service to utilise HITH to manage and prevent hospital admission for patients with chronic disease.

General/Acute Medicine—Work commenced in 2011–12 to develop a model for a General/Acute Medicine service as part of a redesign exercise. Funding in 2012–13 will be utilised to implement a General Medicine Model with designated general medicine beds staffed by nursing and medical staff to better manage patients who present to the hospital for care who have an undifferentiated medical diagnosis. This service will further enhance services already provided in the Medical Assessment and Planning Unit.

Division of Pathology

The Division of Pathology is the provider of public pathology for the territory, providing specialist pathology services to the medical practitioners of the ACT and surrounding region. This includes pathology testing while patients are in hospital and when they return to their homes.

Services are provided in the acute care setting at Canberra and Calvary hospitals and the National Capital Private Hospital and in the community through collection centres across the ACT. A home collection service for patients who are frail or unwell and who cannot attend these collection centres is also provided. Analysis of collected samples is undertaken at the two laboratories within the ACT. The main laboratory is located at the Canberra Hospital and a branch laboratory is located at Calvary Hospital.

Pathology is a medical specialty looking at disease processes and their cause. Body tissue, blood and other bodily fluids are analysed to assist medical practitioners in identifying the cause and severity of disease, and to monitor treatment. The Division of Pathology is made up of a range of clinical specialities—anatomical pathology, chemical pathology, haematology, cytogenetics, immunology, microbiology and molecular pathology. All areas are accredited by NATA/RCPA.

Pathology is a demand-driven service that plays a critical role in more than 70 per cent of clinical diagnoses and many of the decisions concerning the optimal treatment for patients (Legge 2008, DoHA Survey of the Pathology Workforce 2011) . Because of the critical role of pathology testing in diagnosis and treatment, the objective and directions for pathology are intimately tied to the objectives and priorities of the Health Directorate's Corporate Plan.

In addition to its service role, ACT Pathology is the teaching department for the Australian National University (ANU) Medical School and is a major contributor to the Medical Science course at the University of Canberra (UC) and the Canberra Institute of Technology (CIT).

Achievements

Action to meet health workforce shortages—The workforce shortages in the Pathology workforce (both pathologists and scientists) have been clearly documented (Legge, October 2008).

- Pathology holds Royal College of Pathologists of Australasia accreditation for medical postgraduate pathology training in all the major specialisations of pathology and has a sound track record of success in fellowship examinations.
- Pathology is working in collaboration with the University of Canberra to continue to develop and to support the undergraduate Medical Laboratory science course and postgraduate courses. A number of scientific staff prepare and provide lectures for these courses. In addition, students are supported in the pathology laboratories and practical classes while undertaking their professional practice requirements. This initiative is already providing new graduates who are being introduced into the workforce in Canberra.
- The contribution of scientific staff from cytogenetics to the development of the University of Canberra course was mentioned in last year's annual report and it can now be confirmed that this is the only postgraduate cytogenetic course to be offered in Australia.
- Pathology continues to work in collaboration with Canberra Institute of Technology (CIT) delivering courses in histology, blood transfusion, clinical chemistry, immunology, laboratory operations and phlebotomy.

Investment in research—Pathology is a scientific discipline with research as a cornerstone. Many of the pathologists and scientists are actively involved in their own research or work collaboratively with others. This demonstrates the important role of research in teaching and Pathology's increasing link with and contribution to the Australian National University Medical School. Members of the division (scientific and medical) continue to publish in peer-reviewed journals and participate in professional meetings and workshops both within Australia and overseas.

A new and significantly larger PC3 laboratory has been commissioned in microbiology. This is a very secure laboratory required for handling of potentially highly infectious agents and to fulfil obligations for public health relating to bio-terrorism.

Social inclusion—Pathology continues to develop the project to include Aboriginal identification on its pathology testing. This information is then available to feed through to health databases such as the Pap smear register, notifiable diseases and cancer cases, and should enable better health policy planning.

Collaboration—Pathology works in close collaboration with many areas of the Health Directorate to provide access to timely results to facilitate decision-making and help them achieve their outputs. Pathology has seen an overall increase in the number of pathology requests received for hospital patients, as indicated in the table below. Each request generates analysis of multiple tests across many of the different disciplines in the division.

Location	Number of Requests 2010–11	Number of Requests 2011–12	% increase in Requests
Canberra Hospital	320,439	352,519	10%
Calvary Hospital	83,515	94,951	14%

Breast screening—Pathology has improved diagnostic services to Breast Screening ACT, with a turnaround time of two to three days for reporting.

New technology—MALDI-TOF-MS was installed in Microbiology recently. MALDI-TOF-MS is a high-throughput, rapid and reliable method for the classification and identification of microorganisms. It allows identification of bacteria through a peptide fingerprint and should enable more rapid diagnosis. Specific identification of uncommon bacteria will be enhanced. Analysis of its benefit to patient care will be undertaken in the next few months.

Front end automation—A tender has just been let for the installation of an automated system to improve handling of patient samples received in the laboratory. This will assist in the processing and storage of samples, as well reducing pre-analytical errors and the incidence of repetitive strain-type injury. It will benefit both patients (with improved quality) and staff (with improved work safety practice).

E-Health—Pathology embraces electronic delivery of pathology results for better management of patient care and the provision of continuity of services. Pathology results are currently:

- included in the discharge summary
- delivered to the ICU system to support patient care and other data bases in clinical areas, and
- delivered electronically to medical practitioners in the community.

Major work is underway to introduce electronic entry of pathology requests. This will be linked with an electronic system for positive patient identification (PPID) to improve patient safety.

Issues and challenges

The work load in pathology has increased even more in the past 12 months, reflecting the increased patient load and acuity in the public hospital system. This has been achieved across all parts of pathology by the dedication of staff. However we are mindful of the workforce situation and challenge of an ageing population, in terms of both potential recruitment and retirement. There has been some increase in staff numbers, and we particularly welcomed five new members who were recruited from the United Kingdom. The ability to respond to new diagnostic requirements and provide rapid results provides an increasing challenge. Initiatives to address some of these issues have been put in place and there is an ongoing investment in education and training.

Future directions

Improve quality of service delivery through investment in technology—LC-MSMS is an analytical chemistry technique that combines the physical separation capabilities of liquid chromatography (or HPLC) with the mass analysis capabilities of mass spectrometry. It is a powerful technique used for many applications which has very high sensitivity and selectivity. This is an extension of current technology (HPLC) in ACT Pathology which will enable very specific measurement of very low concentrations of some naturally occurring compounds. It will also allow differentiation of closely related compounds that occur in high concentrations, but whose structures are so similar that current technologies do not allow discrimination. Examples of these compounds are steroid hormones and structurally related compounds such as Vitamin D. The areas that will particularly benefit initially are neonatal diagnosis of some inherited conditions as well as cancer patients. Tenders are being developed for this early in the new financial year.

Research that promotes evidence based practice—Pathology supports much of the clinical research being undertaken in the public hospital system in the ACT by undertaking the assays directly required as well as preparing special samples for forwarding to research institutes in other states. This activity is in addition to work initiated within various departments across Pathology, which often entail collaboration with the Australian National University and University of Canberra.

Improve patient safety and quality of care—Pathology is working collaboratively with Health IT to introduce Computerised Physician Order Entry (CPOE). This system will improve completion of mandatory information required for pathology testing, improve legibility and thus accuracy of request information, and provide decision-making support information to the requesting doctor. In conjunction with the CPOE, a pathology collection system providing positive patient identification (PPID) for the collection of blood samples will be introduced. The introduction of both CPOE and PPID is expected to reduce pre-analytical errors that occur before the sample is presented to the laboratory for analysis. This will significantly improve patient safety. The process is necessarily long and intensive and we look forward to implementation in 2013.

Division of Surgery and Oral Health

The Division of Surgery and Oral Health is responsible for delivering inpatient and outpatient surgical services and prevention and treatment dental health programs for children, targeted youth and adults of the ACT Community and surrounding region. The aim is to provide timely access to elective and emergency surgery, with a focus on quality patient-centred care, supported by evidence-based practice. The division includes Surgical Bookings & Pre-Admission Clinic, Anaesthesia, Pain Management Unit, operating theatres, Post-anaesthetic Care Unit, Day Surgery Unit, Admissions/Extended Day Surgery Unit, Medical Imaging, various specialty surgical ward areas, Outpatient Department (medical and nursing only), Shock Trauma Service, Trauma Orthopaedic Research Unit and the Dental Health Program.

Achievements

Surgery

- The Surgical Improvement Plan commenced operation in July 2011 with the overall aim of ensuring that elective surgery is completed within required time frames to meet National Elective Surgery Targets while also providing emergency surgery within appropriate time frames. This aim requires that all physical and human resources are appropriately matched with the services, and that they are provided efficiently and effectively. Waiting lists, capacity and demand, theatre management, staffing equipment and finance are all key improvements being addressed through the current plan.
- The successful trial of the Urology Surgery Liaison nurse has resulted in the recruitment and implementation of four Elective Surgery Liaison Nurses. This has helped with the management of elective surgery long waits and the development of regular auditing of all patients on these waiting lists to ensure that patients remain stable while awaiting surgery .
- The implementation of a telephone triage process within the Pre-Admission clinic has improved the pre-operative management of patients, ensuring that appropriate medical assessments and tests are attended prior to the patient undergoing elective surgery and to ensure postponements or cancellations on the day of surgery, thus improving theatre utilisation practices and times.
- After long negotiations, Canberra Hospital and National Capital Private Hospital (NCPH) have established a public/private partnership for cardiac surgery. Cardiac surgery commenced at NCPH in November 2011. This arrangement will benefit patients, open the door for Anaesthetic Registrars to be involved at NCPH and lead to a close association between hospitals.
- A reduction in permanent vacancies in the Perioperative Unit, along with plans to provide education for the multi-skilling of experienced staff, has assisted in the improvement of theatre utilisation. The multi-skilling of staff will enable staff from other areas across the unit to competently perform in different roles as required to overcome staffing shortfalls with minimal impact on theatre utilisation.
- Since the establishment of the Eye Clinic in 2007, the demand for ophthalmology services in the ACT continued to increase. As a result, the Ophthalmology Clinic was relocated to a new $0.7 million, 250sqm custom-built Eye Clinic, which opened for business in October 2011. In 2010–11 the clinic provided 10,000 occasions of service. With the additional space and second retinal specialist, the Canberra Eye Clinic expects to provide an additional 4000 occasions of service.
- The Executive Director for the Division of Surgery & Oral Health won the 2011 Telstra ACT Business Women's Innovation Award. Ms Reid's achievements include turning a culture of blame in Canberra Hospital's Emergency Department to one of teamwork and high engagement, boosting staff retention, heightened morale and dramatically improved public perceptions of the local health system.

Medical Imaging

- The Medical Imaging Improvement Plan is a collaborative project aimed at improving patient access to the Medical Imaging Department. The plan has increased activity within the department by 8 per cent in comparison to the previous financial year. Initiatives completed so far include a review of the governance structure and recruitment processes. A number of working groups are developing solutions to system issues within the unit, and proposed new solutions are being tested and are in consultation.
- The PET scanner is now operating five days a week. This drops to three to four days a week when consultants are on leave.
- In 2011–12 an average of 76 PET examinations were completed per week (July to June) in comparison to the 2010–11 average of 45 examinations per week (October to June).

Dental Health Program

- In 2012 the Dental Health Program (DHP) is participating in the National Child Dental Health Survey in collaboration with the Australian Research Centre for Population Health. The objective of the study is to gather data regarding child oral health and the utilisation of dental services by children in Australia. The information will assist policy decision makers and dental service providers in shaping the delivery of dental services to improve the oral health of children and young people. The study comprises an oral epidemiological examination on school premises by dental therapists and a two-stage social survey regarding dental service use and other determinants for oral health for children. The DHP will continue to develop and implement the models of care for new community health centres.
- One hundred per cent of clients triaged as a dental emergency were seen within 24 hours. The mean waiting time of 12 months for restorative dental treatment was achieved. The mean waiting time target of 12 months for clients on the dental services waiting list was achieved.
- The DHP provided 1201 dental treatments to detainees at the Alexander Maconochie Centre during 2011–12, an increase of 347 when compared with 2010–11.
- During 2011–12, the DHP removed an additional 71 clients from the denture waiting list when compared to 2010–11.
- The number of pro bono dentists working through the Dental Care for the Homeless and Low Income Clients in the ACT program has been increased by one and negotiations with another are underway.
- Dentistry clinical training placements in the ACT will be further expanded to increase the level of tertiary training in the profession.
- The ACT Health Directorate's figures for decayed, missing or filled teeth index (DMFT) in 2011–12 are 1.73 at six years and 0.63 at 12 years. This compares favourably to the national average of 1.95 for six years and 0.95 for 12 years.
- Yvette Gully of the ACT Dental Health Program has won the Dental Assistant of the Year award for 2011 by the NSW Branch of the Dental Assistants Association of Australia for her contribution to the enhancement of her profession. Yvette played a role in the development and improvement of the infection control accreditation to a world class standard, the design and implementation of the Infection Control Course offered to all CIT Dental Assistant students and Allied Health students and commissioning the Dental Suite at the Hume Health Centre.

Issues and challenges

- The Canberra Hospital elective surgery baseline target for 2011–12 was 6400. Canberra Hospital was not able to achieve this target, with only 6286 of the total being completed. Two hundred and ninety-eight procedures were contracted to the private sector during 2011–12.
- Due to large number of patients requiring Lucentis injections for the treatment of macular degeneration, the Eye Clinic has had to temporarily close its books to new clients. Once a patient joins the clinic, they remain a patient for life.
- Because of the number of patients being referred by other specialists within Canberra Hospital, it has been necessary for the service to decline referrals from the community for children requiring routine strabismus care. Only strabismus referrals for children with other significant problems will be accepted. General practitioners are notified that children will need to be referred to the Children's Hospital at Randwick or Sydney.
- The neurosurgery table in the Neurosuite was fixed to the floor in the original build, which limited the utilisation of the theatre in the long term as patients requiring laminectomy could not be placed on the theatre table and leave sufficient space to operate. To ensure capacity for neurosurgery patients, the table was removed and replaced with a normal theatre table to increase utilisation of the theatre. The neurosurgery table can be returned to the Neurosuite for a specific case if it is clinically required. A new IMRIS table is currently being sourced from Canada.

Future directions

- Negotiations are underway for Urology and General Surgery lists to be undertaken at Queanbeyan Hospital in order to reduce the waiting lists at Canberra Hospital. These lists are expected to commence in August 2012.
- The procurement process is underway for a new CT scanner as the existing equipment will not be supported with parts by the vendor after reaching 10 years in service and will no longer attract full Medicare funding.
- The Commonwealth Government announced in the federal Budget an allocation of $345.9 million to the states and territories over three years to alleviate pressure on public dental waiting lists. The ACT DHP will receive $1.1 million of this allocation, additional and supplementary to current preconditions and the current service level budget. The funding is predicted to reduce dental waiting times for children, adults and the Indigenous population. All states and territories will sign a national partnership agreement before commencing any initiatives. The funding for 2012–13 will not be available until January 2013.
- The DHP is collaborating with Acute Support Services to introduce orthodontic treatment for clients with a cleft palate who are actively managed by the Canberra Hospital Cleft Palate team.
- An upgrade to the dental electronic information system and the introduction of digital radiography will occur in 2012–13 and will include the introduction of an OPG machine based at the Civic Dental Clinic.
- Negotiations are currently underway with CIT and Charles Sturt University to commence a Bachelor of Oral Health course in the ACT in July 2013.
- The DHP received funding from Health Workforce Australia to refurbish one clinic in Civic and build an additional dental clinic to increase the number of dentistry student placements. Planning for the capital works commenced in 2012 and is planned for completion at the end of 2012.
- 'Vision Impaired Hospital Kits' for use by people who are blind or have low vision will be launched at Canberra Hospital later in 2012 in conjunction with the Canberra Blind Society. The kit will include resources for use in hospital, such as signage to increase awareness of patients' needs, checklists to ensure patients are prepared and oriented to the ward environment, sighted guide techniques for staff and carers and information about low vision services in the ACT.

Division of Women, Youth and Children

The Women, Youth & Children Division (WYC) provides a broad range of primary, secondary and tertiary health care services. The provision of services is based on a family-centred, multidisciplinary approach to care in partnership with the consumer and other service providers. Services are provided at the Canberra Hospital, community health centres and in community-based settings, including clients' homes, schools and child and family centres. Some services are provided within other agency facilities.

Women, Youth and Children Division services comprise:

- maternity services—including the Continuity at the Canberra Hospital (CatCH) Program and the Canberra Midwifery Program (CMP)
- women's health, including programs for screening, gynaecology and violence against women
- neonatology, including the Neonatal Intensive Care Unit, Special Care Nursery, specialist clinics, newborn hearing screening and ACT Newborn Retrieval Service
- paediatric, including inpatient care, specialist clinics, community paediatricians and genetics
- maternal and child health, including a universal home visit following birth, support for breastfeeding and parenting, immunisation and referral
- services that support children and their families with complex care needs, such as:
  - the Community Asthma Support Service
  - the Caring for Kids Program (care in the home for children with complex needs)
  - the Child at Risk Health Unit (care for children affected by violence and abuse)
  - the IMPACT service, which coordinates care for women with complex care needs who are pregnant and/or have young children
  - child protection training for clinicians
- school-based nursing services, including immunisation, kindergarten health checks, school youth health checks and special school nurses
- nurse audiometry, providing hearing assessments to children and adults.

Achievements

Output 1.1: Acute Services—Output 1.1 f—This measure provides an indication of the availability of services; Target—100 per cent.

Achievement—The percentage of Women's Health Service Intake Officer's clients who received an intake and assessment service within 14 working days of their initial referral was 100 per cent.

ACT Breastfeeding Strategic Framework—The ACT Breastfeeding Strategic Framework 2010–2015 was launched on 10 November 2010, with the aim of increasing the number of infants being exclusively breastfed from birth to six months, and encouraging ongoing breastfeeding with complementary foods until at least 12 months of age in line with National Health and Medical Research Council recommendations. Implementation of this Framework continues, with a focus on priority groups and consistency with the national Breastfeeding Strategic Framework. Key initiatives include the development of resources for priority and mainstream groups, health professional education, a whole-of-government approach to Breastfeeding Friendly Workplace and enhanced breastfeeding data collection. A dedicated project officer has been tasked with the implementation until June 2013.

Women's Health Service—The Women's Health Service (WHS) Review recommendations regarding the target group and the model of care were endorsed by the Minister for Health in July 2010. An implementation plan was developed to outline short and longer term activities to enhance the Women's Health Service. The Nurse Practitioner Clinical Practice Guidelines have been endorsed. The Medical Officer position has been reclassified to a Staff Specialist General Practitioner, who commenced in May 2012. Clinics are now being offered by the nurse practitioner and the staff specialist. These positions work collaboratively in conjunction with the counselling and nursing team to provide comprehensive care to the priority population groups. The women's health nurses have expanded their outreach to better target vulnerable groups.

School Youth Health Nurse Program—The School Youth Health Nurse Program aims to promote positive health outcomes for young people and their families through the delivery of accessible, acceptable, appropriate and culturally respectful primary health care services in the school setting. They also provide the opportunity for young people, their parents and members of the school community to access a health professional in the school setting. This can be for matters relating to health and wellbeing and includes acting as a curriculum resource for staff. The program has been extended for 2012–13 while the external evaluation is completed during 2012–13.

Maternal and Child Health nursing partnership with Canberra College—The Maternal and Child Health (MACH) nursing partnership with Canberra College (CCCares)—where MACH services are delivered to pregnant young women and young parents who are continuing their education while bringing their child to this unique school setting—continues to grow and develop. Over 100 young parents are engaged with MACH services through this partnership, and an increased number of sessions have been provided by the MACH services. A Community Paediatrician now provides a clinic once a month.

National Perinatal Depression Project—The Australian Government Department of Health and Ageing and the ACT Government Health Directorate have a five-year agreement for the National Perinatal Depression Initiative (2008–2013). Under the agreement, the directorate is required to report against outputs for:

- routine and universal screening for perinatal depression
- follow up support and care for women assessed as being at risk of or experiencing perinatal depression
- workforce training and development for health professionals
- research and data collection, and
- community awareness relating to the importance of detection, treatment and management of perinatal depression.

The division appointed a project officer in March 2012 to continue the implementation plan. Key objectives of the initiative include:

- initiating the comprehensive education framework for workforce training and development
- reviewing the integrated care pathway for women with perinatal depression
- developing an ACT Health Directorate awareness campaign and information flyer, and
- enhancing data collection.

Centre for Newborn Care—Neonatal Intensive Care Unit (NICU) Webcam—In the 2008–09 Budget, the Government allocated $200,000 to develop and implement a video streaming service for parents of infants at the Centre for Newborn Care Neonatal Intensive Care Unit (NICU). The NICUCAM website provides general information on the services provided by the Centre for Newborn Care and can be accessed by the public. From this site parents can access the secure password protected portal to view their own babies daily between 6.00 am and 10.00 am and between 6.00 pm and 10.00 pm via a webcam installed above the baby's cot in the Centre for Newborn Care.

Parents may provide the password and login to family members in Australia and overseas which promotes bonding with the new baby. A total of eight babies can be on the webcam site at the same time and to date six has been the maximum number at any one time. To date the website has received over 100,000 hits and has been accessed from eighty countries as far afield as United Kingdom, Canada, France, Italy, Hungary and India. Further design work is being done to assure correct alignment of baby and viewer. The project was awarded in 2011 with the National Oceania–Pacific Project Management Award in the Category Organisation/Change Management and in 2012 it won the international award in the same category.

ACT Newborn Retrieval Service—The Newborn retrieval service, a satellite of Newborn Emergency Transport Service (NETS) NSW, has been operational since 2008. Each year 40 to 50 babies are retrieved from the ACT and NSW, from as far as Nowra, and taken to Canberra Hospital by the Neonatal retrieval team, consisting of a Neonatal Nurse and Medical Officer. In addition, the service also provides a timely, safe and coordinated return of babies to their local hospitals. The retrieval team (medical and nursing) is being trained in paediatric life support and provides a neonatal and infant (up to 10 months of age) medical emergency team within Canberra Hospital. Within the Centre for Newborn Care, the team provides treatment and stabilisation of children up to the age of 2 years before transfer to Sydney to a paediatric intensive care unit (PICU).

Paediatric and Adolescent Health Services—The Paediatric Department is staffed by seven paediatric staff specialists, six paediatric visiting medical officers, three paediatric surgeons, nine registrars and four resident medical officers. In addition to general paediatrics, the department runs sub-speciality services in paediatric endocrinology and respiratory medicine and outreach visits to Cooma, Batemans Bay and Pambula. The department also has visiting specialists from Sydney in paediatric cardiology, gastroenterology and neurology. There is also a paediatric research section, which runs mostly vaccine trials.

There have been very long outpatient waiting lists in paediatrics and this has been addressed by administrative improvements and the recruitment of two new paediatricians for an additional 1.4 full-time equivalent staff. The department is also continuing to address the concerns of critical care about unwell and deteriorating children with improved monitoring (PEWS scores), training and the introduction of high-flow oxygen in an attempt to reduce referrals to PICUs in Sydney. The department actively participates in teaching Australian National University Medical Students, particularly in their third year block which includes paediatrics.

Within the paediatric outpatient clinics, a Chronic Care Coordinator nursing position has been introduced. This will create a cohesive, family and child-centred approach to care for children with cystic fibrosis, oncological conditions and those receiving growth hormone.

This year the Paediatric Department has worked closely with the Cystic Fibrosis Association of the ACT to improve the service and support children and families with Cystic Fibrosis. The department has modified the clinic to be best practice in Australia for the prevention of cross-infection. Data from this department will be entered into the cystic fibrosis data registry in line with all major centres in Australia, which also enter their data into this registry.

In the acute inpatient wards, nursing initiatives within the i-PatCH Unit include the introduction of a nursing clinical lead and a dedicated nursing roster. This will increase the safety and quality of care for children admitted to i-PatCH.

The Paediatric Palliative Care Committee has been formed to ensure a collaborative, multidisciplinary and multi-agency approach to caring for children requiring palliative care. The committee meets monthly for case conferences on all children known to the Palliative Care Service as well as new referrals. This approach ensures all care needs are met.

For elective surgical patients, there has been a surgical journey redesign to create a smoother surgical admission process. All elective surgical patients are admitted through the Day Stay Unit pre-operatively and post-operatively to the inpatient ward. This allows the child to be admitted into the Day Stay play area rather than directly to their allocated bed, resulting in a less daunting and more child-friendly environment.

New Centenary Hospital for Women and Children—The new Centenary Hospital for Women and Children is making rapid progress. The construction is taking place in two stages. Stage 1 involves an extension to the existing maternity building and the service will move into the building in mid-August 2012. Stage 2 is largely the refurbishment of existing facilities and this will commence shortly after the official opening of stage 1 and will be operational next year. The design of the new Centenary Hospital for Women and Children at Canberra Hospital is the outcome of a highly involved collaboration between staff and consumers, representing paediatrics, neonatology and women and babies services.

The new facility brings together paediatrics, maternity services, the neonatal intensive care unit, gynaecology and fetal medicine, the birth centre and specialised outpatient services, all under one roof. When stage 2 opens in 2013, the three-storey hospital will provide more beds, more ambulatory care (outpatient) consultation rooms, clinical office space, education and training facilities and family accommodation. The hospital will incorporate the latest information and communication technologies, including technology to automate a broad range of clinician and support functions.

Equipment has been worked into the design where possible, so that rooms look less clinical. The features throughout the hospital have been designed to maximise privacy and support, and improve the environment for medical, nursing and midwifery care. The Birth Centre will continue to be a key feature of the new hospital, and Birth Centre birthing rooms will increase from three to five. Bathing pools for birth and pain relief in the Birth Centre and Birthing Suite create a relaxing space. The new Antenatal/ Gynaecology Ward and Postnatal Ward will include single rooms with ensuite bathrooms and space where a support person can stay comfortably overnight.

The Centenary Hospital for Women and Children has been designed to be a family-focused and friendly environment, with a 12-bed Ronald McDonald House family accommodation unit. There will also be a family resource centre for the whole building and family space on each floor. A playground and café have also been included in the design, to be completed in stage 2.

Consultation with the community about the new hospital has been carried out. An example of one of the successful consumer consultation groups is the NICU Redevelopment Parent Discussion Forum. The Department of Neonatology User Group encouraged participation from other groups in the community, such as young mothers and fathers and people living outside Canberra. A web-based discussion forum was developed to encourage these groups to participate in the planning decisions. This is a secure site and members were required to register to be provided with a log-in and password. This was a unique opportunity for the Centre for Newborn Care to involve consumers in important decisions about the new hospital.

Births—Births at Canberra Hospital increased by 5 per cent in 2011–12, recording a result of 2974 (preliminary data) compared with the 2769 births reported in 2010–11. The number of births for 2011–12 is 64 per cent higher (more than 1150 babies) than the number of births recorded at Canberra Hospital for 2001–02.

Future directions

Health services to children and young people with complex health issues in all ACT Government schools—The Health and Education and Training directorates are working together on a project to develop a whole-of-government model to address provision of health services to children and young people with complex health issues in all ACT Government schools. The project is being driven by a steering committee and a working group. A consultation process is currently underway. It is intended to recommend a preferred model for implementation in 2013–14.

Paediatric Services Strategic Plan—Paediatric services in the ACT, both in the private and public sectors have experienced a significant increase in demand, coupled with increasing disability and acuity. To ensure best practice, appropriate use of resources and contemporary models of care, the Division of Women, Youth and Children will undertake a strategic planning process for paediatric services in the ACT. The scope of the plan will incorporate the Paediatric Department at the Canberra Hospital, including i-PatCH, the Emergency Department, child development services, community based paediatric services and Canberra-based paediatricians in the private sector.

Paediatric and Adolescent Health Services—The priorities for the Paediatric Department are to shorten outpatient waiting times and improve the safety of medication administration and prescribing through electronic prescribing. The service would also like to reduce nosocomial transmission through prompt viral studies and improved isolation, expand outreach for treatment of chronic diseases through telemedicine, and promote high-quality research in paediatric endocrinology. The Paediatric Department would also like to improve the resident and registrar training program.

Expansion of Neonatal Intensive Care Services—The $2.5m funding for 2012–13 will provide for an expansion of neonatal intensive care services to meet growing demands for care and enable the new facility to fully implement the agreed model of care for women and children's acute inpatient services. The current Centre for Newborn Care was built for 2000 births per year and 450 admissions. The number of births at the Canberra Hospital increased in the last three years from 2344 to 2769 (18 per cent). Admissions to the NICU increased over the past 10 years from 450 to 700 (60 per cent), increasing the occupancy of the unit above target levels at times. It is not feasible to transfer babies to NSW if the NICU occupancy is above recommended levels, because beds are not available in NSW and this would not be family-friendly, as it separates the family from the baby. It is therefore necessary to increase the bed numbers in NICU to accommodate the increase in workload through the increased birth rate and ongoing referral of unwell babies to this tertiary centre at Canberra Hospital.

Community Advisory Committee—The Division of Women, Youth and Children is establishing a Consumer Advisory Committee to act as a sounding board to the management team on service innovations and improvements within the division.

Calvary Health Care ACT

Calvary Hospital provides public hospital services in the ACT. These services include emergency medicine, critical care, medical care, elective and emergency surgery, day surgery, aged care and rehabilitation, mental health, and inpatient and home-based palliative care services from Clare Holland House (the ACT Hospice).

Calvary Hospital is operated by Calvary Health Care ACT (CHC ACT), a subsidiary of Little Company of Mary Health Care. CHC ACT has operated Calvary Hospital since 1979.

Funding for the operation of Calvary Hospital is provided by the territory. In the reporting period, the arrangements between Calvary Health Care ACT and the Territory were renegotiated and the contemporary arrangements were set down in the Calvary Network Agreement. The agreement has redefined, simplified and brought up to date Calvary's role in the provision of networked public hospital and health services to the ACT and nearby communities. It has established clear networking objectives, it describes service and role delineation, and it has created certainty and confidence about financial arrangements and service partnerships.

The Calvary Network Agreement also formalises the Calvary Performance Plan. This annual plan describes the territory's performance targets, the performance criteria, the reporting processes and reporting schedule for Calvary Hospital. Put simply, it sets out in a simple and transparent document what Calvary Hospital has to achieve within the funding from the territory. The benefits of the agreement are already being realised and will be even greater as the territory joins other jurisdictions in complying with national health reforms.

Achievements

- Attaining record levels of service delivery in all clinical areas and outpatients' occasions of service and achieving these activity levels within the resources provided by the territory.
- Ongoing refinement of the Calvary Patient Access Improvement Program, resulting in the informed forecasting of patient flow. Formalised and closer cooperation between clinical areas is assisting the seamless transition of patients through their treatment and care.
- Enhanced networking in services across the territory, most notably in emergency and critical care.
- Achieving elective surgery targets, which have increased the number of people receiving procedures and reduced surgery waiting times. The Patient Access Improvement Program has been instrumental to increased elective surgery activity.
- Completing a consultation and planning process for the refurbishment of the Calvary Hospital Emergency Department and receiving and reviewing draft plans featuring increased and more suitable treatment spaces for patients.
- Appointing an Aboriginal and Torres Strait Islander Liaison Officer, who has direct contact with Indigenous patients and families and actively participates in Aboriginal and Torres Strait Islander networks in and around the ACT.
- Enriching the Calvary community and the Calvary patient experience through the expanded and innovative engagement and deployment of the Calvary Volunteers Group.
- Reviewing and refining the Calvary Hospital Committee Structure to properly reflect and address the contemporary activity of Calvary Hospital.
- Undertaking a peer review of Calvary Hospital's Emergency Department, focusing on the patient journey and the early and appropriate streaming of patients according to their anticipated clinical progress.
- Implementing new technology and processes to bring Calvary's ICT services in line with territory-wide processes. A significant element of this broader process was the Emergency Department Information System rollout in early 2012.
- Implementing the Chris21 payroll system, which is the foundation of improved human resource systems and enhanced personnel services for the Calvary workforce.
- The continued success of the graduate program for nursing, midwifery and allied health staff, and the enhancement of Calvary's human resources processes for staff recruitment and retention and long-term workforce planning.
- Taking a lead role in the development of the Bruce Precinct Master Plan, which will set the framework for integrated and collaborative health and hospital services on and around the Calvary Bruce campus.

- The completion of the Calvary Health Care ACT Strategic Planning Framework, comprising a 15-year strategic vision, a five-year Strategic Plan and the 2012–13 Local Services Plan.
- Actively contributing to the activities of the Local Hospital Network and the ACT Medicare Local, and moving towards the achievement of the national efficient price for services, as stipulated under the national health reform and activity-based funding.
- Creating through a formal partnership with the Australian Catholic University the Calvary Clinical School, a training and educational program that integrates paid employment at Calvary Hospital into nursing and allied health courses offered at the Australian Catholic University.
- Refining and improving the progress and transition of Emergency Department patients. Notable progress has been made through streaming of patients into Inpatient Admission, the Short Stay Unit or Hospital in the Home services.
- Expanding the Calvary Artist in Residence program through a partnership with the Belconnen Arts Centre, which provides each artist with an exhibition opportunity at the conclusion of their residency.
- Continuing the Calvary Refugee Mentoring Program and offering participants more individualised work placements that better take account of their past experience and their future aspirations and goals.
- Conducting the second annual Calvary Hospital Community Open Day in March 2012.
- During National Palliative Care Week 2012, opening Clare Holland House to visitors on 24 May 2012 and inviting them to find out what happens in a hospice and talk with representatives of the multidisciplinary palliative care service.
- Expanding community engagement through the Calvary Community Advisory Board and undertaking a survey of Calvary Hospital community attitudes and perceptions. This survey data will inform Calvary's ongoing community engagement activities.

Issues and challenges

Prior to the reporting period, the territory confirmed that Calvary Health Care ACT would continue to be the long-term providers of acute care services at the Bruce campus. This announcement set in train the process of developing the previously mentioned Calvary Network Agreement. The announcement also enabled Calvary Health Care ACT to instigate long-term planning of public hospital and health services and to promote future opportunity for clinical and support staff. Complementary announcements of the intended expansion of Calvary's capacity and services, along with confirmation of plans for a new sub-acute public hospital in the area, have enabled Calvary to recognise its long-term role in the ACT health system.

With the certainty of tenure as the operator of public hospital services and the foreshadowed expansion of public hospital capacity at Bruce, involving the repatriation within five years of beds currently in the co-located Calvary Private Hospital, Little Company of Mary Health Care announced that a new stand-alone private hospital facility would be built on the Bruce campus. These decisions and announcement allayed the ongoing concerns of many staff about the future.

The material significance of this is inestimable, but it was undoubtedly a valuable contribution to Calvary being able to provide treatment and care to record patient numbers and unprecedented levels of activity. Increased activity in isolation is a challenge, but the greater challenge is to meet that activity without reducing the quality of the patient experience. The 2011 Patient Satisfaction Survey of Calvary Hospital revealed that, for patients and their families, compassion is the most important aspect of their care. Calvary continues to use a variety of behaviours known as 'Simply Better' to ensure that staff practise generosity of time and clarity of explanations in patient care.

Future directions

Calvary Health Care ACT has mapped its future direction in the previously mentioned strategic planning framework. Significant components of the future plans include:

- continued development of the Bruce Precinct Master Plan
- further refinement of the Calvary Network Agreement in conjunction with the evolution of the Territory Clinical Services Plan
- commencement of the expansion of car parking capacity and further planning for a multi-storey car park on the Bruce campus
- enhanced community engagement activities using the Calvary Hospital Community Attitudes and Perceptions Survey results to identify issues that warrant particular attention
- in partnership with the territory, continued scrutiny of existing models of care and rigorous assessment, trialling and evaluation of alternative models of care and improved practices
- further progress towards achieving national benchmarks for the costs of delivering services
- refining the Patient Access Improvement Program principles and processes and growing inter-disciplinary collaboration and cooperation
- improving admission and information processes for both scheduled and emergency patients to clearly establish the rights of patients and their obligations while at Calvary Hospital
- continuing to develop and implement innovative and effective strategies around the five areas of preventable harm
- introducing 'real-time' bedside patient satisfaction surveys
- installing a new patient entertainment services system.

Output 1.2 Mental Health, Justice Health and Alcohol and Drug Services

Output description

Mental Health, Justice Health and Alcohol and Drug Services provide a range of services in hospitals, community health centres, adult and youth correctional facilities and people's homes across the Territory. They work with community partners to provide integrated and responsive care to a range of services, including hospital-based specialist services, supported accommodation services and community-based service responses.

The key strategic priorities for Mental Health, Justice Health and Alcohol and Drug Services are ensuring that clients' needs are met in a timely fashion and that care is integrated across hospital, community, and residential support services. This means focusing on:

- ensuring timely access to emergency mental health care by reducing waiting times for urgent admissions to acute psychiatric units
- ensuring that public mental health services in the ACT provide consumers with appropriate assessment, treatment and care that result in improved mental health outcomes
- providing hospital and community-based alcohol and drug services and health care assessments for people detained in corrective facilities.

Mental Health, Justice Health and Alcohol and Drug Services provide health services directly and through partnerships with community organisations. The services provided range from prevention and treatment to recovery, maintenance and harm minimisation. Consumer and carer participation is encouraged in all aspects of service planning and delivery. The division works in partnership with consumers, carers and a range of government and non-government service providers to ensure the best possible outcomes for clients.

The division delivers services at a number of locations, including hospital inpatient and outpatient settings, community health centres, detention centres and other community settings such as people's homes. These services include:

Mental Health Services—

- Adult Community and Older Persons Mental Health Services
- Child and Adolescent Mental Health Services
- Mental Health Rehabilitation and Speciality Services
- Access and Acute Mental Health Services
- Academic Unit of Psychological Medicine

Justice Health Services—

- Alexander Maconochie Centre
- Bimberi Youth Justice Centre
- Symonston Periodic Detention Centre
- ACT court cells

Alcohol and Drug Services—

- opioid maintenance treatment services
- withdrawal services
- counselling and treatment services
- diversion services.

Achievements

- Mental Health Services continue to monitor and review all episodes of seclusion and restraint. In April 2012 a consumer-led research project into seclusion reduction was completed. This work is being prepared for publication in late 2012. A further development in 2011 was the introduction of the Early Support and Intervention Team in Psychiatric Services. This initiative was introduced in partnership with Ward Services to reduce aggression and consumer distress. A training package has been developed collaboratively with Ward Services that focuses on engagement and de-escalation.
- The Mental Health Community Policing Initiative was developed after a review of ACT Policing mental health practices and procedures in 2010. A pilot was commenced in April 2011. This project was funded in 2011–12 and is ongoing. The three main components of the initiative are as follows:
  - Two clinicians are embedded in the Police Operations Centre from Thursday to Sunday. These clinicians are a dedicated resource for the police. They have access to Mental Heath's electronic clinical record, MHAGIC, and can provide information relevant to individuals.
  - A four-day training program is delivered monthly to ACT police. Lecturers are drawn from Mental Health Services, ACT Policing, the community sector and experts from interstate. Approximately 280 police officers have undergone this training to date.

  - A third mental health worker has been seconded to work with ACT police on a full-time basis. This clinician works closely with both agencies to address increasing pressure on the system and to promote greater mental health awareness and acceptance in the ACT community.
- The Adult Mental Health Unit was commissioned in April 2012. This is a purpose-built facility with an innovative model of care that has engagement at its centre. The facility has a purpose-built High Dependency Unit, Low Dependency Unit and therapy wing, which includes group therapy rooms, a gym and spiritual space.
- The Perinatal Mental Health Consultation Service provides specialist consultation and treatment planning for pregnant and postnatal women (up to 12 months postpartum). Since its inception, service demand has increased considerably and the program has approximately 80 registered clients. This year has seen the implementation of a group program for women with high levels of emotional 'stress/distress' in the antenatal period. A pilot group co-facilitated with Child and Family Centre staff (Gungahlin) has been completed and is being evaluated.
- The provision of an outreach mental health assessment service to the antenatal clinic at the Canberra Hospital has been implemented.
- The Child and Adolescent Mental Health Service (CAMHS) is being redesigned to incorporate young adults, those aged 18 to 25 years, into its client base. The CAMHS Redesign Project has consulted with service providers, consumers and carers to inform recommendations for the future development of the service. The project is due for completion in 2012.
- At the Hume Health Centre, Justice Health Services have introduced:
  - Suboxone Withdrawal Regime—This is the first time that buprenorphine has routinely been used to manage withdrawal in an ACT correctional facility.
  - Hepatitis C treatments—These are achieved through a shared care model with a referral pathway with the gastroenterology service of the Canberra Hospital. Up to 10 patients are cared for through a complex treatment regime.
  - an alcohol and drug specialist attending fortnightly, with a focus on pre-released clients who present with a history of high risk and dangerous alcohol use.
- Alcohol and Drug Services have introduced the following:
  - The Opiate Treatment Service has established opportunistic health clinics which provide women's health checks, baby clinics, sexual health clinics and antenatal clinics. The Opioid Treatment Service has also commenced liaison with services such as Housing ACT, Street Law and Centrelink to improve access to these services for clients of Alcohol and Drug Services.
  - Alcohol and Drug Services continue to deliver pharmacists, GPs and nursing staff training to support tier 2 and 3 Opiate Treatment Service clients. This training upholds the mandatory requirement in the ACT Opioid Maintenance Treatment Guidelines.
  - The ACT Early Intervention Pilot Program has proved to be a successful collaborative venture between the Health Directorate and ACT Policing, addressing the issue of underage drinking and providing opportunity to divert young people from the justice system to the health system.
  - The Alcohol and Drug Services Counselling and Treatment Service team was the recipient of an Australia Day Award for the successful expansion of its scope of counselling and psychological therapy services for adults to include young people with complex alcohol and other drug issues. One extra staff member was recruited to work with young people. The Youth Alcohol and Drug Program (YDAP) counsellor, John Couto, won the 2011 Allied Health Award for Clinical Excellence. In March 2012, a protocol was signed to embed parameters for the working relationship between Community Youth Justice, Bimberi Youth Justice and alcohol and other drug services working with young people.

- The employment of a registered nurse in the Mental Health Service for People with Intellectual Disability (formerly the Dual Disability Service) has had several positive effects. Mental illness is more prevalent in people with an intellectual disability than in the general population. This enhancement has promoted earlier identification and access to treatment to a marginalised consumer group, whose mental health symptoms can easily be misinterpreted. It has also allowed the service to provide specialist nursing input in the treatment, care and better monitoring of health issues for this consumer group.
- Consumer and carer participation has remained a priority, with a number of consumers and carer consultants employed within the division. These roles support a cultural shift in Mental Health Services, particularly in recovery and consumer empowerment. Roles include systems advocacy for consumers, involvement in the review of the *Mental Health (Treatment and Care) Act 1994,* implementation of the recovery model, development and implementation of advance agreements, and staff training. The division also maintains full representation of consumers and carers on all relevant governance committees.
- The mental health services have been working to implement recovery principles and practices for a number of years; this work is supported through the actions of the ACT Mental Health Services Plan 2009–2014 and the National Standards for Mental Health Services 2010. The ACT has also been involved in consultations on the National Mental Health Recovery Framework, to be released during the next 12 months, and this framework will help to further consolidate a recovery orientation of services. Training and education is offered to all staff and other stakeholders to develop an understanding of recovery and how services can assist through the implementation of practices and processes that promote a person-centred, strengths-focused and collaborative approach to the planning and delivery of services provided by the division.

Issues and challenges

- Mental health services nationally and internationally continue to face shortages of clinical staff. The mental health service is accredited by the Royal Australian College of Psychiatrists for registrar training. Nursing recruitment is supplemented through the Mental Health Nursing Postgraduate Diploma in Mental Health Nursing scholarship program in partnership with the University of Canberra. This partnership has also strengthened links to the undergraduate nursing program by identifying undergraduate nurses' interest in the mental health field. Mental Health Services also provide intern psychologist positions to promote attraction and retention of psychologists.
- Mental Health Services have continued to improve the electronic clinical record, MHAGIC. In the past year Mental Health Services have worked closely with the vendor to upgrade the product to the latest version in September 2010. This version of MHAGIC has considerable improvements built in and operates on a different and better platform.
- In May 2010 the Auditor-General advised that, under the *Auditor-General Act 1996*, a performance audit on the ACT Mental Health Services was to be conducted. The audit made 16 key recommendations related to Older Persons Mental Health Services (OPMHS). All the recommendations from the Auditor-General's report have been accepted and actioned by Mental Health, Justice Health and Alcohol and Drug Services. Some of the improvements made as a result of the audit were:
  - provision of refresher training on the mental health electronic record
  - establishment of an additional registered nurse position to increase the capacity of the OPMHS Community Team
  - development of OPMHS-specific Suicide Assessment (Introduction and Advanced)
  - initiation of a shared approach to training between the residential aged care facilities (RACFs), agencies such as Alzheimer's ACT and the OPMHS.

- The review of the *Mental Health (Treatment and Care) Act 1994* continues. The review aims to ensure that the Act remains consistent with contemporary mental health policy and service delivery. Working groups are in progress addressing several areas of detailed content of the Act. Following drafting of the revised legislation, a double exposure draft process is planned. The Bill is scheduled to be considered by the ACT Legislative Assembly in mid-2013.
- Alcohol and Drug Services are facing challenges in finding staff to fill clinical vacancies in counselling services. Strategies include the implementation of health professional officers' career pathways to ensure ongoing development, mentoring and sustainability of the health professional officers in this sector.

Future directions

- A budget enhancement in 2012–13 will enable the Mental Health Community Policing Initiative to expand services.
- Further funding in 2012–13 will allow for the recruitment of additional allied health staff to the AMHU and the full implementation of the model of care, including the development of the therapy program.
- A budget initiative for 2012–13 allows the funding of an additional mental health clinician in each of the four Adult Community Mental Health teams. The primary function of these clinicians will be to support the transition and coordinate care for people exiting from either of the two public ACT psychiatric inpatient units (Adult Mental Health Unit, Calvary Psychiatry Ward 2N) into the community setting.
- An alcohol and drug counsellor position will be established at the Alexander Maconochie Centre.
- A review of existing Adult Community Mental Health Team catchment area boundaries is being undertaken. It is envisaged that changing the boundaries will result in benefits of improved access to mental health services, including reduced waiting times for appointments, reallocation of clinical staff, and reduced response time to referrals.
- Mental Health and Alcohol and Drug Services will be provided in the new Gungahlin Community Health Centre for the local catchment population. They will serve to increase the accessibility and availability of mental health services for the Gungahlin community.
- A further expansion of the Aboriginal Liaison Service will be realised as a result of the recruitment of a senior mental health nurse to work with Winnunga Nimmityjah Aboriginal Medical Services. They will provide direct mental health interventions and clinical management for consumers of that community with mental health issues seeking treatment and care.
- A streamlined induction process will be established at the Bimberi Youth Detention Centre. The new process will reduce duplication and engage specialist services when they are assessed as clinically required.
- Medication management at Bimberi Youth Justice Centre will be strengthened with the recruitment of endorsed enrolled nurses who support a through-care model.
- Chronic disease management will be enhanced for Justice Health with additional staffing levels in 2012–13.
- Forensic Services will provide training on mental health awareness and processes to the magistrates of the ACT law courts. It is hoped this initiative will be expanded to other agencies, such as the office of the Director of Public Prosecutions and Legal Aid services.
- A further neuropsychology position will provide expert input into the range of services provided and allow for a quicker response to applications for assessment.
- MHJHADS has initiated a number of working groups to implement a smoke-free environment in response to concerns about passive smoking raised by consumers, carers and staff.

Output 1.3 Public health services

Output description

Public Health Services provides high quality health and community services to the ACT and surrounding region. The key strategic priorities for Public Health Services include monitoring the health of the ACT Population; promoting health; preventing disease; improving health equity; protecting the health of the public; and supporting workforce excellence (Population Health Division).

Public health services in the ACT are largely provided through the Population Health Division. The division is headed by the Chief Health Officer, who is appointed under the *Public Health Act 1997* and reports to the Director-General of the Health Directorate. The Chief Health Officer is also required to report biennially on the health of the ACT population on specific health-related topics, which is done through the Chief Health Officer's Report.

The Population Health Division has primary responsibility for the management of population health issues in the Health Directorate. The division undertakes the core functions of prevention, assessment, policy development and assurance, and contributes to local and national policy, program delivery and protocols on population health issues. On 1 July 2012, the Population Health Division implemented a new structure; however, in 2011–12 the division had four branches:

- The Policy Support Office was responsible for the development and implementation of policy on a range of public health issues, including sexual and reproductive health, blood and blood products, organ and tissue donation, healthcare facility licensing, gene technology and climate change.
- The Health Promotion Branch was responsible for policy and program delivery in the areas of health promotion and prevention. Health promotion activities aimed to strengthen the skills and capabilities of individuals and influence the social, environmental and economic conditions that impact on public and individual health.
- The Epidemiology Branch collected, analysed and disseminated information on the health status and health-related behaviours of the ACT population. This information was used to monitor, evaluate and guide health planning and policy. It provided advice and assistance for research and evaluation activities across the Health Directorate and broader research community. The ACT Cervical Cytology Register, a sub-unit of the Epidemiology Branch, is a confidential, computerised database of ACT women's Pap test results. Through the National Cervical Screening Program, the register seeks to reduce morbidity and mortality from cervical cancer by encouraging women to have regular Pap smears.
- The Health Protection Service managed risks and implemented strategies to prevent, and make a timely response to, public health events. This was achieved through a range of regulatory and policy activities in food safety, communicable disease control, environmental health, emergency management, pharmaceutical products, tobacco control and analytical services.

Achievements

- In 2011–12, the Population Health Division fulfilled its statutory and national reporting requirements, including the collection of data for and maintenance of the ACT Cancer Registry and the Maternal and Perinatal Data Collection. The division met its national reporting requirements on public health expenditure, cancer incidence and mortality, and maternal and perinatal statistics.
- The Population Health Division's survey program supports the monitoring of population health trends across the Australian Capital Territory. Results are published in a number of reports and health series publications, which are used to inform health policy and program development. In 2011–12, the program included the following surveys:

  - The ACT Year 6 Physical Activity and Nutrition Survey (ACTPANS) has been conducted every three years since 2006. Data collection for the 2012 survey is due for completion in July 2012. The survey monitors and identifies trends in weight status, participation in physical activity, eating patterns and environments, and general health and wellbeing in Year 6 children.
  - The ACT Secondary Student Alcohol and Drug Survey (ASSAD) investigates trends in risk behaviours among young people attending secondary schools. Information is collected on the prevalence of alcohol, tobacco and drug use and other lifestyle factors such as physical activity, nutrition and obesity. The survey has been conducted nationally every three years since 1984 and was most recently conducted in 2011. Results are expected to be available in late 2012.
  - The ACT General Health Survey (ACTGHS) is conducted through the New South Wales Ministry of Health on the Health Directorate's behalf. A 20-minute questionnaire is administered to participants over the telephone. Information is collected throughout the year on chronic disease, health risk behaviours, health service use, child health and other health matters for approximately 1250 people living in ACT households. The survey is designed to flexibly incorporate new and emerging priorities and population groups. The 2012 survey is in progress.
- The Health Directorate published a number of health series publications describing trends in a range of health indicators. These include: Mental Health and Wellbeing in the ACT; 2010 ACT Inmate Health Survey: Summary Results; Cancer in the ACT, Incidence and Mortality 2011; Review of Colorectal Cancer in the ACT; Health Snapshots: Statistical Subdivisions ACT 2007–09; and the Report on the 2009 ACT Year 6 Physical Activity and Nutrition Survey.
- The analytical toxicology service was enhanced to support new road and traffic legislation. The service provides oral fluid and blood drug confirmations from samples obtained at the roadside and from motor vehicle accidents for drugs including methylamphetamine, MDMA (ecstasy) and THC (from cannabis).
- The Health Protection Service responded to a large outbreak of measles in the ACT in late 2011. Over a six-week period, 19 cases of measles were notified, with most cases linked to an unvaccinated student who had acquired the infection overseas. Three cases in New South Wales residents were also linked to this outbreak. More than 500 people were contacted through the contact tracing process for the 19 cases, and those not immune to measles were offered post-exposure treatment to prevent them from developing the infection. As the index case and many of the secondary cases were from a local school with low immunisation rates, a two-week exclusion of non-vaccinated children from school was implemented to help prevent the spread of the disease. As a result of these measures, the outbreak was controlled and no further cases were reported after 31 December 2011.
- A case of Hepatitis A in a school canteen food handler was investigated. Following a risk assessment, a public health response was commenced to prevent those who may have been exposed from developing the disease. The Health Directorate offered free post-exposure hepatitis A vaccinations to students, teachers, canteen workers and school visitors. In November 2011, a temporary clinic was conducted at the school over two days, in which 598 students, teachers and staff were vaccinated. No secondary cases of hepatitis A were reported.
- On 31 December 2011, the Population Health Division completed the Targeted Adult Pertussis Vaccination Program, in which a combination vaccine that includes protection against pertussis was provided to new parents and grandparents as part of a temporary disease control strategy for infants. The focus of pertussis disease control is now on strengthening other forms of disease prevention such as early identification, encouraging people to stay at home if they have the disease, and timely immunisation of infants.
- In June 2011, the Health Directorate first published a newsletter informing individuals and groups of current issues in immunisation. The bimonthly publication is distributed to community groups and immunisation providers, such as general practitioners, practice nurses, hospital staff, pharmacies and specialist doctors. The newsletter is mailed to over 500 recipients and hand-delivered to all general practices.

- Following the tragic deaths of two people who ingested death cap mushrooms in January 2012, the Health Directorate ran a general public awareness campaign to highlight the dangers of picking and eating wild mushrooms. The campaign included the development of new posters and flyers in consultation with stakeholders and targeted distribution to tourists, new students and the multicultural community.
- In February 2012, the Legislative Assembly passed the Food Amendment Bill 2011, which allows for greater regulatory transparency for the public in food business compliance with food safety standards. The amendments include provision for a register of food businesses that have offences proved in court, closure notices to be displayed at food businesses that have been served a prohibition order, and the display of registration certificates.
- On 1 January 2013, the *Food (Nutritional Information) Amendment Act 2011* will commence, requiring certain food businesses to display the kilojoule (kJ) content of their standard items on menus and price tags. The Population Health Division has been implementing the point-of-sale nutritional information display requirements, and a web page entitled 'kJ Displays' has been placed on the Health Directorate website with information on such displays. The Population Health Division has published communication material to alert food businesses of the upcoming requirements and provide guidance on implementation. A national point-of-sale working group has been developing industry assistance material, consumer education material and a communication strategy that will be consistent across jurisdictions. This information will be added to the web page once it is finalised.
- The translation of several posters into 10 languages has improved food safety information. The posters will be available on the Health website and will be distributed during inspections. A food safety guide for businesses has also been finalised and provides comprehensive information about the most common food safety requirements. It will be published in English and the most appropriate alternative languages.
- On 1 November 2011, the Legislative Assembly passed the *Smoking in Cars with Children (Prohibition) Act 2011*. The Act, which came into effect on 1 May 2012 after a six-month awareness and education campaign, prohibits smoking in cars where children under 16 are in attendance.
- The 2010–11 Health Directorate Annual Report noted that the directorate had been working closely with the ACT Pacific Island community and Office of Aboriginal and Multicultural Affairs on legal restrictions for kava in the ACT. Kava is classified as a prescription-only medicine under Commonwealth law, which is automatically adopted under ACT medicines legislation. The Health Directorate lodged a submission to the Therapeutic Goods Administration in 2011 seeking a change to the legal classification of kava such that it could be used for traditional purposes. Following thorough consideration of the submission, in February 2012 the Therapeutic Goods Administration announced its final decision not to change the kava classification. The Therapeutic Goods Administration announcement shortly preceded the 2012 National Multicultural Festival, and many from the Pacific Island community expressed concern that kava restrictions would be maintained for the 2012 festival. On 8 February 2012, the Office of Aboriginal and Multicultural Affairs and the Chief Health Officer held a public meeting attended by many from the Pacific Island community. Their views were forwarded from the Chief Health Officer to the Minister the following day. Based on the Chief Health Officer's advice, the Minister agreed to grant a temporary trial exemption for cultural kava use at the 2012 festival by way of an amendment to the Medicines, Poisons and Therapeutic Goods Regulation 2008.
- From December 2011 to February 2012, the Health Directorate led a consultation process on options for ongoing community pharmacy regulation in the ACT. The existing restriction on who may own a community pharmacy under the *Health Act 1993* expired on 1 July 2012; therefore, a permanent solution was sought in order to maintain this restriction beyond its expiry while ensuring that the associated regulatory scheme is sustainable. Stakeholder views were forwarded to the Minister. The Minister agreed to proceed with the Health Directorate's preferred option of introducing a new licensing scheme for community pharmacy owners under the *Public Health Act 1997* and effectively maintaining the restriction on who may own a pharmacy by inserting this into the Public Health Regulation 2000. The amendment regulation was approved and effective from 2 July 2012. The new licensing scheme will be implemented in the latter half of 2012.

- The Health Protection Service led the development and conduct of a large-scale multi-agency EmergoTrain System—Exercise Ayotu—in March 2012. The EmergoTrain System is a pedagogic educational simulation system used for training and testing health sector preparedness and management of major incidents and disasters. Magnetic symbols are used to represent patients, staff, resources and structures. The use of a large patient bank with associated validated clinical protocols provides the basis for the realism and measurable outcomes of the EmergoTrain System. The exercises run in real time and according to staffing and occupancy profiles at the time of the exercise, but do not impact on core business in clinical units in hospitals or the ambulance service. Exercise Ayotu involved the ACT Ambulance Service, Calvary Hospital, Canberra Hospital and Health Services, and the National Capital Private Hospital. The exercise simulated the health sector response to mass casualty incidents generating more than 570 casualties. A number of valuable lessons were identified after the exercise and a formal exercise report was drafted to provide recommendations to consolidate and strengthen future major incident preparedness and response across the Health Directorate and with partners in the private sector.
- The Health Protection Service undertook a major revision of the Health Emergency Plan on behalf of the Health Emergency Subcommittee. The Health Emergency Plan is a supporting plan of the ACT Emergency Plan that outlines the strategic governance arrangements for the ACT health sector in an emergency. The revised Health Emergency Plan was endorsed in January 2012 by the Security and Emergency Management Senior Officials Group and the Emergency Services Commissioner. The revised Health Emergency Plan will strengthen major incident preparedness across the Health Directorate, enhance future response and coordination, and integrate the health sector's activities into the broader ACT emergency management framework.
- From 16 to 18 September 2011, the Health Directorate provided operational support to the emergency response to the chemical fire in Mitchell. The Chief Health Officer provided advice to the government and incident controller about the health risks posed by the fire, including toxins which might be produced. The Health Directorate worked closely with the ACT Environmental Protection Agency to advise the public during the fire, to advise people returning to the Mitchell area after it was extinguished, and subsequently to interpret the results of environmental testing.
- In 2011–12, the Health Directorate provided $2,497,779 in funding to support key non-government partners to deliver sexual health and blood-borne virus services to the community. The following partners hold three-year service funding agreements with the Health Directorate: the AIDS Action Council of the ACT, the ACT Hepatitis Resource Centre, Sexual Health and Family Planning ACT, Medicare Local's HIV Program and the Haemophilia Foundation.
- The Population Health Division maintained significant activity to address the increasing number of ACT chlamydia notifications. Under a 2009 ACT Government budget initiative, the Population Health Division has continued to fund the Stamp Out Chlamydia 2 project and a range of other outreach-based activities which promote and provide a range of readily accessible sexual health screening 'events' to identified high-risk populations. These activities are delivered through a partnership with the Population Health Division, the Canberra Sexual Health Centre, Sexual Health and Family Planning ACT, the ANU Academic Unit of Internal Medicine and community organisations. A final evaluation of the Stamp Out Chlamydia 2 project has been commissioned so that other regions may replicate its positive outcomes and achievements.
- In line with priorities under the National Sexually Transmissible Infections Strategy 2010, the Population Health Division formed a useful collaborative partnership with the Education and Training Directorate to better integrate the delivery of sexual health and sexuality education for young people. It is hoped this partnership will have a positive effect on reducing the burden of sexually transmissible infections in this group. In 2011, more than 120 teachers attended a Health and Physical Education Teachers' Association dinner which promoted the optimisation of the health and education sectors' efforts to provide sexual health and sexuality education to young people.

- On 31 August 2011, the Chief Minister launched the ACT rollout of BloodNet, Australia's first national online system for ordering blood. BloodNet has been developed for use in public and private hospitals and is being progressively rolled out across the country by the National Blood Authority. BloodNet provides ACT hospitals with a standardised electronic platform that enhances the visibility and transparency of online blood ordering and receipting systems.
- The Population Health Division Research Strategy is almost complete. The strategy will provide a framework for the Population Health Division to maximise the use of current knowledge to improve the health and wellbeing of the ACT population and reduce health inequities. It will assist in prioritising research areas and outline how knowledge transfer will occur and how research capacity will be enhanced. It aims to develop a research culture within current budget.

Issues and analysis

- A major part of the ACT's annual blood budget now relates to expenditure required for the therapeutic support of high-cost patients receiving coagulation factor replacement therapies. Support of these patients continues to be extremely costly. Blood and blood products are provided free of charge to all patients.
- In past years, there have been a number of incidents where algal indicator organisms have been extremely high in ACT recreational water bodies. In relation to Lake Burley Griffin, water quality is subject to environmental variations in the lake and its catchments. In favourable conditions, elevated blue-green algae levels may persist in the lake, and recreational activities such as swimming, rowing, canoeing and sailing may be restricted, as high levels of toxic blue–green algae in a water body may pose an increased health risk for users. There have been reported cases of adverse health consequences for swimmers exposed to blue–green algal blooms. The ACT Guidelines for Recreational Water Quality address the risk from blue–green algae and microbial pathogens. They specify a blue–green algae action plan, which provides alert levels and typical actions by ACT waterway managers: the National Capital Authority for Lake Burley Griffin and the Environmental Protection Authority for other waterways. The action plan also contains key points for media messages used by both authorities when advising the public of possible risks associated with using ACT waterways for recreational purposes.
- In 2011–12, the Population Health Division provided public health advice on recreational water usage to the National Capital Authority with respect to Lake Burley Griffin and to the Environmental Protection Authority of the Territory and Municipal Services Directorate with respect to other ACT waterways. This occurred in response to risks associated with the levels of blue–green algae found. The Population Health Division also participated in an investigation into the state of the water courses and catchments for Lake Burley Griffin conducted by the Commissioner for Sustainability and the Environment. The Population Health Division provided input into the process with a representative on the advisory group.
- In 2011, the ACT Auditor-General's office undertook a performance audit of the Health Directorate's administration of food safety regulation. The audit report, Management of Food Safety in the Australian Capital Territory, was tabled in the Legislative Assembly on 21 December 2011. It provided 10 recommendations, which the Health Directorate agreed to. The Population Health Division had already identified many of the issues raised and much of the required work had already commenced or been completed by the time the report was released.
- The Population Health Division continues to see an increase in non-compliance with the *Food Act 2001* and the Food Standards Code, resulting in the issuing of improvement notices and prohibition orders. It is probable that factors such as a lack of familiarity with food safety and terminology are contributing to this non-compliance. Initiatives to address this are listed above under 'Achievements'.

- Two initiatives from the Commonwealth 5th Community Pharmacy Agreement will require changes to local regulation in order to be adopted locally. The Minister will consider the possibility of adopting these initiatives under ACT medicines law in the latter half of 2012. They include continued dispensing, which will allow the supply of a Pharmaceuticals Benefits Scheme quantity of a medicine by a pharmacist under defined circumstances where the patient has run out of their prescription, and residential aged care facilities medication charts, which will allow a pharmacist to claim the supply of a medicine under the Pharmaceuticals Benefits Scheme from a facilities medication chart, as opposed to a separate Pharmaceuticals Benefits Scheme prescription.

Future directions

- The biennial ACT Chief Health Officer's Report is due for publication in August 2012. This report, which profiles the Territory's health and wellbeing and is aligned with local and national health priorities, fulfils the Population Health Division's obligations under section 10 of the *Public Health Act 1997*.
- The Population Health Division has recently experienced a significant increase in workflow and demand for its services. This increase in demand is expected to continue for the foreseeable future. To address this, the division will implement a new structure on 1 July 2012.
- In 2012–13, the Population Health Division will expand the ambient air monitoring network by establishing an Ambient Air Quality National Environment Protection Measure Performance Monitoring Station in the Belconnen region. This station will assist with assessing and developing policies on ambient air quality.
- In 2011–12, a regulatory impact statement was undertaken for Scores on Doors, a system whereby food establishments' inspection results are displayed at their entrance. The KPMG regulatory impact statement found that, for any option to be cost-effective for the community, it need only generate a small reduction in the overall incidence of food-borne illnesses estimated to be caused by registered food businesses and that, given the reported increased compliance rates and reductions in food-borne illnesses in jurisdictions with Scores on Doors schemes, such a scheme could be cost-effective in the ACT. The Health Directorate will provide advice to the Minister for Health on the regulatory impact statement and its findings.
- A requirement that each food business have a food safety supervisor will commence in August 2013 to address emerging gaps in food safety knowledge in ACT food businesses.
- A central component of the Health Emergency Sub-Committee 2012 work plan is the development of four operational appendices to the Health Emergency Plan by priority, including a Health facility mass evacuation plan, a severe burn injury plan, a chemical, biological and radiological incident plan, and a mass fatality management plan.
- A major revision of the Public Health Emergency Response Plan 2007 has commenced. Endorsement of the revised plan as a tier 2 Hazard Plan to the ACT Emergency Plan is expected by mid-2013.
- In 2011–12 the Population Health Division continued to strengthen its quality systems in population health data collection and reporting. This included working towards the development of systems for the electronic transmission of maternal and perinatal data, with one notifier developing the capacity to transmit data electronically during the reporting period. The Population Health Division has also continued to build local capacity in data linkage between key population health data collections.

Output 1.4 Cancer Services

Output description

Capital Region Cancer Services provides a comprehensive range of screening, assessment, diagnostic, treatment, and palliative care services. Services are provided in inpatient, outpatient, and community settings.

The key strategic priorities for cancer care services are early detection and timely access to diagnostic and treatment services. These include: ensuring that population screening rates for breast and cervical cancer meet targets; ensuring waiting times for access to essential services such as radiotherapy are consistent with agreed benchmarks; and increasing the proportion of females screened through the BreastScreen Australia program for the target population (aged 50 to 69 years) to 70 per cent over time.

The Capital Region Cancer Service (CRCS) division is responsible for the provision of oncology, clinical haematology, radiation oncology, BreastScreen and immunology services to the ACT and surrounding region. Services are offered as screening, inpatient and outpatient services, and community-based psycho-social support services. The division also manages and coordinates clinical outpatient administrative support, health centre administration, community health intake and transcription services.

The clinical services of CRCS integrate existing cancer services across the ACT and surrounding region to ensure a continuum of care for consumers, ranging from prevention and screening through to diagnosis, treatment, rehabilitation and palliative care. Services are provided on an area-wide basis and delivered at a number of locations, including hospital and community settings and the patient's home.

Achievements

- On 1 July 2011, BreastScreen ACT became a single entity, no longer providing breast screening and assessment services on behalf of NSW Health. This has resulted in an increased capacity to screen and assess women residents in the ACT and a significant reduction in the wait time for a screening appointment.
- The total number of ACT women screened by BreastScreen ACT has increased from 11,666 in 2010–11 to 15,019 in 2011–12. The average wait time for an appointment has been reduced from 55 days to seven days. This strategy, along with an active promotional campaign, has led to an increase in participation of women in the target age group (50 to 69 years).
- The CRCS Department of Immunology enhanced its service with the establishment of a multidisciplinary Vasculitis Clinic in April 2012.
- Immunologist Dr Cook was part of a team that was awarded a National Health and Medical Research Council (NHMRC) program grant of $15.4 million. The grant will fund research into autoimmune deficiencies and will commence in 2012.
- In 2011–12, CRCS had representation on the following national committees:
  - panel of examiners, Royal College of Pathologists of Australasia
  - NHMRC grant review panel
  - Chairman, Joint Specialist Advisory Committee, Immunology, RACP
  - College Education Committee, RACP.

- Phase 1 of the CHARM Cancer Information Management System was implemented on 23 April 2012. CHARM provides a single system for the scheduling, billing and ordering of complex chemotherapy regimens for medical oncology, haematology and immunology. This will be followed by the transition to electronic clinical information capture and clinical records management. Phase 2 of the implementation will examine ways in which CHARM can be extended to radiation oncology. This will support electronic multidisciplinary communication, recording and appropriate sharing of patient data and treatment information across CRCS and the Canberra Hospital. Patients will benefit from electronic prescribing and streamlined administrative and scheduling services within the Division of CRCS.
- A new full-time medical oncology staff specialist was appointed in February 2012, increasing the department's expertise and capacity in melanoma, colorectal cancer and lung cancer.
- Procurement and installation of major radiation therapy equipment to support expansion to a four Linear Accelerator (Linac) service was undertaken in 2011–12. This includes a second CT Simulator, a new Linac in the fourth bunker and replacement of the ageing Linac #1. Implementation of advanced functionality has been incorporated as part of this process, including contrast for CT simulation, 4D CT Simulation, image-guided radiation therapy (IGRT) and intensity-modulated radiation therapy (IMRT).
- Extended hours for radiation therapy treatment service have been implemented since November 2011 to accommodate increased demand in the lead-up to the four Linac service. This has provided a 5.7 per cent increase in capacity for patients requiring treatment services.
- CRCS provided care for 1525 new radiation oncology patients in 2011–12. This is a 1.2 per cent increase on the 1507 new patients referred to the service in the same period last year.
- CRCS also provided 1286 courses of radiation therapy treatment to ACT and regional cancer patients in 2011–12. This is a 4.6 per cent increase on the 1229 treatment courses provided in 2010–11.

Percentage of radiotherapy patients who commence treatment within ACT Health reporting guidelines

	Year to June				
	2007–08	**2008–09**	**2009–10**	**2010–11**	**2011–12**
100% of urgent patients receive treatment within 48 hours	100.00%	100.00%	100.00%	98.90%	100.00%
95% of semi-urgent patients receive treatment within 28 days	83.50%	90.00%	92.90%	100.00%	99.80%
95% of non-urgent category patients receive treatment within 42 days	82.70%	87.60%	87.20%	100.00%	99.30%
Total—All radiotherapy patients	**88.73%**	**92.53%**	**93.37%**	**99.63%**	**99.70%**

- Through provision of additional capacity by extending operational hours to accommodate the increase in demand for services, waiting times for radiotherapy services have remained relatively consistent. Nearly 100 per cent of all patients received care in line with reporting guidelines in 2011–12, compared with nearly 100 per cent in 2010–11 and 93.4 per cent two years ago.
- Ten patients have been provided with prostate high dose rate (HDR) brachytherapy treatment since the program was implemented in August 2010. This program allows the provision of a highly focused treatment option to a specific group of prostate cancer patients.
- The Canberra Hospital Palliative and Supportive Care Team received the Systems and Support category award for their work to improve data capture and enhance the patient's medical record with regard to palliative and supportive care. The team was also named the 2011 Overall Winner.

- Establishment of a redesign process for Outpatient Services at the Canberra Hospital has initially focused on the three main areas of referral registration, booking and scheduling, and transfer of care. Processes and interfaces with e-health projects and new systems have been reviewed. Significant improvements have been made to ensure timely registration of referrals and booking and scheduling processes.
- In mid-June 2012, a number of administration staff responsible for booking and scheduling for the outpatient departments were relocated. The co-location of administration staff has facilitated better communication and cross-training of skills in a less disruptive environment, away from the busy reception areas, where the teams were previously located. In addition to improvements in business processes in this department, staff morale has markedly improved.

Issues and challenges

- Increased demand for service has continued to challenge CRCS to provide timely access and quality care to all clients. The current review and improvements to data sources, reporting and analysis are enabling a greater understanding of pressure points. This information is informing redesign of services and improvements to models of care.
- The CRCS continues to find the recruitment of haematologists a challenge. The division is working with professional bodies and the Human Resources Branch on strategies to attract suitable applicants to positions.

Future directions

Capital Region Cancer Centre

- The Australian Government is supporting the ACT with a grant of $27.9 million from the Health and Hospital Fund for the ACT Capital Region Cancer Centre. This fund is set up to invest in high-priority health infrastructure across the country. The ACT Government has provided additional funding of $15.4 million to enable the completion of the Capital Region Cancer Centre in early 2013.
- The Capital Region Cancer Centre will be run by the Capital Region Cancer Service and will be built around the recently expanded and refurbished Radiation Oncology Department at the Canberra Hospital. The centre will provide:
  - dedicated cancer centre facilities and patient information services
  - co-located outpatient services providing formal multidisciplinary clinics
  - radiation oncology
  - coordinated care through multidisciplinary team meetings
  - clinical offices
  - services for inpatients across the Canberra Hospital campus
  - teaching and research facilities
  - a service delivery hub for rural and regional outreach and locally delivered cancer support services.
- The construction of the building is under way. Completion is scheduled for September 2013. Development of the operational model of care, along with commissioning planning, has commenced.
- The building is a five-storey construction providing a treatment floor, consultation floor, clinical office space and resource areas for consumers. Education and meeting rooms will be provided for tumour-specific support groups.

Other

- BreastScreen ACT continues to work on implementing digital mammography across the ACT. It is anticipated that phase 2 of the project, a new BreastScreen Information System, will be completed by June 2013. The capital outlay for the digital project was $5.7 million, with a recurrent budget of $1.27 million. The project is currently on budget.
- The CHARM Cancer Information Management System will continue to be refined and developed as the primary means of electronic multidisciplinary communication, recording and appropriate sharing of patient data and treatment information across CRCS and the Canberra Hospital.
- The Radiation Oncology Department is fully accredited by the Royal Australasian College of Radiologists for the training of radiation oncologists and will expand the number of its program trainees (registrars) to cope with the enhanced clinical capacity and delivery of more sophisticated treatment techniques that are offered to patients.
- Radiation Oncology is developing the stereotactic radiosurgery (SRS) capability offered with the new linear accelerator to treat brain cancers, increasing the range of services available for patients and reducing the need for patients to travel interstate for treatment. The SRS service is planned to commence clinical operation in late 2012.
- Gungahlin Community Health Centre will open in September 2012 and provide a wide range of health services. Tuggeranong Health Centre will also move to an alternative site close by in October 2012, facilitating the commencement of work to refurbish and extend the existing centre. Work is being undertaken to streamline administration processes and will lead to a shared reception model operating at all health centres in the future.

Output 1.5 Rehabilitation, Aged and Community Care

Output description

The provision of an integrated, effective and timely response to rehabilitation, aged care and community care services in inpatient, outpatient, emergency department, sub-acute and community-based settings.

The key strategic priorities for Rehabilitation, Aged and Community Care are:

- ensuring that older persons in hospital wait the least possible time for access to comprehensive assessment by the Aged Care Assessment Team. This will assist in their safe return home with appropriate support, or access to appropriately supported residential accommodation
- improving discharge planning to minimise the likelihood of re-admission or inadequate support for independent living, following completion of hospital care
- ensuring that access, consistent with clinical need, is timely for community-based nursing and allied health services and that community-based services are in place to better provide for the acute and post-acute health care needs of the community.

The Rehabilitation, Aged and Community Care (RACC) division integrates the public health system rehabilitation, aged and community and primary care services across the ACT. The division aims to improve the quality and accessibility of services to clients. RACC promotes a continuum of care in prevention, assessment, diagnosis, treatment, support, rehabilitation and maintenance.

RACC adopts an area-wide approach to client-centred care. To this end, RACC works closely with others to improve the communication between primary, acute, subacute and community health care, as well as fostering professional development and promoting best practice in rehabilitation, aged and community care.

RACC services are delivered across a broad range of sites throughout the ACT, including hospitals, community health centres and patients' homes. This includes health care and support for people with acute, post-acute, long-term and terminal illnesses at community health centres and dementia-specific day care. The provision of these services includes:

- hospital-based admitted and outpatient geriatric and rehabilitation medicine services, including ortho-geriatrics, at both the Canberra Hospital and Calvary Public Hospital
- geriatric medicine and rehabilitation medicine outpatient services for regional New South Wales
- the Rapid Assessment of the Deteriorating and At-Risk Aged (RADAR) Service, providing services to older people in their own homes, including to residents of aged care facilities upon referral from a GP
- aged care client assessment services
- residential aged care liaison
- the Partners in Culturally Appropriate Care Program
- the Community Partners Program
- community nursing and allied health services, such as podiatry, social work, nutrition and weight management, physiotherapy, continence services, occupational therapy and self-management of chronic conditions training courses
- the Transitional Therapy and Care Program, providing allied health services supporting clients in the post-hospital discharge period, either in a residential setting or in their own homes; RACC provides this service in partnership with Baptist Community Services
- falls injury prevention service, including falls assessment clinics, the Stepping On program and related health promotion activities
- transitional rehabilitation at the Rehabilitation Independent Living Unit (RILU)
- community-based multidisciplinary rehabilitation services
- services provided by exercise physiologists, including programs for gym rehabilitation, cardiac rehabilitation and hydrotherapy
- vocational assessment and rehabilitation services
- driver assessment and rehabilitation services
- geriatric outpatient speech pathology and neuropsychology services
- a multidisciplinary memory assessment service
- ACT Equipment Subsidy Scheme
- Equipment Loan Service
- Domiciliary Oxygen and Respiratory Support Scheme
- ACT Continence Support Service
- Clinical Technology Services
- specialised wheelchair and posture seating service
- prosthetics and orthotics services
- information and advice on assistive technologies by the Independent Living Centre.

Achievements

- The formal refurbishment and addition of four subacute beds on the Acute Care of the Elderly Ward in August 2011. This was well planned and implemented with a positive outcome. It improved the ward environment for patients and staff and increased the unit's ability to provide improved access for patients presenting through the emergency department.
- The care of clients at the Tuggeranong Aged Day Care centre was successfully transferred to a non-government organisation—Goodwin Aged Care Services—in December 2011. The Still Ticking men's dementia group and Belconnen Aged Day Care centre remain within the Health Directorate's Aged Day Care program and operate from the Belconnen Health Centre.
- A multidisciplinary Memory Assessment Service was developed and implemented, with the first patients seen in February 2012. An evaluation of this service will follow.
- The Driver Assessment and Rehabilitation Service expanded the driving education component to meet increased demand for services to older clients. On 1 July 2012, funding was permanently increased to make the driving instructor full time.
- The management of RACC Intake Service was smoothly transitioned back to RACC in January 2012. The team was collocated with relevant services at the Village Creek Centre.
- The Walk-in Centre continues to receive an exceptional amount of positive consumer feedback. Since opening, the Walk-in Centre has received 196 complimentary letters. Clients report high levels of satisfaction with the wait times and service provided.
- The Acute Care of the Elderly Ward Volunteer Program is well established. Volunteers assist with meal set-up and encourage patients to eat. They visit for approximately two hours over meal times, generally at lunch time and in the evening. Volunteers have expressed a high level of satisfaction.
- The Aged Care Assessment Team (ACAT) undertook a redesign project to improve its responsiveness and capacity to process aged care assessments in order to meet all stakeholder requirements. As a result of this project, the backlog of referrals awaiting ACAT assessments has been reduced from 406 in September 2011 to 122 at 30 June 2012. This improvement has been sustained. The response time for conducting ACAT referrals for hospital inpatients has met Health Directorate targets since September 2011.
- In the Community Care Program, both allied health and nursing services exceeded their targets in providing service to clients in the community through home visits or health centre appointments. To meet increasing service demand, Community Nursing established a second stomal therapy clinic at Belconnen Health Centre in July 2011.
- There continues to be a focus on supporting clients to 'self-manage' their chronic conditions in the community. In 2011–12, 105 participants completed the RACC Living a Healthy Life with Long-Term Conditions program. The RACC Community Nutrition service has been evaluated, revised and commenced an Adult Healthy Weight management group in 2011. This session enhances self-management by encouraging mindfulness, realistic goal setting, healthy eating and physical activity.
- RACC has delivered a variety of group health education programs in health centres across the ACT, including pelvic floor workshops, pre-prostatectomy education, Adult Healthy Weight Group, Heart Fare and the Footsure program.
- The Commonwealth funded project, the Healthy Communities initiative, continued to be delivered in 2011–12. As part of this project, Community Care coordinated mini-health checks and flu vaccinations and taught food skills targeting disadvantaged people.
- The ACTES Equipment Mobile Repairs and Maintenance Service was established to provide improved access for clients with high need to enable a timely response for repairs and to ensure ongoing servicing and maintenance to ensure longevity of funded equipment.

- The Exercise Physiology Department has implemented a number of service improvements, including diabetes and epilepsy checklists, cardiac handouts and diabetes groups with education components, and participated in the rollout of the Beat It program to Health Directorate staff.
- The Independent Living Centre, Canberra, joined other state and territory independent living centres in the development of a new information database that will enable community residents to access information relating to equipment, aids and assistive technology through a web-based catalogue.
- RACC Canberra Hospital-based rehabilitation services achieved better than the Australian Rehabilitation Outcomes Centre benchmarks for the calendar year 2011:
  - The average length of stay for patients requiring rehabilitation after a spinal cord injury was 29.0 days, against a benchmark of 63.0 days.
  - The average length of stay for patients requiring rehabilitation after amputation was 28.9 days, against a benchmark of 36.1 days.
  - The average length of stay for patients requiring rehabilitation after brain dysfunction was 20.1 days, against the benchmark of 36.1 days.
- The ACT Artificial Limb Scheme Advisory Committee was established to enhance governance of the ACT Artificial Limb Scheme. The committee contains multidisciplinary and consumer representation.
- The Falls Injury Prevention Service conducted 466 falls clinic assessments in 2011–12, which is 11 per cent above the target of 420.
- The Falls Injury Prevention Service continued to promote falls awareness through involvement in community expos, including the Seniors Week expo, and by running a month-long initiative at the Canberra Hospital to link in with the NSW April Falls Day initiative and promote the service through access to falls prevention staff and the provision of fact sheets for community, clients and staff.
- The final report for a HWA Workforce Innovation and Reform project entitled the Caring for Older People Program was completed in July 2011. The project developed and tested a workforce solution to ensure the safe, effective and sustained transition of older adults from an acute setting to the community. In response to the Caring for Older People Program HWA project, the new position of Discharge Support AHA was established and permanently recruited to in February 2012. This role provides a client-centred approach to the implementation of discharge plans for elderly clients discharged to go home.
- An Aged Care Nurse Practitioner was recruited to support follow-up post-discharge contacts and a discharge support allied health assistant role was established to ensure that service provision post-discharge is adequate and required supports have been initiated.
- Successful consultation between staff, management and unions has resulted in the establishment of a team leader position for a new community-based rehabilitation team, incorporating Community Rehabilitation, Vocational Assessment and Rehabilitation, and Falls Injury Prevention staff. This position is being recruited to and is expected to be filled in August 2012.
- A number of RACC Allied Health Assistants completed their participation in the Allied Health Assistant Traineeship Program, employing a trainee to undergo the Certificate IV training at CIT to become an Allied Health Assistant (AHA). Following evaluation, the AHA positions will become permanent healthcare assistant roles within RACC. These roles are currently being recruited to. This will assist in addressing some allied health workforce challenges.
- The roles of the AHA podiatry trainee and AHA speech pathology trainee were formally evaluated in partnership with the Office of the Allied Health Adviser and academic consortiums. These evaluations were presented by the relevant service managers within RACC at the National Allied Health Conference in Canberra in April 2012.

- The Health Directorate Australia Day team awards were presented to both Community Care Program Clinical Nurse Consultants for Complex Care in recognition of their significant contribution to care planning for patients with very complex care needs, the Clinical Technology Services Manager of Client Support Services, and the Community Rehabilitation Team for demonstrating significant innovations that improved access and clinical outcomes for clients.
- RACC staff were finalists in the ACT Quality in Healthcare Awards for the development of a multidisciplinary approach in the management of the residual limb in the pre-prosthetic phase of rehabilitation.
- RACC staff were finalists in the ACT Health Directorate Better Practice Awards for:
  - an MDT approach to improve the management of the residual limb during the pre-prosthetic phase in patients following lower lib amputation
  - improving knowledge of consumers and referring agents about driving with a medical condition
  - rehabilitation assessment and therapy clinics
  - Young Persons' Group
  - Evidence-Based Practice Education Project in physiotherapy
  - establishment of a Dysphagia Clinic in speech pathology
  - physiotherapy outpatient clinic frequency of review appointments
  - Nutrition Essentials Training for Disability Support Workers
  - nursing-initiated review, assessment and treatment planning for rehabilitation inpatients—nursing weekly ward round
  - optimum antiemetic management for community chemotherapy/radiation patients
  - implementation of program DNA policy and procedures
  - Community Care Nutrition Heart Fare program
  - reducing frequency of urinary catheter valve changes
  - Mobile Repairs and Maintenance Service.
- Rehabilitation and geriatric presentations at conferences in 2011–12 included:
  - an Update on Neuroplasticity and Central Sensitisation of Pain and Implications for Rehabilitation Professionals, 4th Middle East Physical Medicine and Rehabilitation Conference, Abu Dhabi Medical Congress, UAE, 23 to 25 October 2011, presented by Dr Keith Chan
  - Vitamin D, Secondary Hyperparathyroidism (SHPT), Bone Fractures and Cardiovascular Diseases: Toward a Unifying Hypothesis, RACP Future Directions in Health Congress in 2012, Brisbane, Queensland, presented by Associate Professor Alex Fisher
  - Cardiovascular Diseases and Osteoporotic Hip Fracture: Prevalence, Similarities and Differences in Mineral and Bone Metabolism Characteristics, 16th Annual Meeting of the European Council for Cardiovascular Research (ECCR), La Colle sur Loup, Nice, France, presented by Associate Professor Alex Fisher
  - Gender Differences in Hip Fracture: Epidemiological Trends, Pathophysiological Characteristics, Comorbidity and Outcomes, European Journal of Internal Medicine, Athens, Greece, presented by Associate Professor Alex Fisher
  - Post-stroke Hip Fractures: Pathophysiological Consideration and Gaps in Prevention, European Federation of Neurological Societies European Journal of Neurology, Budapest, Hungary, presented by Associate Professor Alex Fisher
  - staff receiving an award for a poster presentation at the 2011 ASM of the Canadian Geriatrics Society in Toronto
  - an occupational therapist, speech pathologist, social worker and physiotherapist presenting sessions at the Motor Neurone Disease Day for Health Professionals.

- The Acute Care of the Elderly Ward (11A) has participated in the Clinical Audit program through the Research Centre for Nursing and Midwifery Practice, which is now an approved affiliate of the Australian Capital Regional Centre for Evidence-Based Nursing and Midwifery Research of the Joanna Briggs Institute, University of Adelaide.
- Within nutrition screening, early referral was identified as essential to ensure that all patients requiring nutritional support are seen by a dietitian as soon as possible and are provided with appropriately nutritious meals and supplements. A nutrition assessment screening and referral tool has been developed which enables inpatient nursing staff to easily identify patients who are at risk of malnutrition. The assessment is completed for all patients on admission. The tool has now been implemented. It is being evaluated through random weekly audits and is a formal quality improvement project.
- RACC's learning, research and development activities in 2011–12 included providing student placements for allied health staff from educational tertiary institutions, including the Canberra Institute of Technology, the University of Canberra, ANU, Charles Sturt University, University of Sydney, Australian Catholic University and Canberra Institute of Technology.

Issues and challenges

- Work will resume on the draft Rehabilitation and Aged Care Services Plan, incorporating the findings of the July 2012 Poulos report entitled *Service Models and Projected Service Demand for Adult Rehabilitation and Aged Care Services*.
- Final expansion of the Transitional Therapy and Care Program (TTCP) community places will occur, increasing total availability (residential and community) to 58 places. The overall occupancy for the TTCP in 2011–12 was: for the residential unit, 74.5 per cent; for community places, 50.7 per cent. The overall average occupancy was 63 per cent. Recommendations from the TTCP Access Project designed to improve entry into the service are being implemented to increase occupancy.
- Workforce pressures on professional allied health staffing vacancies remain a barrier to fully implementing proposed best practice models. Strategies to recruit and retain staff, as well as provide innovative models of care, continue to be developed. Strategies are being collaboratively discussed and implemented across allied health disciplines in the Health Directorate.
- As a result of ongoing issues with subacute access, a redesign project was formed to address inpatient referrals and flows to all subacute areas. The redesign project was started in September 2011 and involves stakeholders from acute and subacute areas. Current SOPs and referral processes were reviewed and amended to reflect demand and a pilot project commenced in early 2012.
- The average length of stay in subacute areas remains above the benchmark and also impacts on access and flows into subacute wards. Work continues in meeting increased demands on ACT subacute areas from both ACT and NSW residents.
- RACC has been experiencing a shortage in geriatricians due to an unavailability of suitably qualified applicants for positions available in the division. In June 2012, there were 1.4 FTE positions vacant. It is anticipated that current trainees may also be suitable for employment as geriatricians in the near future. RACC is also working with the Human Resources Branch and recruitment agencies to attract suitable applicants to positions.
- Due to increased demand and workforce issues in RACC Prosthetics and Orthotics (P&O), there has been a steady increase in waiting times for appointments. P&O also continue to provide services to a large number of clients outside the ACT. A triage clinic was developed to better manage client need and wait times. As of June 2012, the non-urgent wait time for P&O was 20 weeks.

Future directions

- RACC Nursing was successful in receiving a Better Practice Scholarship for a project aimed at enhancing the experience of the elderly patient in the Emergency Department. The target audience is all patients presenting from residential aged care facilities and all patients over 85 years, with a focus on improved assessment, diagnosis and treatment of delirium. This is a collaborative project with the Emergency Department.
- RACC Allied Health is involved in a cross-divisional project looking at recognition of the deteriorating patient in the community, with Transitional Therapy Allied Health clients targeted to be involved in a pilot.
- Evaluation of new services and/or positions will be completed in the next 12 months, including the team leader for the newly amalgamated community-based rehabilitation team disability counsellor role 11A, discharge support Allied Health Assistant (AHA), Community Rehabilitation Team (CRT) spasticity clinic and the Memory Assessment Service.
- Access to RACC nursing and allied health community-based services in Canberra's north will be improved through the offering of clinics at the new Gungahlin and Belconnen Health Centres, opening during 2012–13.
- A custom medical-grade footwear service is being established as part of Clinical Technology Services. This service was previously provided through an interstate contractor. The establishment of this in the Territory will enable more timely intervention and improved service delivery to clients. The service will be implemented once capital works are completed in August–September 2012 at the Village Creek Centre in Kambah.

Output 1.6 Early intervention and prevention

Output description

Increasing the focus on initiatives that provide early intervention to, or prevent, health care conditions thatresult in major acute or chronic health care burdens on the community.

The key strategic priorities for intervention and prevention are reducing the level of youth smoking in the ACT and maintaining immunisation rates for children above 90 per cent.

The Health Directorate undertakes several activities aimed at increasing the focus on initiatives that provide early intervention to, or prevent, health conditions that may result in major acute or chronic health care burdens on the community.

Early intervention is managed in many ways, including the Health Directorate screening programs such as BreastScreen, cervical screening and newborn hearing screening, and immunisation programs.

The Health Directorate has programs and projects that aim to improve the health of the ACT population through a mixture of whole-of-population health promotion and disease prevention actions, as well as those that target individuals and population groups with the most need and/or potential for the greatest health gains.

Achievements

- The ACT maintained its position as the jurisdiction with the highest life expectancy. Projections suggest that life expectancy will continue to increase. By 2015, life expectancy at birth in the ACT is projected to be 83.1 years for males (up 2.4 years from 2007) and 86.5 for females (up 2.5 years from 2007). Cancer, mental disorders and cardiovascular disease contribute nearly half of the total burden of disease in the ACT.

- The Health Directorate will receive $8.75 million in facilitation payments through the National Partnership Agreement on Preventive Health (NPAPH) between July 2010 and June 2018. This funding was extended and varied in late June 2012, within the existing funding envelope, to add a further three years, from June 2015 to June 2018. The NPAPH is aimed at stimulating action in preventing lifestyle risks associated with chronic disease and funds the delivery of five different initiatives: Social Marketing, Enabling Infrastructure, Healthy Children, Healthy Workers, and Healthy Communities.
- Social Marketing: The Health Promotion Branch and the Aboriginal and Torres Strait Islander Health Unit collaborated to develop a social marketing campaign promoting smoking cessation and uptake of healthy lifestyles in the Aboriginal and Torres Strait Islander community. A working party was established to progress findings from previous community-based social research, and a consultant was engaged to develop the campaign. This work progresses a recommendation from the Aboriginal and Torres Strait Islander Tobacco Control Strategy.
- Healthy Children: The Health Directorate is receiving $4.09 million over seven years from July 2011 to deliver programs aimed at reducing rates of overweight and obesity in children aged zero to 18 years. The programs being delivered through this initiative are aligned with activities funded through the 2009–11 ACT Government's Healthy Futures Program. NPAPH funding will contribute towards the expansion and further development of activities funded through the Healthy Futures Program, including:
  1. Healthy School Environments, involving the delivery of three interventions in school settings:
     - Healthy Food@School: a program that develops a healthy food and drink culture in ACT schools using a whole-school approach. The program will embed changes in school culture so healthy options become part of the school ethos. This includes the implementation of the new national healthy school canteen guidelines to assist canteen managers to make food choices that encourage the development and reinforcement of healthy eating patterns in students, healthy eating as part of the curriculum, and a set break during the school day specifically for students to eat salad vegetables or fruit and drink water in the classroom. The program targets children from kindergarten to Year 10.
     - It's Your Move: a research-focused intervention in high schools in collaboration with Deakin University. Using a whole-of-school systems approach, it aims to reduce unhealthy weight gain in young people from 12 to 17 years by encouraging the adoption of healthy eating patterns and participation in regular physical activity.
     - Active Travel to School: the promotion of riding and walking to school as part of the 60 minutes of recommended activity for school-aged children, and working with students, their families or carers and school communities.
  2. the Family Wellbeing Program, a parenting program that addresses lifestyle behaviour issues in families of overweight children and children at risk of obesity aged from birth to seven years, aiming to improve children's nutritional intake and activity levels by increasing parents' skills and confidence to manage children's lifestyle behaviour
  3. Sport and Active Recreation Environments—Healthy Sporting Canteens aims to increase healthy food choices available to children and young people through sporting club canteens and to promote water as the drink of choice.
- Healthy Workers: The Health Directorate is receiving $3.61 million over seven years to deliver programs that promote and support healthy lifestyles in and through ACT workplaces. The following activities were initiated by the Healthy Workers program in 2011–12:
  - Promotion of healthy environments—Provision of resources and support to workplaces to increase their readiness and capacity to be health-promoting environments. The main component of this activity is a workplace facilitation service that will provide enabling and capacity-building healthy living programs to workplaces. The service will be responsible for marketing, communication and supporting resources, including a toolkit, a website and training that will provide education and information to ACT workplaces. The Healthier Work Service was launched in May 2012.

  - Healthy living program incentives—Provision of incentives for workplaces to access healthy living programs that target individual workers, groups of workers or the organisation as a whole. These incentives are to be provided as subsidies to high-need and hard-to-reach workplaces to access approved healthy living programs.
  - Public sector health promotion—Provision of specific programs and policy guidance for public sector organisations. The core aspect of this program is analysis of the Health Directorate's experience in developing and implementing a comprehensive staff health and wellbeing program. In addition, an ACT Public Service Staff Health and Wellbeing Policy was developed in partnership with the Chief Minister and Cabinet Directorate and endorsed in May 2012.
  - Program evaluation—Provision of resources, including tools, to evaluate the success of the ACT Healthy Workers Program against NPAPH performance benchmarks. This will include an evaluation of the methodology for the full program, including specific activity evaluations.
- Healthy Communities Initiative: In March 2010, the Health Directorate was selected as one of 12 pilot sites to receive funding for the Healthy Communities Initiative (HCI). HCI focuses on reducing the prevalence of overweight and obesity among at-risk adults who experience relatively high levels of socioeconomic disadvantage and are not in paid employment by increasing their access to and involvement in registered healthy lifestyle programs and initiatives. This has concentrated on the Inner North of Canberra. Activities to date include:
  - extensive consultation with local organisations and the community, and subsequent partnership development
  - the establishment of nationally endorsed healthy lifestyle programs in the ACT, including: BEAT It, which targets diabetes, Healthy Eating and Active Lifestyles (HEAL), AustCycle cycle education and Heartmoves, Heart Foundation walking
  - delivery of other programs such as nutrition education in collaboration with Health Directorate dieticians, Nutrition Australia and the Red Cross Foodcents program, and outreach mini-health checks delivered by allied health staff using a health coaching model of service delivery.
- The 2009–10 ACT Budget allocated $11 million over three years for initiatives aimed at preventing or reducing risk factors for chronic disease. These initiatives focused on priority areas of action that closely reflect developments in the national preventive health agenda through the National Partnership Agreement on Preventive Health:
  - Healthy Kids, Healthy Future—This aims to establish healthy habits in young children to prevent excess weight gain. Funding includes programs to: promote active play; manage screen time; promote and support the adoption of healthy eating habits; promote and support acceptance of water as the drink of choice; and develop and provide oversight of implementation resources and programs to promote and support breastfeeding.
  - tobacco use in Aboriginal and Torres Strait Islander people—An Aboriginal and Torres Strait Islander Tobacco Control Strategy has been developed.
  - the Healthy at Work program—This involves the development and implementation of workplace health promotion programs, including health assessments, risk modification programs and referral for people in need of further assistance in workplace settings. Activities under the Healthy at Work program promote physical activity and healthy eating, smoking cessation, reduction in hazardous consumption of alcohol, and mental health or stress management. Formative research under the guidance of an advisory group included a report on the health status of ACT workers conducted by PriceWaterhouseCoopers and a pilot work health and wellbeing program conducted in five workplaces.
  - chlamydia awareness campaign—A range of social marketing and peer education strategies targeting young people at risk of developing chlamydia and related sexually transmitted infections have been undertaken.

  - adolescent health—A feasibility report on a centre for youth health was approved for publication online on 2 April 2012. Final activities under this initiative include: support for the YMCA Youth Assembly to be held in July 2012; support for the Youth InterACT conference, held in April 2012 with Healthy Lifestyle: A Balancing ACT as one of the headline forum topics for the day; and the evaluation of the school youth health nurse initiative.

- The ACT Health Promotion Grants Program aims to improve the health of people in the ACT by providing funding to and supporting programs that promote and facilitate healthy lifestyles, policies and environments, and build the capacity of individuals, groups and communities to make healthy choices. There were four separate funding rounds for projects in 2011–12: the Community Funding Round, the Stay On Your Feetâ Falls Prevention Funding Round, the Healthy Schools, Healthy Children Funding Round, and the Health Promotion Sponsorship Funding Round. In 2011–12, 95 projects and sponsorships were funded across the four rounds, providing $2,250,644 to promote health and wellbeing in the ACT community.
- The ACT continued to achieve high childhood immunisation coverage in the general population. Coverage rates for children in all three cohorts were consistently above the national average. In 2011–12, ACT childhood immunisation coverage rates remained above the national target of 90 per cent for 12-month-old children. Coverage rates for children in all three cohorts were consistently above the national average. The Health Directorate's target of 92 per cent of one-year-old children being fully immunised was exceeded in all quarters (92.5 per cent, 93.6 per cent, 93.3 per cent and 92.7 per cent).
- In July 2009 the National Partnership Agreement on Essential Vaccines was implemented. The objective of this agreement is to improve the health and wellbeing of Australians through the cost-effective delivery of the National Immunisation Program. The agreement sets out performance benchmarks that must be achieved for the ACT to be eligible for an incentive payment. The performance benchmarks associated with the essential vaccines agreement are:

  1. maintaining or increasing vaccine coverage for Indigenous Australians
  2. maintaining or increasing coverage in agreed areas of low immunisation coverage
  3. maintaining or decreasing wastage and leakage
  4. maintaining or increasing vaccination coverage for four-year-olds.

  In 2011–12, the ACT achieved three of the four performance benchmarks. As the ACT does not have areas of low immunisation coverage, the other benchmark is unable to be assessed. From 1 April 2011 to 31 March 2012, the mean immunisation coverage for Aboriginal and Torres Strait Islander children in the ACT was: 12 to 15 months—87.2 per cent, 24 to 27 months—93.8 per cent, and 60 to 63 months—88.5 per cent. From 1 April 2010 to 31 March 2011, the mean immunisation coverage for four-year-old children in the ACT was 91.4 per cent.
- The Cervical Screening Program captures and reports data over a two-year period, as recommended by the National Cervical Screening Program. At 30 June 2012, the ACT participation rate for the target population was 57.9 per cent. The AIHW report, Cervical Screening in Australia 2007–08, puts the ACT in the top three jurisdictions in Australia for participation in cervical screening. During 2011–12 the Cervical Screening Program actively promoted screening among community groups. The main message was that young women should continue to be screened even if they have been vaccinated against HPV. Program staff attended several women's health events to promote screening in the community. In addition, a radio campaign was implemented to promote screening among young women.
- BreastScreen ACT and South-East New South Wales is part of a national population breast screening program aimed at reducing deaths from breast cancer through early detection. Further information can be found under 'Cancer services' on page 170 of this report.

- Hearing screenings are provided to every newborn in the ACT. They aim to identify babies born with significant hearing loss and introduce them to appropriate services as soon as possible. Further information can be found under Division of Women, Youth and Children on page 152 of this report. School-based nursing programs include immunisations and kindergarten health checks. The School Youth Health Nurse Program promotes positive health outcomes for young people by providing access to a nurse in the high school setting. Further information can be found under Division of Women, Youth and Children on page 152 of this report.
- As part of the Commonwealth-funded National Bowel Cancer Screening Program, colonoscopy services are provided to patients. Further information can be found under the Division of Medicine on page 141 of this report.
- Well Women's Checks were provided to 40 per cent of women from culturally and linguistically diverse communities. This is above the target of 30 per cent and an increase of 8 per cent from 2010–11. This growth was due to increased targeting of culturally and linguistically diverse women through location of services.
- Eighty per cent of children aged zero to 14 who entered substitute and kinship care in the ACT were referred to the Child at Risk Health Unit's Out-of-Home Care Clinic, which met the target.
- The ACT Chronic Disease Strategy 2008–2011 provided the overarching framework for the provision of appropriate programs and supports to address the increasing prevalence of people at risk of, or living with, chronic disease. From 2008 to 2011, this strategy made considerable progress in ensuring chronic disease prevention, detection and management are coordinated, collaborative and interprofessional, and address the needs of specific groups.
- The ACT Primary Health Care Strategy 2011–2014 is a high-level document that reflects feedback from the ACT community in relation to their needs and priorities for primary health care. The strategy was developed in the context of the outcomes of the Council of Australian Governments (COAG) health reforms and a range of existing health-related strategies and plans. It includes six key principles:
  - Principle 1—Empowered person centred care
  - Principle 2—Focus on disease prevention and promotion of a holistic understanding of health as wellbeing rather than absence of disease
  - Principle 3—Services are evidence based, safe, appropriate, effective and efficient
  - Principle 4—Equity and access
  - Principle 5—Collaborative model of team-based coordinated care
  - Principle 6—Integration and collaboration to support the patient journey.
    The strategy also identifies seven priority areas for action. The first four priorities focus on improving outcomes and addressing areas for improvement in current arrangements. The last three priority areas focus on providing enablers or building blocks which are essential to achieve improvement. The key priorities are based on those identified in the National Primary Health Care Strategy. The Primary Health and Chronic Disease Strategy Committee is overseeing implementation of the strategy.

Issues and analysis

- CSL Fluvax® influenza vaccine has not been recommended for use in children under five years since April 2010. The vaccine is associated with a higher incidence of febrile illness and febrile convulsions in this age group. Fluvax® is not registered by the Therapeutic Goods Administration for use in children under five in 2012. Other influenza vaccines (Vaxigrip, Influvac®, Fluarix® and Agrippal®) are registered for children in this age group. The Health Protection Service regularly communicates with immunisation providers on the influenza vaccination of children under five. In 2012, the communication consisted of letters to immunisation providers, articles in immunisation newsletters and advice on the Health Directorate web page.

Future directions

- The ACT Government has committed $0.3 million over three years for the Healthy Weight Action Plan, an initiative which supports activities to reduce obesity rates. Obesity is a major target for whole-of-government action because of its potential to adversely affect the health of the population and drive increased expenditure on health services in coming decades.
- The Population Health Division was successful in winning an Australian Research Council Grant in partnership with the Australian National University. This grant will enable the development of methods by which research in population health can be better used by policy makers. Studies will be undertaken with decision makers and policy advocates, and tools to assist policy makers to use evidence will be developed. The study will identify barriers to the uptake of research evidence in population health and will look to develop a training model to improve the processes by which researchers and policy makers work together.
- A new immunisation strategy 2012–2016 has been developed and is expected to be launched in late 2012.
- A consultant has been engaged to develop, in collaboration with a small working group, a strategy for improving care and support for those living with chronic conditions. A draft Strategy for Improving Care and Support for Those Living with Chronic Conditions 2012–2017 will be released for six weeks of public consultation following agreement from the Minister for Health.
- Enabling infrastructure: The Health Directorate received $630,000 in 2011–12 to support the collection of data through population surveys to measure the eight performance benchmarks. This funding will be used to support the delivery of the ACT General Health Survey, National Secondary Students' Diet and Activity survey and the Australian Secondary Schools Alcohol and Drug Survey.

Quality and Safety Unit

Safety and quality of care are core elements in the provision of health services. The Quality and Safety Unit (QSU) takes a lead role in planning, managing and evaluating patient safety and quality for the Health Directorate. QSU focuses on quality improvement, evaluation and review, clinical management systems and measurement, consumer engagement, clinical performance related to patient safety and quality, and risk management. QSU is committed to advancing the national agenda on patient safety and is working closely with the Australian Commission on Safety and Quality in Health Care to progress the ten national priority standards. The Workplace Safety section within QSU has overarching responsibility for keeping our staff healthy and safe.

The QSU also coordinates the accreditation process for the organisation: the Accreditation and Evaluation Team is currently preparing the organisation for an Organisation Wide Survey in 2012.

The Business Plan for the QSU has highlighted three themes that underpin the functions of the unit. These themes are that care provided to consumers will be:

- consumer centred
- driven by information, and
- organised for safety.

These themes have been compiled using recommendations and information from reviews and monitoring processes carried out within the Health Directorate, national and international health improvement methods and national priority and reform processes.

Achievements

- Monitored the Quality and Safety Framework 2010–2015 for the Health Directorate. This document describes a vision and direction to improve safety and quality in the Health Directorate and sets out the key activities that will be happening throughout the organisation to improve the safety and the quality of the service we provide for our consumers. This document will be revised in 2012 to incorporate the 10 National Standards.
- Collected first round of data for the 'Effective Communication in Clinical Handover (ECCHO) project, a national Australian Research Council funded project in collaboration with the University of Technology Sydney and three other jurisdictions. This project included observation of clinical handovers of patient information in the Canberra Hospital's Medical Assessment and Planning Unit and examined the usefulness and effectiveness of clinical handover tools.
- Partnered with the Healthcare Consumers Association ACT to provide forums on 'How to Complain Properly', consumer representative training and advocacy training.
- Participated in developing in the Rural Health Education Foundation DVD and toolkit titled 'The Patient's Choice: Quality at the End of Life'.
- Planned for future implementation of core standards for forms outlined in 'A National Framework for Advanced Care Directives' through working with the Medicare Local Aged Care Forums and Council on the Ageing ACT.
- Provided education and training to staff on National Recommendations for User Applied Labelling of Injectable Medications, Fluids and Lines.
- Completed a training strategy to further support the implementation of Open Disclosure in the Health Directorate.

- Developed clear policy documents on important safety and quality issues such as:
  - Restraint—clearly outlines the limited circumstances when patients may be restrained for safety reasons
  - Searching—outlines the limited situations when a consumer's property or person may be searched in the interests of safety
  - Violence and Aggression—provides clear advice to staff about responding to violence and aggression from consumers, patients and/or visitors to health services
  - Policy Management—realigned the policy management governance processes to the new organisational structure and provided clear information, processes and supports for the effective governance of policy documents.
- Facilitated the ACT Quality in Healthcare Awards, which showcase patient safety and quality initiatives across the territory, and the Health Directorate Better Practice Awards which celebrate local quality improvement activities.
- Revised the *Framework for the Management of Business arising from the Office of the Coroner*, which provides information regarding the processes associated with the flow of information between the Health Directorate and the Office of the Coroner.

Future directions

- Refinement of the Riskman incident management system to integrate quality improvement, accreditation and risk functions. The upgrade will enable more useful reporting on incident and risk data.
- The Safety Management System document has been amended and is almost finalised. The changes reflect the amendments to workplace legislation, in particular, the responsibilities of managers.
- Revise Safety and Quality Framework to align with the 10 National Safety and Quality Health Service Standards and review criteria for progress against these standards.
- Coordinate the implementation of Patient Experience Leader position to lead work and emphasise the focus on patient and family-centred care.
- Coordinate the Medical Advisor to the Quality and Safety Unit to assist in identifying, designing and prioritising directorate-wide quality improvement activities.

A.10 Triple bottom line report

	INDICATOR	2010–11 Result	2011–12 Result	% Change
ECONOMIC	**Employee Expenses**			
	Number of staff employed (head count)	5,953	6,228	4.6%
	Total employee expenditure (dollars)	$537,493,000	$593,999,000	10.5%
	Operating Statement			
	Total expenditure (dollars)	$1,093,396,000	$1,177,762,000	7.7%
	Total own source revenue (dollars)	$241,069,000	$255,862,000	6.1%
	Total net cost of services (dollars)	$852,327,000	$921,900,000	8.2%
	Economic Viability			
	Total assets (dollars)	$806,615,000	$996,190,000	23.5%
	Total liabilities (dollars)	$221,115,000	$266,500,000	20.5%
ENVIRONMENTAL	**Transport**			
	Total number of fleet vehicles	320	321	0.3%
	Total transport fuel used (kilolitres)	358	365	2.0%
	Total direct greenhouse emissions of the fleet (tonnes of CO2e)	968	987	2.0%
	Energy Use			
	Total office energy use (megajoules)	10,474,606	11,234,403	7.3%
	Office energy use per FTE (megajoules)	26,789	23,820	–11.1%
	Office energy use per square metre (megajoules)	1,647	1,642	-0.3%
	Greenhouse Emissions			
	Total office greenhouse emissions – direct and indirect (tonnes of CO2e)	2,507	1,644	–34.4%
	Total office greenhouse emissions per FTE (tonnes of CO2e/FTE)	4.20	3.90	–7.1%
	Total office greenhouse emissions per square metre (tonnes of CO2e/m^2)	0.25	0.27	8.0%
	Water Consumption			
	Total water use (kilolitres)	152,278	183,174	20.3%
	Office water use per FTE (kilolitres/FTE)	n/a	n/a	
	Office water use per square metre (kilolitres/m^2)	n/a	n/a	
	Resource Efficiency and Waste			
	Estimate of co-mingled office waste per FTE (litres)	142.97	286.57	100.4%
	Estimate of paper recycled (litres)	1,312,855	1,477,222	12.5%
	Estimate of paper used (by reams) per FTE	7.75	7.11	–8.3%

	INDICATOR	2010–11 Result	2011–12 Result	% Change
SOCIAL	**Diversity of Our Workforce**			
	Women (Female FTEs as a percentage of the total workforce)	76.63%	76.06%	–0.7%
	People with a disability (as a percentage of the total workforce)	1.93%	1.88%	–2.6%
	Aboriginal and Torres Strait Islander people (as a percentage of the total workforce)	0.84%	0.84%	0.0%
	Staff with English as a second language (as a percentage of the total workforce)	16.93%	18.10%	6.9%
	Staff Health and Wellbeing			
	OH&S Incident Reports	1,219	1,209	–0.8%
	Accepted claims for compensation (as at 31 August 2012)	72	89	23.6%
	Staff receiving influenza vaccinations	2,641	2,481	–6.1%
	Workstation assessments requested	128	129	0.8%

Footnotes

Total office energy use (megajoules)
As buildings 22, 23 and 24 on the Canberra Hospital campus are not submetered, the office areas in those buildings are not able to be included in the reported figures.
The increase from 2010–11 is due to the inclusion of Health Protection Services Holder which was not included in the figure reported last year.

Total office greenhouse emissions – direct and indirect (tonnes of CO2e)
As buildings 22, 23 and 24 on the Canberra Hospital campus are not submetered, the office areas in those buildings are not able to be included in the reported figures.

Total water use (kilolitres)
As per Table of C.19 reporting criteria. Increase due to construction and clinical activity.

Office water use per FTE (kilolitres/FTE)
Office water use per square metre (kilolitres/m²)

n/a as these are not submetered.

Estimate of co-mingled office waste per FTE (litres)
Waste co-mingled at all Health Directorate sites.

Staff receiving influenza vaccinations
This information is prepared by calendar year.