ANNUAL REPORT 2013 2014

ACT Government Health Directorate

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ISBN: 978-0-642-60623-5

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ABBREVIATIONS AND ACRONYMS

Abbreviation	Meaning
AACB	Australian Association of Clinical Biochemists
ABF	Activity-based funding
ABS	Australian Bureau of Statistics
ACAT	Aged Care Assessment Team ACT Civil and Administrative Tribunal
ACHS	Australian Council on Healthcare Standards
ACP	Advanced care planning
ACTES	ACT Equipment Scheme
ACTGS	ACT Government Solicitor
ACTPS	ACT Public Service
ACTPAS	ACT Patient Administration System
ACU	Australian Catholic University
AGAR	Australian Group on Antimicrobial Resistance
AHA	Allied Health Assistant
AIDS	Acquired Immune Deficiency Syndrome
AIHW	Australian Institute of Health and Welfare
AMAP	Aboriginal Midwifery Access Program
AMC	Alexander Maconochie Centre
AMHU	Adult Mental Health Unit
ANU	Australian National University
APTSRH	Antenatal care, pre-pregnancy and teenage sexual and reproductive health
ARM	Admitting Registrar for Medicine
ARPANSA	Australian Radiation Protection and Nuclear Safety Agency
ASSAD	Australian Secondary School Alcohol and Drug survey
ATODA	Alcohol, Tobacco and Other Drug Association ACT
AVA	Australian Veterinary Association
AVBC	Australasian Veterinary Boards Council
AWA	Australian Workplace Agreement
AWOL	Absence Without Leave
BCHC	Belconnen Community Health Centre
BFHI	Baby-Friendly Health Initiative
BHRC	Brian Hennessy Rehabilitation Centre
CAA	Council of Ambulance Authorities
CALD	Culturally and Linguistically Diverse
CAHMA	Canberra Alliance for Harm Minimisation
CAMHS	Child and Adolescent Mental Health Service
CARE	Care and Response Escalation Call and Respond Early
CaTCH Program	Continuity at the Canberra Hospital
CCCS	Community Care Common Standards
CCL	Cardiac Catheter Laboratory
CDM	Chronic Disease Management
CDMR	Chronic Disease Management Register
CEO	Chief Executive Officer
CHF	Chronic heart failure
CHO	Chief Health Officer
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
CHWC	Centenary Hospital for Women and Children
CIT	Canberra Institute of Technology
CMP	Canberra Midwifery Program
CO2e	Equivalent carbon dioxide
COAG	Council of Australian Governments
COPD	Chronic Obstructive Pulmonary Disease
CPCHS	Community Paediatric and Child Health Service
CPD	Continuing Professional Development
CPOE	Computerised Physician Order Entry
CPSU	Community and Public Sector Union
CRCS	Capital Region Cancer Service
CSS	Commonwealth Superannuation Scheme
CSTD	Closed system transfer devices
CT	Computerised Tomography
CTSC	Clinical Trials Subcommittee
DA	Development application
DDG	Deputy Director-General
DG	Director-General
DHP	Dental Health Program
DMFT	Decayed, missing or filled teeth
DVA	Department of Veterans' Affairs
ECCHO	Effective Communication in Clinical Handover
ECT	Electro-convulsive therapy
ED	Emergency Department
EDIS	Emergency Department Information System
EDSU	Extended Day Surgery Unit
EEG	Electro-encephalogram
EH	Environmental Health team
EISGP	Education Infrastructure Support Grant Payment
EMM	Electronic medication management
EN	Enrolled Nurse
ESA	ACT Emergency Services Agency
FAMSAC	Forensic and Medical Sexual Assault Care
FMA	Financial Management Act 1996
FOI	Freedom of Information
FTE	Full-time equivalent
GAAP	Generally Accepted Accounting Principles
GHICS	Get Healthy Information and Coaching Service®
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
HAAS	Healthcare Access at School
HACC	Home and Community Care
HCCA	Health Care Consumers' Association of the ACT
HCI	Healthy Communities Initiative
HCV	Hepatitis C virus

HIP	Health Infrastructure Program
HITH	Hospital in the Home
HIV	Human Immunodeficiency Virus
HPS	Health Protection Service
HRC	ACT Human Rights Commission
HSU	Health Services Union
HPV	Human papillomavirus
HREC	Human Research Ethics Committee
HWA	Health Workforce Australia
IBLCE	International Board of Lactation Consultant Examiners
ICU	Intensive care unit
IMPACT	Integrated Multi-agencies for Parents and Children Together
IRCTN	Integrated Regional Clinical Training Network
ISS	ISS Health Services
JACSD	Justice and Community Services Directorate
LHN	Local hospital network
LSTS	Loan Scheme for Tertiary Study
MACH	Maternal and Child Health
MAPU	Medical Assessment and Planning Unit
MET	Medical Emergency Team
MEWS	Modified Early Warning Score
MHAGIC	Mental Health Assessment Generation and Information Collection
MHCPI	Mental Health Community Policing Initiative
MOU	Memorandum of understanding
NATA	National Association of Testing Authorities
NEAT	National Emergency Access Target
NEST	National Elective Surgery Target
NETS	Newborn Emergency Transport Service
NEWS	Neonatal Early Warning Score
NGO	Non-government organisation
NHMRC	National Health & Medical Research Council
NHRA	National Health Reform Agreement
NICU	Neonatal Intensive Care Unit
NIMC	National Inpatient Medication Chart
NIP	National Immunisation Program
NPAPH	National Partnership Agreement on Preventive Health
NPDI	National Perinatal Depression Initiative
NRVR	national recognition of veterinary registration
NSFATSIH	National Strategic Framework for Aboriginal and Torres Strait Islander Health
NSQHSS	National Safety and Quality Health Service Standards
OCHO	Office of the Chief Health Officer
OCYFS	Office of Child, Youth and Family Services
OH&S	Occupational health and safety
OMATSIA	Office of Aboriginal and Torres Strait Islander Affairs
OPG	Orthopantomograph
OPMHIU	Older Persons Mental Health Inpatient Unit
ORE	Occupational risk exposure
OSCAR	Online System for Comprehensive Activity Reporting
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
PCEHR	Personally Controlled Electronic Health Record
PCHR	Personal Child Health Record
PET	Positron Emission Tomography
PH&CDS	Primary Health and Chronic Disease Strategy Committee
PHD	Population Health Division
PIN	Provisional improvement notice
PMHCS	Perinatal Mental Health Consultation Service
PND	Perinatal depression
P&O	Prosthetics and Orthotics
PPEI	Promotion, prevention and early intervention
PPID	Positive patient identification
PPM	privately practising midwife
PRRAC	Palliative Radiotherapy Rapid Access Clinic
PRSC	Practitioner Regulation Subcommittee
PSS	Public Sector Superannuation Scheme Pharmaceutical Service Section People Strategy and Services
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
RADAR	Rapid Assessment of the Deteriorating and At-Risk
RCD	Residual current device
RCPA	Royal College of Pathologists of Australasia
RED	Respect, Equity, Diversity
RILU	Rehabilitation Independent Living Unit
ROGS	Review of Government Service
RPC	Respecting patient choices
RRC	Rapid Response Committee
SEA	Special Employment Arrangement
SHAHRD	ACT Ministerial Advisory Council on Sexual Health, HIV/AIDS, Hepatitis C and Related Diseases
SHFPACT	Sexual Health and Family Planning ACT
SHOUT	Self Help Organisations United Together
SLE	Simulated Learning Environment
SOG	Strategic Oversight Group
SOP	Standard operating procedure
SPIEWG	ACT Suicide Prevention Implementation and Evaluation Working Group
SRG	Survey Resource Group
SRRM	Seclusion and restraint review meetings
SRS	Stereotactic radiosurgery Social Research Subcommittee
STI	Sexually transmissible infection
TAMS	Territory and Municipal Services Directorate
TCH	(the) Canberra Hospital
TIA	Transient ischaemic attack
TIS	Translating and Interpreting Service
TRIM	Total Records Information Management
TTCP	Transitional Therapy and Care Program
UNSW	University of New South Wales
VMO	Visiting medical officer
VTE	Venous thromboembolism
WHA	Women's Health Australasia
WHO	World Health Organization
WHS	Women's Health Service
WiC	Walk-in Centre
WHOS	We Help Ourselves
WIL	Workplace Integrated Learning
WYC	Women, Youth & Children Division
YPN	Young Professionals' Network

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.
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.
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 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.

Copies of the ACT Health 2013–14 Annual Report is also available online at:
www.health.act.gov.au/2013–14annualreport

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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11 Moore Street, Canberra City ACT 2601
GPO Box 825, Canberra ACT 2601

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 2014
ACT Human Rights Commission Annual Report 2013–14
Australian hospital statistics 2012–13, Australian Institute of Health and Welfare
Australia's health 2014, Australian Institute of Health and Welfare

SECTION A

TRANSMITTAL CERTIFICATE

TRANSMITTAL CERTIFICATE

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 ACT Health.

I certify that the attached Annual Report is an honest and accurate account and that all material information on the operations of ACT Health during the period 1 July 2013 to 30 June 2014 has been included.

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

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 MBBS (Hons) FRANZCP
Director-General
5 September 2014

GPO Box 825 Canberra ACT 2601 | phone: 132281 | www.act.gov.au

SECTION B
PERFORMANCE
REPORTING

B.1 ORGANISATIONAL OVERVIEW

Vision and values

ACT Health's vision is 'Your Health—Our Priority.'

Our values are:

- Care
- Excellence
- Collaboration
- Integrity.

Our vision, and these values developed by ACT Health staff, represent what we believe is important and worthwhile. Our values underpin the way we work and how we treat others.

We aim to deliver the best service to meet the needs of our community.

Role, functions and services of the agency

ACT Health partners with the community and consumers for better health outcomes by:

- delivering patient- and family-centred care
- strengthening partnerships
- promoting good health and wellbeing
- improving access to appropriate health care, and
- having robust safety and quality systems.

We aim for sustainability and improved efficiency in the use of resources, by designing sustainable services to deliver outcomes efficiently, and embedding a culture of research and innovation.

ACT Health aims to support our people and strengthen teams, by helping staff to reach their potential, promoting a learning culture and providing high-level leadership.

Clients and stakeholders

ACT Health works closely with other ACT Government agencies such as the ACT Government's Community Services Directorate, Justice and Community Safety Directorate, Chief Minister and Treasury 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), ACT Medicare Local and mental health, alcohol and drug, and other community service providers.

The tertiary and training sectors remain key partners in the planning, development and delivery of healthcare 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 serve to assure the future supply of skilled health professionals.

Organisational structure

The ACT Health Organisational Chart (page 6) provides an overview of the structure of the Health Directorate on 30 June 2014.

ACT Health comprises four major divisions, each led by a Deputy Director-General reporting to the Director-General.

The ACT Health Director-General guides the organisation in delivering its vision.

The Deputy Director-General—Canberra Hospital and Health Services (CHHS) oversees the majority of staff working within the Health Directorate, and CHHS provides acute, sub-acute, primary and community-based health services to the population of the ACT and surrounding region. The Little Company of Mary also provides public hospital services through Calvary Public Hospital under a contractual agreement with ACT Health.

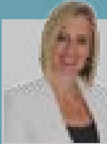
The Strategy and Corporate Division provides policy guidance, funding and strategic planning support to clinical service areas, while planning for ACT Health's future workforce and health service needs.

Health Infrastructure and Planning Division oversees the Health Infrastructure Program, which is the single largest capital works project undertaken in the history of the Australian Capital Territory. The Health Infrastructure Program involves the modernisation of all aspects of the ACT Health system.

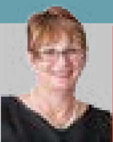
ACT Health's Population Health Division provides a range of public and environmental health services, health protection and health promotion services, under the guidance of the ACT Chief Health Officer/Deputy Director-General.

Other operational areas also report directly to the Director-General and provide a range of corporate support and organisation-wide services, such as quality and safety oversight and sound financial management.

Organisational chart



Minister for Health
Katy Gallagher

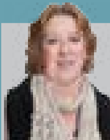


Director-General
Dr Peggy Brown

Deputy Director-General
Strategy & Corporate
Stephen Goggs

Chief Health Officer
Population Health
Dr Paul Kelly

Chief Finance Officer
Financial Management
Ron Foster

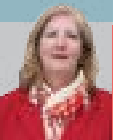


Deputy Director-General
Health Infrastructure & Planning
Jacinta George
A/g

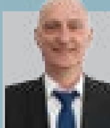
Deputy Director-General
Canberra Hospital & Health Services
Ian Thompson

Chief Information Officer, E-Health & Clinical Records
Judy Redmond

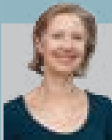
Executive Director
Policy & Government Relations
Ross O'Donoughue



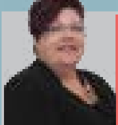
Executive Director
Business & Infrastructure
Rosemary Kennedy



Director
Performance Information
Phil Ghirardello

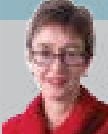


Quality and Safety
Libby Trickett



Director
People, Strategy & Services
Judi Childs

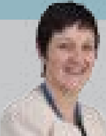
GP Advisor
Marianne Bookallil



Academic Unit of General Practice
Prof. Kirsty Douglas

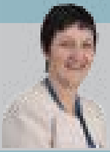
Chief Medical Administrator
Prof Frank Bowden
A/g

Executive Director
Division of Rehabilitation, Aged & Community Care
Linda Kohlhagen

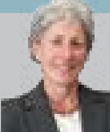


Executive Director
Division of Surgery, Oral Health & Imaging
Barbara Reid

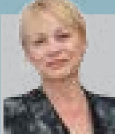
ACT Chief Nurse
Veronica Croome



Executive Director
Division of Critical Care
Barbara Reid
A/g



Executive Director
Division of Mental Health, Justice Health and Alcohol & Drug Services
Katrina Bracher

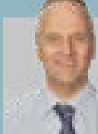


Executive Director
Division of Cancer, Ambulatory & Community Health Support
Denise Lamb

Executive Director
Division of Medicine
Rosemary O'Donnell

Executive Director
Division of Pathology
Prof Peter Collignon
A/g

Executive Director
Division of Women Youth & Children
Elizabeth Chatham

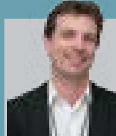


Director
Division of Clinical Support Services
Adrian Scott
A/g

Chief Allied Health Advisor
Karen Murphy

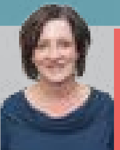
Senior Manager
Information Integrity
Charles Palmer

Director
Territory Wide Surgical Services
Dr Andrew Mitchell

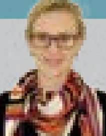


Director
DonateLife ACT
Dr Frank Van Haren

Manager
Canberra Hospital Foundation
Alexis Mohay



Senior Manager
Executive Coordination
Jackie Andersen



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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 through its key service divisions: Surgery, Oral Health and Imaging; Women, Youth and Children; Critical Care; Cancer, Ambulatory and Community Health Support; Rehabilitation, Aged and Community Care; Mental Health, Justice Health and Alcohol and Drug Service; Pathology; Medicine; and Clinical Support.

The key strategic priority for acute services is to deliver timely access to effective and safe hospital care services.

A significant achievement in 2013–14 was the opening of Stage 2 of the Centenary Hospital for Women and Children in December 2013, bringing services for women and children under one roof, including paediatrics and specialised outpatient services, maternity, birthing, gynaecology and fetal medicine, the Neonatal Intensive Care Unit and the Special Care Nursery. It has set a benchmark for women's, paediatric and newborn care within Australia.

Community health centres

ACT Health completed construction of Belconnen Community Health Centre in September 2013. The centre was officially opened and a community open day held in November 2013.

Refurbishment and expansion of the Tuggeranong Community Health Centre was completed in March 2014. Services recommenced and a community open day was held in March 2014.

The community health centres provide expanded health services to assist people to manage acute and chronic conditions in the community.

Walk-in centres

ACT Health fulfilled the ACT Government's election commitment to double the number of nurse-led walk-in centres (WiC), following the closure of the WiC on the Canberra Hospital (TCH) campus on 25 June 2014.

The TCH WiC demonstrated the model of care to be a safe and effective means of providing free, extended hours primary healthcare services to the public.

The Tuggeranong WiC opened to the public on 26 June 2014, and the Belconnen WiC opened on 1 July 2014.

National Elective Surgery Targets

As part of the National Elective Surgery Targets (NEST), the ACT was required to remove 11,000 people from the surgical waiting list in 2013–14.

Although the Canberra Hospital component of this target was 6300 removals, the hospital exceeded this target by delivering 6365 removals from the list. This contributed to the ACT meeting eight of the nine components of the NEST targets in 2013.

Moreover, Canberra Hospital is currently admitting 100 per cent of the most urgent, category 1 patients within the clinically recommended timeframe of 30 days.

Canberra Hospital Emergency Department performance

Canberra Hospital's Emergency Department (ED) had a total of 70,614 presentations in 2013–14, up by 7 per cent and the highest number of presentations for a year on record. Admissions to hospital via the ED also grew, with almost 24,000 admissions or 7 per cent growth in 2013–14.

Despite this increased demand, Canberra Hospital's ED timeliness for patients seen continued to improve. Overall triage category timeliness for 2013–14 was 54 per cent, a 9 per cent improvement when compared with the same period last year, and the best result for this indicator since 2004–05.

National Emergency Access Target (NEAT)

Canberra Hospital significantly reduced waiting times for patients in the ED against the National Emergency Access Target (NEAT). NEAT measures the proportion of patients who are either admitted to hospital or discharged from the ED within four hours of presenting.

Canberra Hospital's NEAT result improved in 2013, reaching 54 per cent, which is consistent with results of other similar-sized hospitals around the country. In the first six months of 2014, Canberra Hospital again improved its NEAT result, achieving 58 per cent.

The number of patients waiting to be seen by a doctor who actually leave before being seen reduced considerably in 2013–14. The 'did not wait' rate was 6 per cent, a 3 per cent improvement when compared with 2012–13. The result is particularly impressive for Canberra Hospital, given the increase in demand over 2013–14.

Public dental waiting list

Another significant achievement for CHHS was a reduction in the public dental waiting list.

Funding received under the National Partnership Agreement (NPA) has increased workforce capacity and the utilisation of the private sector to reduce public dental waiting lists.

The ACT was allocated $5.5 million over three years in January 2013. By June 2014, the Dental Health Program met baseline NPA activity targets, attracting an additional $2.5 million in 2013–14.

At 30 June 2014, there were 932 people waiting for non-urgent restorative dental services, compared to 1659 clients on the waiting list at 30 June 2013 and 2310 clients on the waiting list at 30 June 2012. The actual waiting time for restorative treatment at 30 June 2014 was three months, compared to 7.73 months at 30 June 2013 and 12.01 months at 30 June 2012.

The denture waiting list has also been reduced considerably, with 24 people waiting at 30 June 2014. The waiting time is now at 1.78 months, compared to 13.79 months at 30 June 2013 and 14.91 months at 30 June 2012.

Strategy and Corporate overview

The Strategy and Corporate division supports national health reforms and National Partnership Agreements, develops strategies for attraction and retention of the health workforce, and maintains critical physical and technological infrastructure for the ACT's hospitals and health services.

The Strategy and Corporate division consists of eight branches: Policy and Government Relations; Business and Infrastructure; People, Strategy and Services; Performance Information; eHealth and Clinical Records; Quality and Safety; Academic Unit of General Practice; and Canberra Region Prevocational Management Committee.

Strategy and Corporate administers ACT Health's contract for the provision of public hospital services by Calvary Health Care ACT at Bruce and at Clare Holland House, and supports these close working relationships. Calvary Health Care ACT's report on its achievements in 2013–14 is provided in an annexed report.

Senior appointments during the reporting period included Professor Kirsty Douglas as Director of the Academic Unit of General Practice (AUGP), Dr Marianne Bookallil as GP Advisor and Dr Andrew Mitchell as the Director of Territory Wide Surgical Services.

Much of the work supported by Strategy and Corporate appears elsewhere in this report. Other highlights for the division during this reporting period are set out below.

National Disability Insurance Scheme

The National Disability Insurance Scheme (NDIS) was launched on 1 July 2014 and its implementation continues across ACT Health. Strategy and Corporate's work in this area includes financial planning, service configuration, community sector contracting, phasing in for clients of ACT Health services, and workforce issues.

eHealth

In September 2013, ACT Health became the first jurisdiction with the capability to access and view national eHealth records within the existing clinical portal. This functionality builds on the work that had already been done to enable ACT Health to submit its clinical documents to the national Personally Controlled Electronic Health Record, and assists ACT Health in its commitment as an effective and efficient service provider.

Real-time reporting

For the first time, ACT Health is using real-time reporting to help clients make decisions about the best treatment options available to them. These initiatives improve the patient journey and contribute to the sustainability of the health service.

A web-based report called ED Live was developed during the reporting period and released to the public in July 2014. The website, the first of its kind for the Territory, reports on the current status of the two public hospital emergency departments. Clients can use this information to decide which service to access, and consider alternative services for less urgent medical needs. ED Live links to the Digital Canberra and dataACT Government strategies.

The Performance Information Portal now allows ACT Health users to view real-time activity in many areas of the organisation, as well as access historical trends and activities in particular areas of its operations. Further developments will be rolled out during 2014–15, including a theatre utilisation module and a bed management tool.

The ACT Health Surgeon Waiting Times web page has a new and improved format, containing different information on waiting times. The new format was developed with key stakeholders and shows the current number of people on each surgeon's waiting list and the median time waited. The web page also shows the number of theatre sessions allocated to each surgeon each four-week cycle. The web page will be updated monthly.

Wi-fi

To improve users' experience of ACT Health facilities, free wireless internet access for healthcare consumers is now available within the Canberra Hospital and community health centres at Belconnen, Tuggeranong and Gungahlin.

ACT Health is now recognised by the National E-Health Transition Authority as a leading jurisdiction in supply chains, after ACT Health's reforms in this area. In late 2013, Supply Services, with the assistance of Health ICT and SSICT, initiated a project to use wi-fi to replenish ward stock at Canberra Hospital. The wi-fi pilot program was completed in May 2014. Supply Services staff are now able to scan a ward imprest room and upload the replenishment order instantly, without disruption to service or time wastage. Warehouse staff are able to process orders, prioritise workflow and deliver supplies. This is a huge benefit for the warehouse and supply chain scheduling. With wi-fi, Supply Services is better equipped to handle the continued growth of the Canberra Hospital.

Systems and technology

ACT Health now trades electronically with 22 of its major suppliers, which represents about half of spending on medical and related consumables. Electronic catalogue synchronisation has reduced the number of price and payment variations for the trading suppliers, by more than 60 per cent. Electronic trading provides early shipping status from suppliers, and Supply Services (in the Business and Infrastructure Branch) uses this information to advise its internal customers of when goods can be expected to be delivered, enhancing the customer service experience.

In 2013–14, the Canberra Hospital Business Intelligence Unit was established as part of the Performance Information Branch. Information management staff were realigned to ensure a more consolidated approach to information provision across the organisation.

The eHealth and Clinical Records branch oversaw the upgrade of the clinical portal, including software and underlying ICT infrastructure.

The Data Warehouse core framework implemented in 2013–14 uses widely available technology to integrate, manage and share information via a web portal.

The division continued to use e-learning to strengthen staff skills and professionalism, including for the workplace induction pathway and training on writing, aseptic techniques and neonatal care. New e-learning programs were rolled out across the directorate, and others were updated. Further initiatives are addressed in E.2 Learning and development.

Reviews and planning

A significant review of the *Mental Health (Treatment and Care) Act 1994* was completed during the year, and an extensive amendment bill was tabled in the ACT Legislative Assembly on 15 May 2014.

Policy and Government Relations Branch has identified 20 strategic priorities for the ACT Alcohol, Tobacco and Other Drug Strategy for 2015–19. A draft for consultation is expected to be ready by late 2014.

In 2014–15, ACT Health will chair an inter-directorate committee to lead the development of a 10-year whole-of-government mental health and wellbeing (MH&W) framework. This framework will work towards the directorate's strategic priorities of continuing to meet the growth in demand for mental health services, and protecting vulnerable groups.

It will explicitly address self-harm and suicide prevention. The government acknowledges that many of the social determinants affecting mental health, wellbeing and suicide prevention lie outside the health domain and therefore require a whole-of-government, whole-of-community approach. The framework will be ready by July 2015.

A replacement for the *ACT Mental Health Services Plan 2009 – 2014* will be developed in parallel to the whole-of-government MH&W framework. The replacement will be specific to ACT Health and will sit within the *Health Directorate Corporate Plan 2012–2017*. It is also expected to be ready by July 2015.

A new reconciliation action plan is planned for release in July 2015.

Workforce planning

Workforce planning will be one of the key pillars required to support major projects and reviews across ACT Health, including the establishment of the University of Canberra Public Hospital. The abolition of Health Workforce Australia as part of the 2014–15 Federal Budget presents challenges and opportunities in this area, including the redesign of workforces to support the requirements of national registration and the Australian Health Practitioner Regulation Agency.

People Strategy and Services is also investigating strategies to support the retention of the mature workforce (those aged 45 and over).

Further information about People Strategy Services activities can be found in E.1 Human resources management reporting and E.4 Workplace relations.

Performance Information Branch

The review and redesign of the Performance Information Branch has progressed during the reporting period. The new structure is establishing a more streamlined governance and reporting arrangement; enhanced workflows and communication between business units; a strategic information management governance approach; a renewed data quality assurance framework; and a timely, efficient and responsive service for our clients' needs.

Digitisation

In addition to routine scanning of clinical records, the Clinical Record Service undertook a significant back-scanning project to digitise a range of paper records, including 'baby cards', and physiotherapy and medical oncology records. In total, 86,031 records were scanned by the Back-scanning Project Team, in addition to the usual scanning workload. A team of 26 temporary staff members was employed to carry out this work. During the first six months of 2014, the Clinical Coding Team achieved a 46 per cent reduction in the number of records waiting to be coded.

Research

The Academic Unit of General Practice (AUGP) has developed research activities that encompass child health, integrated service development, clinical research, individual routes to health and healing, social determinants of medical care, and scholarship in teaching and learning.

The AUGP has led the research stemming from the ACT Health Kindergarten Health Check, which it has been conducting with the school health nurses of the directorate's Women Youth and Children since 1998. During 2013–14, a new Kindergarten Health Check parent questionnaire was developed using validated survey tools. Research is currently being conducted on the most appropriate manner in which to give parents data on their child's body mass index. Work in 2015 will include a broad evaluation of the program.

Despite the rising rates of obesity, almost no research has been done regarding the management of obesity by general practitioners. The AUGP is reviewing the literature and synthesising the many clinical guidelines on obesity into a single document for use in general practice.

Future work will focus on developing more systematic and reliable ways to articulate, measure and value the complex nature of primary care consultation.

Canberra Region Prevocational Management Committee

The Canberra Region Prevocational Management Committee (CRPMC) was established in October 2013 to provide local contextual input to the junior medical officer accreditation process and to improve the overall junior doctor education and training program.

The program had previously been assessed by the Health Education and Training Institute of NSW. CRPMC, a body with direct and comprehensive knowledge of the ACT context, will now oversee and improve the program, and will work to establish a clearer and more effective governance structure in this area. It expects to apply to the Australian Medical Council to become an accrediting body.

Sustainability

In early 2014, two Nissan LEAF electric vehicles became part of ACT Health's motor vehicle fleet, as part of an ACT Government initiative. Staff were trained in the use of the electric vehicles, which proved very popular.

In 2014–15, Strategy and Corporate will explore opportunities to include additional electric vehicles in the fleet. Charge stations have been included as part of the major upgrade to the Tuggeranong Community Health Centre.

Health Infrastructure and Planning overview

Health Infrastructure and Planning Division 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.

The division also directs and manages ACT Health's Health Infrastructure Program, which includes health planning, coordination, management and implementation. It is also responsible for strategic accommodation, the Capital Upgrades Program and the Arts in Health Program.

Planning activities

During 2013–14, Health Infrastructure and Planning conducted planning activity for the *ACT Health Business Plan 2013–14*, the draft *Clinical Services Plan 2014–2018*, the draft *ACT and Southern NSW Local Health District Cancer Services Plan 2014–2018*, and capital and facility planning in support of the Health Infrastructure Program.

Health Infrastructure Program

The Health Infrastructure Program delivered a number of significant projects in 2013–14, including:

- Canberra Hospital Emergency Department and Intensive Care Unit extension
- Centenary Hospital for Women and Children, Stage 2
- Belconnen Community Health Centre
- Tuggeranong Community Health Centre
- Tuggeranong Walk-in Centre
- Belconnen Walk-in Centre.

Section F.3 Capital Works, provides a detailed description of the progress on Health Infrastructure Program works.

Staging and decanting

The staging and decanting project provides for the continuity of services and multiple sub-projects that are a core requirement during the rollout of the Health Infrastructure Program.

Staging and decanting projects include:

- relocating services and staff from various facilities to allow building works to progress
- providing capacity for planned bed growth for service continuity
- implementing strategies to ensure health service operations are not adversely affected during the demolition, rebuilding and refurbishment work on facilities.

Staging and decanting projects completed in 2013–14 are as follows:

- the re-design and refurbishment of the former Emergency Services Australia building in Curtin to relocate staff from various sites to free up space in other health facilities
- Gaunt Place—refurbishment and relocation of peritoneal dialysis
- Canberra Hospital, Building 1, Level 7—additional beds
- Canberra Hospital, Building 1, Level 8—additional beds
- Canberra Hospital, Ward 14A, additional oncology clinics and office space
- the relocation project of administrative staff from Calvary campus to Thynne Street, Bruce, which enabled the space released on the Calvary campus to be used for clinical care
- the Calvary Car Park Feasibility Study to determine the future car parking requirements for both the public and private hospitals at the Calvary campus
- Gungahlin Community Health Centre—relocation of staff to the new centre
- Belconnen Community Health Centre—relocation of staff and services to the new facility
- Centenary Hospital for Women and Children—relocation of staff and services to the new facility
- 12 Moore Street—redesign and refurbishment of a leased area to provide office space
- Tuggeranong Community Health Centre—relocation of staff and services into the new facility. This includes the fitting out and decant from the temporary decanting site, Greenway Waters Suites.

Planned staging and decanting projects in 2014–15 include:

- finalisation of the refurbishment of Building 1, Level 5, at the Canberra Hospital for inpatient wards
- commencement of construction works for a series of subprojects to provide clinical and office space for decanting at the Canberra Hospital.

Arts in Health Program

The Arts in Health Program includes the development and implementation of briefs for art in new Health Infrastructure Program projects. In 2013–14, this included the procurement of works for the Centenary Hospital for Women and Children, the Canberra Region Cancer Centre and the new and refurbished community health centres.

Corporate and operational plans

The following planning instruments and strategies have guided ACT Health's efforts over the reporting year.

Corporate Plan 2012–2017

The Corporate Plan articulates key focus areas, priorities for improvement, key strategies for achieving the priorities, and achievements planned for the long term (five years).

In 2013–14, ACT Health continued to measure its performance against these areas through key performance measures identified in the ACT Public Health Service's quarterly performance report, ACT Health's strategic and accountability indicator sets in the ACT Budget Papers. The target achievements for each year are contained in ACT Health's Business Plan.

Clinical Services Plan 2014–2018

The Clinical Services Plan is being finalised following extensive consultation with stakeholders and taking into consideration recent federal budget announcements. The plan will provide strategic guidance for the development of publicly funded health services in the ACT. The strategies in the plan have been developed to position ACT Health to meet future demand for health services and improve access for those most in need.

ACT Primary Health Care Strategy 2011–2014

The ACT Primary Health Care Strategy 2011–2014 aims to improve integration between general practice and the wider primary health care sector in the provision of primary health care. Six-monthly reports outlining progress against the annual implementation plan are provided to the ACT Health Executive Council and primary health care stakeholders.

Safety and Quality Framework 2010–2015

The Safety and Quality Framework 2010–2015 describes a vision and direction to improve safety and quality in ACT Health. It sets out organisational activities which will improve the safety and quality of ACT Health services. The framework is being reviewed against the areas for action and alignment with the 10 National Safety and Quality Health Service Standards (NSQHSS). The framework provides actions under three themes. These align with the themes of the Australian Commission on Safety and Quality in Health Care's framework, which provides a national vision for safe and high-quality health care for Australia. These themes are that care will be consumer centred, driven by information and organised for safety.

To meet these themes, the Quality and Safety Branch:

- Coordinated the performance of two plays written exclusively for healthcare professionals, patients and organisations: Hear Me explored the impact of medication errors and the importance of patient-centred care, and Four Funerals in One Day explored how individuals, including healthcare professionals, cope with death and grief
- submitted a successful budget initiative proposal to resource and enhance the Respecting Patient Choices® (RPC) Program to which included provision for a NGO to provide community education and awareness focused on culturally and linguistically diverse populations in the ACT region
- coordinated a promotional campaign with standard groups raising awareness of the National Safety and Quality Health Service Standards. Each standard had a promotional month where QSB provided:
  - promotional materials labelled with the relevant national standard icon
  - a stand in the foyer of Canberra Hospital
  - screensavers on computers and posters
  - quizzes and word searches to raise staff awareness
- released the Surgical Safety Checklist video to increase theatre staff's understanding of the value of the checklist and how to use it
- engaged Governance Plus to assist with preparation for the organisation-wide accreditation survey. The review resulted in the proposal to restructure quality and safety resources from the Quality and Safety Branch to CHHS

- continued the Effective Communication in Clinical Handover (ECCHO) project, an Australian Research Council funding project in collaboration with the University of Technology Sydney. A new grant was awarded in 2014 with a focus on handover for those over 65 years of age
- continued Open Disclosure Master Classes for senior clinical and executive staff
- facilitated the ACT Quality in Healthcare Awards and the ACT Health Better Practice Awards
- worked with the Local Hospital Network Council to develop a concept for a safety and quality report for consumers based around the 10 NSQHSS
- implemented the Oral Dispensers and Enteral Feeding project in response to increased awareness nationally of wrong route errors
- facilitated the Family Escalation Program, Call and Respond Early (CARE)
- implemented the web-based Safety Management System for ACT Health staff.

Chronic Conditions Strategy 2013–2018

The ACT Chronic Conditions Strategy—Improving Care and Support 2013–2018 provides overarching direction for chronic condition care and support in the ACT for the next five years and outlines the requirement for a coordinated approach across the government and non-government sector. It concentrates on improving care and support services for every person living with a chronic condition.

ACT Palliative Care Services Plan 2013–2017

People with a life-threatening illness in the ACT and their families and carers need timely access to quality palliative care that is consumer and carer focused, respects their choices and is appropriate to their needs. The ACT Palliative Care Services Plan 2013–2017 provides strategic direction for the development of palliative care in the ACT to best meet current and projected population needs.

ACT Children's Plan 2010–2014

The ACT Children's Plan 2010–2014 was launched in June 2010 to provide an aspirational whole-of-government and whole-of-community vision to make Canberra a great and safe place for children and to ensure their needs are a priority for government and community. Its aim is for Canberra to be a child- and youth-friendly city that supports all children and young people to reach their potential, make a contribution and share the benefits of our community.

ACT Mental Health Services Plan 2009–2014

The ACT Mental Health Services Plan 2009–2014 is a strategic-level document giving broad direction for the future development of public mental health services in the ACT. It was developed in consultation with stakeholders over a two-year period. The plan covers the years 2009 to 2014 but conveys a vision for how mental health services will be delivered in the ACT in 20 years' time.

The guiding vision for mental health services in the ACT is that by 2020 the mental health needs of the community will be met by a comprehensive network of complementary and integrated mental health services that enhance knowledge and understanding, intervene and provide support early and for as long as is necessary, and address as far as possible mental health issues in community settings, working with and developing natural systems of support.

Managing the Risk of Suicide: A Suicide Prevention Strategy for the ACT 2009–2014

This strategy provides a service development framework to guide an integrated, whole-of-community approach to suicide prevention across the lifespan. It aims to: reduce rates of suicide and self-harm in the ACT; increase resilience, coping skills and connectedness; improve awareness of, and access to, suicide prevention training, education and information; and increase collaboration among organisations providing suicide prevention and postvention services in the ACT.

ACT Aboriginal and Torres Strait Islander Health Plan 2014–2019

A draft discussion paper on the development of a new Aboriginal and Torres Strait Islander Health Plan 2014–2019 has been developed and will inform the community consultations due to take place in 2014. The review of several national Aboriginal and Torres Strait Islander plans, strategies and frameworks, including outcomes from consultations with the local Aboriginal and Torres Strait Islander communities, was completed.

Community organisations and members of the new ACT Aboriginal and Torres Strait Islander Elected Body will be invited to a community consultation workshop to discuss health issues and contribute to the development of a new health plan.

Health Workforce Plan 2013–2018

The ACT Health Workforce Plan 2013–2018 aligns with national health workforce reform, including the research and evidence provided by the Health Workforce Australia (HWA) National Health Workforce Innovation and Reform Strategic Framework for Action 2011–2015. The plan provides strategies under focus areas for direction, action, accountabilities and measures of success, which are able to be applied for operational workforce planning in all areas of ACT Health. In 2013–14, a Tier 1 Workforce Innovation and Reform Committee was formed to oversee the rollout of actions and implementation of the plan.

ACT Breastfeeding Strategic Framework 2010–2015

The ACT Breastfeeding Strategic Framework 2010–2015 sets the context for the protection, promotion and support of breastfeeding in the ACT. The framework is consistent with, and supports the implementation of, the action areas in the Australian National Breastfeeding Strategy 2010–2015. In November 2013, ACT Health gained Breastfeeding-Friendly Workplace (BFW) accreditation for its 12 breastfeeding rooms.

ACT Alcohol, Tobacco and Other Drug Strategy 2010–2014

In 2014, the Minister for Health approved the commencement of work on the ACT Alcohol, Tobacco and Other Drug Strategy 2015–2019.

A status report on actions implemented under the ACT Alcohol, Tobacco and Other Drug Strategy 2010–2014 prepared for the ACT Alcohol, Tobacco and Other Drug Strategy Evaluation Group indicated that, of the 66 actions in the strategy, 77 per cent had been started. Of these, 28 per cent had been completed, 17 per cent had been partially completed and 32 per cent were ongoing; 23 per cent of actions had not been completed.

Towards Culturally Appropriate and Inclusive Services—A Coordinating Framework for ACT Health 2014–18

A new Multicultural Health Policy Unit (MCHPU) within Policy and Government Relations was established and commenced on 1 July 2013. Its role is to facilitate an organisation-wide approach to multicultural health issues so that culturally and linguistically appropriate services and information are a focus not only in clinical areas but across the organisation, including in preventive health, health promotion and public health services.

After extensive consultation, the MCHPU developed a strategic document to improve responsiveness to cultural and linguistic diversity across the organisation.

Summary of performance

ACT Health performed well against a range of strategic priorities over the reporting period.

Preliminary results show that 11,780 people were removed from the ACT elective surgery waiting list in 2013–14.

ACT Health saw 100 per cent of emergency dental clients within 24 hours.

100 per cent of urgent, semi-urgent and non-urgent radiotherapy patients commenced treatment within standard time frames.

56 per cent of women in the target age group (50 to 69 years) had a breast screen in the 24 months prior to each counting period, slightly below the target for 2013–14 of 60 per cent.

ACT Health met its responsiveness target for the Aged Care Assessment Team (ACAT) of two days to assess the needs of clients for patients in public hospitals.

Public mental health services were effective over time in providing services that minimise the need for seclusion, with 1.8 per cent of mental health clients subject to a seclusion episode while being an admitted patient in an ACT public mental health inpatient unit.

Only 6.9 per cent of clients returned to hospital within 28 days of discharge from an ACT public acute psychiatric unit following an acute episode of care, reflecting the high quality of care provided to acute mental health patients.

ACT public hospitals achieved an average bed occupancy rate of 90 per cent over the reporting period, an improvement on the 92 per cent reported for 2012–13.

The ACT continues to enjoy the highest life expectancy of any jurisdiction in Australia.

Life expectancy at birth of 85.1 years for females in the ACT (against a national average of 84.3 years) and 81.2 years for males (against a national average of 79.9 years) indicates the general health of the population and reflects on a range of issues other than the provision of health services, such as economic and environmental factors.

The prevalence of diabetes in the ACT, of 3.8 per cent, was similar to the national rate of 3.7 per cent.

The ACT comfortably exceeded the national rate of expenditure on infrastructure. The Australian Institute of Health and Welfare (AIHW) reported that in 2010–11 the ACT recorded an investment rate of 3.84 per cent (against a national rate of 2.15 per cent) in capital expenditure on healthcare infrastructure.

Reflecting ACT Health's priority of reducing the long-term chronic disease burden, the AIHW also reported that in 2010–11 the ACT recorded a rate of 2.6 per cent (against a national average of 2.1 per cent) for total government expenditure on public health activities as a proportion of total current health expenditure.

Overall, the ACT Aboriginal and Torres Strait Islander immunisation rate of 92.6 per cent indicates a high level of investment in public health services to minimise the incidence of vaccine-preventable diseases among the ACT's Aboriginal and Torres Strait Islander population.

For the two-year participation rate in the cervical screening program, the ACT achieved 57 per cent, exceeding the national average of 57.2 per cent and demonstrating the effectiveness of early intervention health messages.

According to the AIHW, the ACT achieved lower than the Australian average in the decayed, missing, or filled teeth (DMFT) index both at six years and 12 years of age benchmarks, which is the lowest of all jurisdictions.

In 2013–14, the ACT rate of admissions in persons aged 75 years and over with a fractured neck of femur was 5.3 per 1000 persons in the ACT population, slightly below the long-term target and following a generally decreasing trend over the 10-year period from 2001–02, indicating the success of public and community health initiatives to prevent hip fractures.

Results from the 2011 Australian Secondary School Alcohol and Drug Survey (ASSAD) show that 5.8 per cent of students were current smokers in that year, well below the national average. This demonstrates a continued decline in smoking, from 15.3 per cent in 2001 to 5.8 per cent in 2011.

Outlook for 2014–15

Although there are many challenges in the year ahead, 2014–15 promises to be another year of growth and achievement for ACT Health.

Despite significant changes to Commonwealth funding for health and hospital services as announced in the federal budget in May 2014, continued investment in health by the ACT Government will see recurrent spending approach $1.4 billion.

There will be additional endoscopy services and elective surgery, including public bariatric surgical services for the first time in the ACT.

More beds will be opened at Canberra Hospital, Calvary Public Hospital and the Centenary Hospital for Women and Children. This will be complemented by additional resources for the emergency departments at both Canberra Hospital and Calvary Public Hospital and for Belconnen and Tuggeranong Community Health Centres. Walk-in centres will now operate at both of these sites, meeting the needs of the community for treatment of one-off minor injuries and illnesses.

The newly opened Canberra Regional Cancer Centre will also receive a boost in staffing levels.

There will be continued expansion of community nursing and ambulatory care services at Canberra Hospital, expansion of community-based mental health services and further investment in suicide prevention services and lymphoedema services.

Along with this investment in additional staff and services, we will be working to transform our services, through service innovation and redesign, to deliver the most care in the most cost-efficient and effective way. Working collaboratively with healthcare consumers and the primary care sector will be central to achieving this objective, and the launch of Health Pathways will be a key milestone, signalling new ways of working across the spectrum of care.

This approach will complement the work done on models of care through the Health Infrastructure Program. The continued investment in new e-health services will also support the transformation of service delivery.

Under the Health Infrastructure Program, work will commence on construction of the Calvary car park and the Secure Mental Health Unit as well as the University of Canberra Public Hospital at Bruce. A dedicated area for paediatrics within the Emergency Department at Canberra Hospital will also be progressed, along with a range of staging and decanting projects.

Post-occupancy evaluations will also be delivered on the Adult Mental Health Unit, the Mental Health Assessment Unit and Gungahlin Community Health Centre to inform our continuing developments under the Health Infrastructure Program.

The Healthy Weight Initiative will remain a key focus for ACT Health as part of the whole-of-government initiative to reduce the of growth in obesity in our population.

Importantly, ACT Health will undergo an accreditation survey against the National Health and Safety Standards in May 2015.

B.2 PERFORMANCE ANALYSIS

Health Directorate Strategic Indicators

Strategic objective 1: Removals from waiting list for elective surgery

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

Strategic indicator 1: Number of people removed from waiting list

	2013–14 Target	2013–14 Result
People removed from the ACT elective surgery waiting list for surgery	11,000	11,780

Strategic objective 2: No waiting for access to emergency dental health services

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

Strategic indicator 2: Percentage of assessed emergency clients seen within 24 hours

	2013–14 Target	2013–14 Result
Percentage of emergency clients seen within 24 hours	100%	100%

Strategic objective 3: Improving timeliness of access to radiotherapy services

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

Strategic indicator 3: Percentage of radiotherapy patients who commence treatment within standard time frames

	2013–14 Target	2013–14 Result
Category		
Urgent — treatment starts within 48 hours	100%	100%
Semi-urgent — treatment starts within 4 weeks[1]	95%	100%
Non-urgent — treatment starts within 6 weeks[1]	95%	100%

Notes:

1 Discontinued measure. This measure was replaced to match National Radiation Oncology Practice Standards.

Strategic objective 4: Improving the breast screen participation rate for women aged 50 to 69 years

Strategic indicator 4: The proportion of women in the target age group (50 to 69 years) who had a breast screen in the 24 months prior to each counting period.

	2013–14 Target	2013–14 Result
Proportion of women aged 50 to 69 who had a breast screen	60%	56%

Strategic objective 5: Maintaining the waiting times for in-hospital assessments by the Aged Care Assessment Team

This provides an indication of the responsiveness of the Aged Care Assessment Team (ACAT) in assessing the needs of clients.

Strategic indicator 5: The mean waiting time in working days between the request for, and provision of, assessment by ACAT for patients in public hospitals

	2013–14 Target	2013–14 Result
Mean waiting time in working days	2 days	1.9 days

Strategic objective 6: Reducing the usage of seclusion in mental health episodes

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

Strategic indicator 6: The proportion of mental health clients who are subject to a seclusion episode while being an admitted patient in an ACT public mental health inpatient unit

	2013–14 Target	2013–14 Result
The proportion of mental health clients who are subject to a seclusion episode while being an admitted patient in an ACT public mental health inpatient unit	<3%	1.8%

Strategic objective 7: Maintaining reduced rates of patient return to an ACT public acute psychiatric inpatient unit

This indicator reflects the quality of care provided to acute mental health patients.

Strategic indicator 7: The proportion of clients who return to hospital within 28 days of discharge from an ACT public acute psychiatric unit following an acute episode of care

	2013–14 Target	2013–14 Result
Proportion of clients who return to hospital within 28 days of discharge from an ACT acute psychiatric mental health inpatient unit	<10%	6.9%

Strategic objective 8: Reaching the optimum occupancy rate for all overnight hospital beds

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

Strategic indicator 8: The mean percentage of overnight hospital beds in use

	2013–14 Target	2013–14 Result
Mean percentage of overnight hospital beds in use	90%	90%

Strategic objective 9: Management of chronic disease: maintenance of the highest life expectancy at birth in Australia

Australians are living longer, and gains in life expectancy are continuing. Premature deaths (those of people aged under 75 years) from leading potentially preventable chronic diseases have decreased by 17 per cent between 1997 and 2007.

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

Strategic indicator 9: Life expectancy at birth in Australia 2012

	ACT rate (years)	National rate (years)
Females	85.1	84.3
Males	81.2	79.9

Source: ABS 2012, Deaths, Australia, 2012, cat. no. 3302.0, ABS, Canberra.

Strategic objective 10: Lower prevalence of circulatory disease than the national average

Population projections suggest that the ACT population is ageing faster than other jurisdictions. The median age of the ACT population (36.9 years in 2010) has increased by 4.8 years since 1990. While people of all ages can present with a chronic disease, the ageing of the population and longer life spans mean that chronic diseases will place major demands on the health system for workforce and financial resources.

Strategic indicator 10: Proportion of the ACT population with some form of cardiovascular disease

	ACT rate	National rate
Proportion of the population diagnosed with some form of cardiovascular disease	18.4%	16.9%

Source: Australian Health Survey: First Results, 2011–12. Australian Bureau of Statistics Catalogue No: 4364.0.55.001.

Strategic objective 11: Lower prevalence of diabetes than the national average

This indicator provides a marker 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 as 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. The prevalence of diabetes in the ACT was similar to the national rate.

Strategic indicator 11: Proportion of the ACT population diagnosed with some form of diabetes

	ACT rate	National rate
Prevalence of diabetes in the ACT	3.8%	3.7%

Source: Australian Health Survey: First Results, 2011–12.Australian Bureau of Statistics Catalogue No: 4364.0.55.00.

Strategic objective 12: Government capital expenditure on healthcare infrastructure

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 aim for the ACT is to exceed the national rate of expenditure on infrastructure.

Strategic indicator 12: Capital consumption

	ACT rate	National rate
Government[1] capital expenditure as a proportion of government[2] capital consumption expenditure by healthcare facilities		
2008–09	2.76%	1.90%
2009–10	2.67%	1.57%
2010–11	3.84%	2.15%

Source: Health Expenditure Australia 2010–11 (Australian Institute of Health and Welfare).

Notes:

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

Strategic objective 13: Higher proportion of government recurrent health funding expenditure on public health activities than the national average

Improvements in the 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 exceed the Australian average rate of recurrent health funding on public health activities as a strategy to reduce the long-term chronic disease burden.

Strategic indicator 13: Estimated total government expenditure on public health activities as a proportion of total current health expenditure

	ACT rate	National rate
2008–09	3.1%	2.7%
2009–10	2.7%	2.2%
2010–11	2.6%	2.1%

Source: Health Expenditure Australia 2010–11 (Australian Institute of Health and Welfare).

Strategic objective 14: Addressing gaps in Aboriginal and Torres Strait Islander immunisation status

The immunisation rate provides an indication of the level of investment in public health services to minimise the incidence of vaccine preventable diseases. The ACT has low numbers of Aboriginal and Torres Strait Islander children, which can result in wide fluctuations in coverage rates. The ACT's Aboriginal and Torres Strait Islander population often has a lower rate of immunisation than the general population. The ACT aims to minimise disparities between Indigenous and non-Indigenous Australians through a targeted immunisation strategy.

Strategic indicator 14: Immunisation rates – ACT Aboriginal and Torres Strait Islander population

	2013–14 Target	2013–14 Result
Immunisation rates[1] for vaccines in the national schedule for the ACT indigenous population		
12 to 15 months	≥90%	89.7%
24 to 27 months	≥90%	94.8%
60 to 63 months	≥90%	93.7%
All	≥90%	92.6%

Notes:

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. This small population can cause rate fluctuations.*

Strategic objective 15: Higher participation rate in the cervical screening program than the national average

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.

Strategic indicator 15: Two-year participation rate in the cervical screening program

	ACT rate	National rate
Two-year participation rate	57.6%	57.2%

Source: Cervical screening in Australia 2010–11 (Australian Institute of Health and Welfare, June 2013).

Strategic objective 16: Achieve lower than the Australian average in the decayed, missing, or filled teeth (DMFT) index

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

Strategic indicator 16: The mean number of teeth with dental decay, missing or filled teeth at ages 6 and 12

	ACT rate[1]	National rate
DMFT index at 6 years	1.03	2.13
DMFT index at 12 years	0.70	1.05

Source: Child Dental Health Survey, 2009 (Australian Institute of Health and Welfare, 2013).

Notes:

1 Lowest of all jurisdictions.

Strategic objective 17: Reducing the risk of fractured femurs in ACT residents aged over 75 years

This provides an indication of the success of public and community health initiatives to prevent hip fractures. In 2012–13, the ACT rate of admissions in persons aged 75 years and over with a fractured neck of femur was 5.5 per 1,000 persons in the ACT population. This is slightly above the long-term target and follows a generally decreasing trend over the 10-year period from 2001–02.

Strategic indicator 17: Reduction in the rate of broken hips (fractured neck of femur)

	2013–14 Target	2013–14 Result
Rate per 1,000 people	5.5	5.3

Source: ACT Admitted Patient Care data, 2012–13.

Strategic objective 18: Reduction in the youth smoking rate

Results from the 2011 Australian Secondary School Alcohol and Drug Survey (ASSAD) show that 5.8 per cent of students were current smokers in that year. This demonstrates a continued decline in current smoking from 15.3 per cent in 2001, to 6.7 per cent in 2008, and to 5.8 per cent in 2011. The national rate for current smoking in youths in 2011 was 6.7 per cent.

Strategic indicator 18: Percentage of persons aged 12 to 17 years who smoke regularly

	2011 Outcome	National rate
Percentage of persons aged 12 to 17 who are current smokers	5.8%	6.7%

Source: ASSAD confidentialised unit record files 2011, ACT Health. Australian secondary students' use of tobacco, alcohol, and over-the-counter and illicit substances in 2011 report, Cancer Council Victoria, December 2012.

Local Hospital Network strategic objectives and indicators

The ACT Local Hospital Network Directorate (ACT LHN) consists of a networked system that includes the Canberra Hospital and Health Services, Calvary Hospital, Clare Holland House and Queen Elizabeth II Family Centre. The ACT LHN has a yearly service level agreement (SLA) which sets out the delivery of public hospital services and is agreed between the ACT Minister for Health and the Director General of the ACT LHN. This SLA identifies the funding and activity to be delivered by the ACT LHN and key performance priority targets. The ACT Government manages system-wide public hospital service delivery, planning and performance, including the purchasing of public hospital services and capital planning, and is responsible for the management of the ACT LHN.

The following strategic indicators include some of the major performance indicators implemented under the requirements of the National Health Reform Agreement.

Strategic objective 1: Percentage of elective surgery cases admitted on time by clinical urgency

Strategic indicator 1: Percentage of elective surgery cases admitted on time by clinical urgency

Clinically recommended time by urgency category	2013 Target[1]	2013 Result
Urgent – admission within 30 days is desirable for a condition that has the potential to deteriorate quickly to the point that it may become an emergency	97%	97.6%
Semi-urgent – admission within 90 days is desirable for a condition causing some pain, dysfunction or disability which is not likely to deteriorate quickly or become an emergency	66%	65.7%
Non-urgent – admission at some time in the future is acceptable for a condition causing minimal or no pain, dysfunction or disability, which is not likely to deteriorate quickly and which does not have the potential to become an emergency[2]	86%	90.4%

Notes:

1 Targets are based on calendar year data in accordance with national reporting requirements.

2 Health Directorate establishes a 365-day maximum desirable waiting time for category 3 non-urgent patients.

Strategic objective 2: Improved emergency department timeliness

Strategic indicator 2.1: The proportion of emergency department presentations that are treated within clinically appropriate time frames

	2013 Target	2013 Result
One (resuscitation, seen immediately)	100%	100%
Two (emergency, seen within 10 mins)	80%	83%
Three (urgent, seen within 30 mins)	75%	50%
Four (semi-urgent, seen within 60 mins)	70%	57%
Five (non-urgent, seen within 120 mins)	70%	86%
All presentations	70%	61%

Strategic indicator 2.2: The proportion of Emergency Department presentations whose length of stay in the emergency department is four hours or less

	2013 Target[1]	2013 Result
The proportion of Emergency Department presentations who physically leave the Emergency Department for admission to hospital, are referred for treatment or are discharged, whose total time in the Emergency Department is within four hours.	65%	59%

Notes:

1 Targets are based on calendar year data in accordance with national reporting requirements.

Strategic objective 3: Maximising the quality of hospital services

The following four 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 in meeting these indicators requires a consideration of performance over time rather than for any given period.

This indicator represents the quality of theatre and post-operative care.

Strategic indicator 3.1: The 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

	2013–14 Target[1]	2013–14 Result[2]
Canberra Hospital	<1.0%	0.6%
Calvary Public Hospital	<0.5%	0.3%

Notes:

1. *Hospital targets are based on similar rates for peer hospitals, based on the Australian Council of Healthcare Standards (ACHS).*
2. *Canberra Hospital & Health Services (CHHS) results have only been reported to May 2014 due to the larger cohort of patients that need to be clinically reviewed. As this process can take some time, results for CHHS have been reported from 1 July 2013 to 31 May 2014.*

Strategic indicator 3.2: The proportion of people separated from ACT public hospitals who are readmitted 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 indicator highlights the effectiveness of hospital-based and community services in the ACT in the treatment of persons who receive hospital-based care.

	2013–14 Target	2013–14 Result[1]
Canberra Hospital	<2.0%	1.2%
Calvary Public Hospital	<1.0%	0.5%

Notes:

1. *Canberra Hospital & Health Services (CHHS) results have only been reported to May 2014 due to the larger cohort of patients that need to be clinically reviewed. As this process can take some time, results for CHHS have been reported from 1 July 2013 to 31 May 2014.*

Strategic indicator 3.3: The number of people admitted to hospitals per 10,000 occupied bed days who acquire a staphylococcus aureus bacteraemia infection (SAB infection) during their stay

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

	2013–14 Target	2013–14 Result[1]
Canberra Hospital	<2 per 10,000	1.2 per 10,000
Calvary Public Hospital	<2 per 10,000	0.3 per 10,000

Note:

1. *Very small numbers can cause fluctuations in the results for this strategic indicator.*

Strategic indicator 3.4: The estimated hand hygiene rate

The estimated hand hygiene rate for a hospital is a measure of how often (as a percentage) hand hygiene is correctly performed.

It is calculated by dividing the number of observed hand hygiene 'moments' where proper hand hygiene was practised in a specified audit period, by the total number of observed hand hygiene 'moments' in the same audit period.

	2013–14 Target	2013–14 Result
Canberra Hospital	70%	72.5%
Calvary Public Hospital	70%	75.6%

Output 1.1 Acute Services

Output description

The Canberra Hospital provides 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 focusing on:

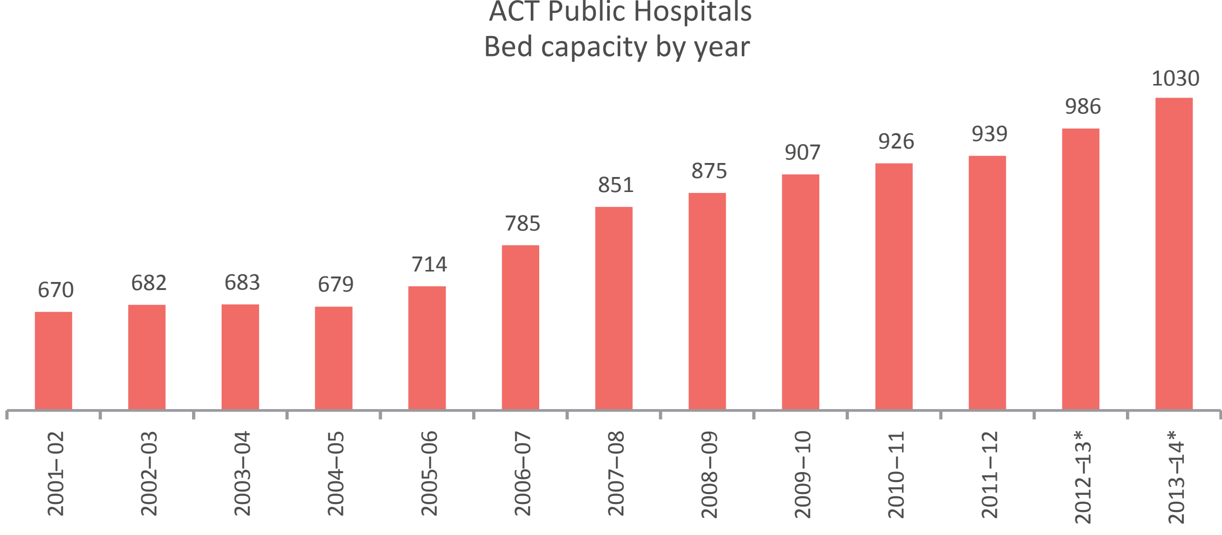
- implementing work arising from the National Health Reform Agreement which the Commonwealth Government has put into place, that contains a number of national partnerships and agreements, with the aim of improving services to the Australian community
- strategies to improve access to emergency services under the NHRA
- meeting the increasing demand for elective surgery in the Territory and reducing the number of people waiting longer than the recommended standard waiting times
- strategies to meet performance targets for the emergency department, elective and emergency surgery, and
- continuing to increase the capacity of acute care services within the ACT and surrounding region.

ACT Public Hospitals—increasing the capacity of the ACT's public health services

More beds to manage increasing demand for hospital services

The Australian Institute of Health and Welfare (AIHW) reported that in 2012–13 ACT public hospitals provided an average of 986 beds.

ACT Public Hospitals
Bed capacity by year



* 2013–14 figures provides estimated impact of Government investment in additional capacity

Source: Australian Hospital Statistics , AIHW, 2001–2002 to 2012–13 publications

The ACT Government funded a further 44 inpatient beds in 2013–14, including:

- 16 general inpatient beds at Canberra Hospital
- 15 general inpatient beds at Calvary Public Hospital
- an 8-bed Rapid Assessment and Planning Unit at Calvary Public Hospital
- 5 new beds in the Centenary Hospital for Women and Children.

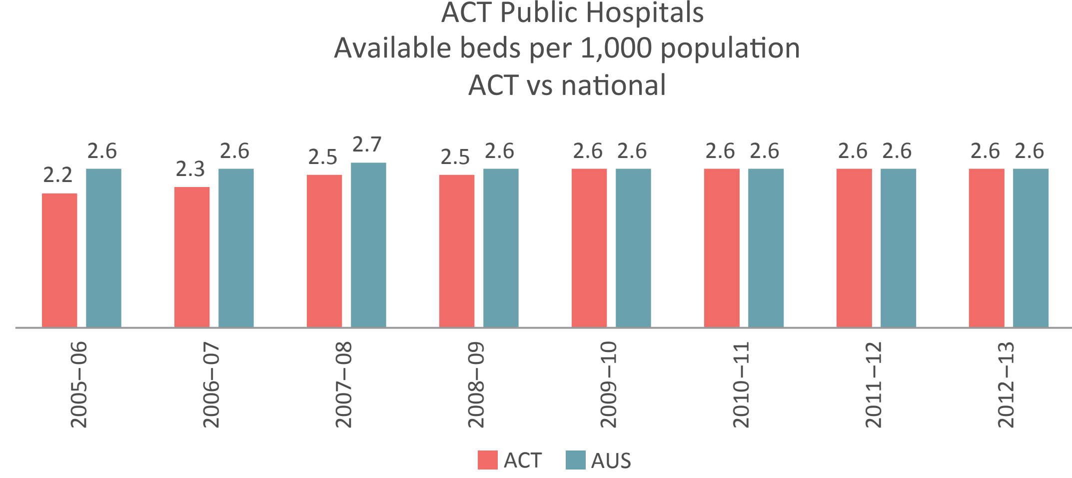
This represents an extra 360 beds since 2001–02.

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

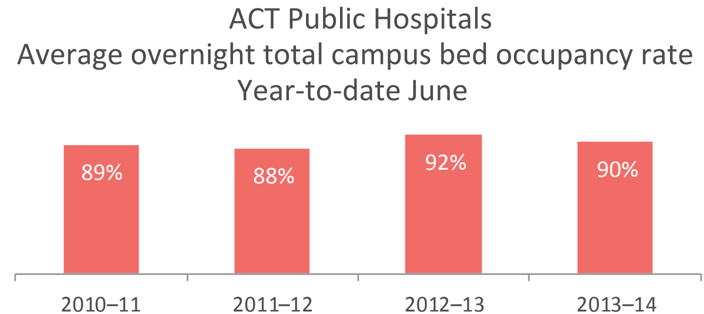
The ACT Government has appropriated funding for another 31 inpatient beds in 2014–15, including:

- 16 general inpatient beds at Canberra Hospital
- 15 general inpatient beds at Calvary Public Hospital
- 6 bed-equivalents for Hospital in the Home (HITH) program.

In 2013–14, ACT's public hospitals provided 280,939 overnight hospital bed days of care, a 1 per cent increase on 277,993 in 2012–13. The *Australian Hospital Statistics Report* for 2012–13 issued by the AIHW in April 2014 showed that the ACT had achieved the national average in providing public hospital bed availability for the fourth time in the almost 22 years of reporting by the AIHW. ACT Health reached 2.6 public hospital beds per 1000 people—which is on par with the Australian national average.



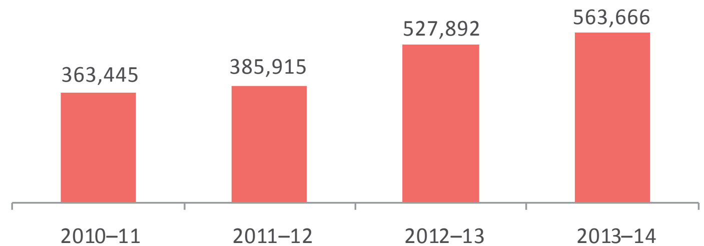
The ACT public hospitals overnight average bed occupancy rate for 2013–14 was 90 per cent. This is a 2 per cent improvement when compared to the 92 per cent reported for the same period last year. The long-term target is to maintain bed occupancy levels for best patient outcomes and to achieve maximum efficiency. However, with increasing pressure on ACT public hospitals each year, the ACT target for this indicator in 2013–14 was revised to 90 per cent. This recognises a more realistic target in the transition period while the necessary infrastructure and process improvements take effect, which will allow ACT public hospitals to achieve the 85 per cent in coming years. The additional 44 beds funded in the 2013–14 budget have assisted in reducing bed occupancy rates over this financial year. The additional 31 beds funded in the 2014–15 budget should reduce bed occupancy rates towards the 85 per cent target.



Over recent years, there have been significant increases in the demand for non-admitted outpatient services. In response to this growth, resources have been committed to improve the function and processes of Outpatient Services.

In 2013–14, ACT public hospitals provided 563,666 outpatient non-admitted occasions of service, a 7 per cent increase when compared to the 527,892 occasions of services reported in 2012–13. Outpatient services for 2012–13 and 2013–14 now encompass all non-admitted activity, including activity provided off-campus in the community health spectrum. This change in counting methodology, which was driven by the implementation and adoption of activity-based funding under the National Health Reform Agreement (NHRA), means comparisons of outpatients/non-admitted data can no longer be made with previous years.

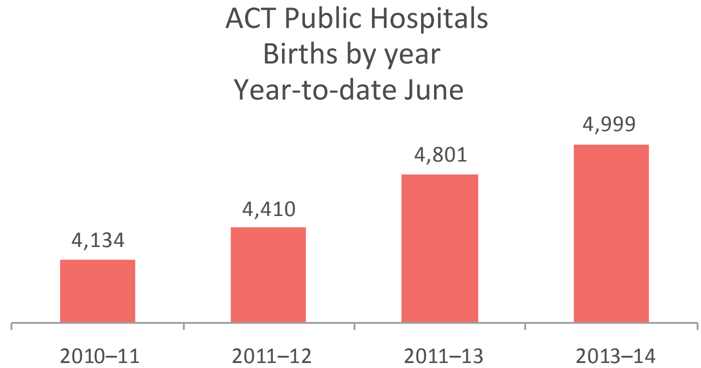
ACT Public Hospitals
Growth in non-admitted outpatient occasions of service
Year-to-date June



Source: ACT Outpatient published dataset

Births

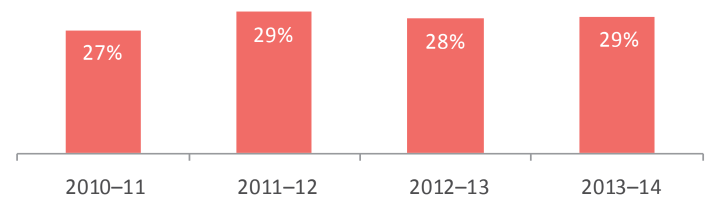
A total of 4,999 babies were born at ACT public hospitals in 2013–14. This is a 4 per cent increase on the 4857 reported for 2012–13 and the highest amount of births ever recorded for a single year. The result of 4,999 births in 2013–14 also represents a 70 per cent growth (over 2000 additional births) in the number of ACT public hospital births since 2001–02.



Source: ACT Outpatient published dataset

In 2013–14 the number of births by caesarean section was 29 per cent of all births. This is a 1 per cent increase on 28 per cent reported for 2012–13.

ACT Public Hospitals
Proportion of births that required a caesarean procedure
Year-to-date June



Source: ACT Outpatient published dataset

Caesarean rates have been steadily rising since 2001, both in the ACT and nationally. The ACT rate of 29 per cent in 2013–14 was lower than most recent national figures published by the AIHW for 2012–13. ACT public hospitals continue to have a low caesarean rate compared to benchmarking hospitals. ACT public hospitals are moving towards further implementation of the 'continuity of maternity model of care', which has proven improved clinical outcomes for women—including a reduced rate of caesareans.

The ACT Government 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 there. In March 2014, a Community Midwifery Program (CMP) at Calvary Public Hospital was established to further enhance obstetric services there.

Operations in ACT public hospitals

Over the past four years, the number of surgical operations performed at ACT public hospitals has risen by 6 per cent, from 17,991 in 2010–11 to 18,998 in 2013–14. 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 performed (elective and emergency surgery)
Year-to-date June

Source: Admitted patient care dataset June 2014

Access to elective surgery

ACT public hospitals provided 11,780 elective surgery procedures in 2013–14. This result is now the highest number of elective surgery procedures performed ever in a single year for the ACT. This is also the fourth consecutive year that ACT Health has performed more than 11,000 elective surgery procedures.

This was achieved in part by utilising the private sector, 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 366 people accessed elective surgery under this agreement in 2011–12, and over 2012–13 a further 224 patients had elective surgery in the private sector. In 2013–14, 323 patients accessed elective surgery at private hospitals, which makes a total of 1084 patients since this initiative was first established.

ACT Public Hospitals
Number of elective surgery operations performed
Year-to-date June

11,780
11,624
11,392
11,360
2010–11
2011–12
2012–13
2013–14

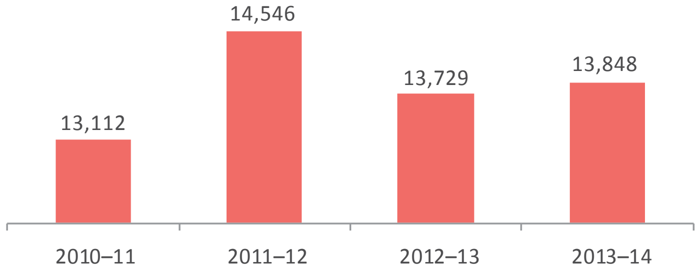
Source: Elective surgery waiting list dataset June 2014

In addition to the work contracted with the private sector, the ACT Government and Southern New South Wales Local Health District have utilised Queanbeyan Hospital to provide elective surgery. In 2013–14, 41 patients accessed elective surgery at Queanbeyan Hospital, covering urological and gynaecological procedures.

Additions to elective surgery waiting list

The number of additions to the elective surgery waiting list continues to increase. In 2013–14, 119 more people were added to the elective surgery waiting list than in 2012–13. Urgency category 2 experienced the most growth, making up 42 per cent of the total number of additions in 2013–14. Despite the increase in demand for elective surgery, ACT public hospitals have ensured that patients can access elective surgery as quickly as possible, according to their urgency category.

ACT Public Hospitals
Number of additions to elective surgery waiting list
Year-to-date June



Source: ACT elective surgery published dataset June 2014

Median waiting time to surgery for ACT public hospitals

ACT Health reports the median waiting time to access elective surgery. This ensures that any improvement or deterioration in the way the directorate manages the elective surgery waiting list is evident, so it can adjust management to improve access as required.

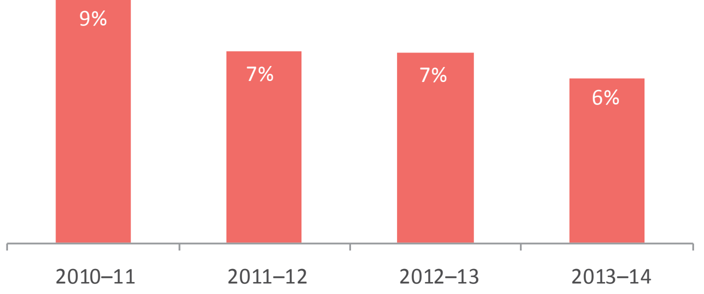
The latest AIHW report, titled *Elective Surgery Waiting Times 2012–13*, shows the ACT still has a high median waiting time. ACT Health has worked to reduce the number of overdue patients for the last few years. The result of 48 days reported for 2013–14 is a continued improvement on the 77 days reported in 2010–11 and 64 days reported in 2011–12.

Median wait time	2010–11	2011–12	2012–13	2013–14
Category 1	15	14	14	14
Category 2	103	89	72	59
Category 3	225	198	171	166
Median wait time all categories	77	64	51	48

Hospital-initiated postponement

Hospital-initiated postponements (HIP) measure how many patients have their elective surgery postponed. This performance indicator is very useful in measuring the efficiency and effectiveness of the ACT's elective surgery management. The most common reason for postponements occurring is lower acuity patients being substituted because another higher acuity patient is given priority. ACT Health aims to ensure that less than 8 per cent of patients' elective surgery is postponed. For 2013–14, ACT public hospitals achieved well below the target for this indicator, with a result of 6 per cent, which compares favourably with the 7 per cent reported for 2012–13.

ACT Public Hospitals
Hospital initiated post ponement rate
Year-to-date June



Source: ACT elective surgery published dataset June 2014

ACT public hospitals have recorded a slight increase in the number of patients waiting longer than the recommended timeframe for their elective surgery procedure—726 patients at 30 June 2014. This is an increase of 14 patients when compared with the same period for last year. However, when comparing the 726 patients with the same period two years ago there has been a 19 per cent reduction in long-wait patients.

ACT Public Hospitals
Reducing the number of patients waiting too long for elective surgery
Year-to-date June

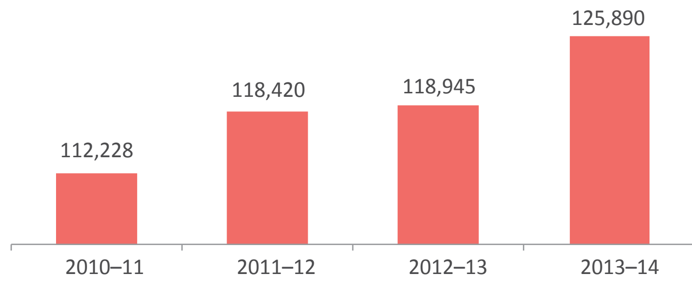
Source: ACT elective surgery published dataset June 2014

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.

Access to emergency department services

ACT Health is committed to improving waiting times in our emergency department (EDs). In 2013–14, ACT public hospital EDs saw 125,890 presentations, a 6 per cent increase compared with the same period last year and the highest number of presentations ever recorded in a single year. In March 2014 there were 11,321 ED presentations, the highest number of ED presentations in a month on record.

ACT Public Hospitals
All presentations to the emergency department
Year-to-date June



Source: Emergency department published dataset June 2014

Admissions to hospital via the ED have also grown, with 34,218 admissions (10 per cent growth) reported for 2013–14 compared to 31,206 recorded in 2012–13.

Waiting times for emergency treatment

Despite the increase in demand in ACT public hospital EDs, timeliness for patients to be seen continued to improve in 2013–14 compared to 2012–13, across all categories. National targets were met for triage category 1, 2 and 5 patients. Overall timeliness also improved by 10 per cent compared to the 2012–13 result of 51 per cent.

Category 5 continued to exceed national benchmarks, with 86 per cent of this cohort seen on time. This is despite a significant increase in category 5 patient presentations during 2013–14. This improvement in performance for ACT EDs is very positive for ACT Health and shows that recent initiatives are starting to take effect. While more needs to be done, ACT public hospitals have made good progress in reducing waiting times in our EDs.

Triage Category	2013–14 Target	2013–14 Result
Category 1 (resuscitation – seen immediately)	100%	100%
Category 2 (emergency – seen within 10 mins)	80%	83%
Category 3 (urgent – seen within 30 mins)	75%	50%
Category 4 (semi-urgent – seen within 60 mins)	70%	57%
Category 5 (non-urgent – seen within 120 mins)	70%	86%
All presentations	70%	61%

Recent initiatives implemented to improve timely access to emergency services include:

- 'front loading'—where patients can be assessed and treated by an ED doctor more rapidly
- expansion of the Canberra Hospital discharge lounge, enabling patients to leave the inpatient wards earlier, thereby freeing up inpatient beds and allowing increased access from the ED
- purchase of beds at Monash Goodwin Village for sub-acute patients with an extended length of stay in the acute setting.

In March 2013, the ACT Government tabled its Emergency Access Plan for 2013–17, which detailed actions to be implemented over the next four years to improve waiting and treatment times within ACT Health public hospital EDs. The plan recognises that improvements to ED times must include changes to the way the whole hospital works and improved partnerships between hospitals and community services.

'Did not waits'

Despite the increase in demand on EDs in 2013–14, the number of presentations that did not wait to be treated has improved across all triage categories compared to 2012–13 and overall has reduced from 7 per cent to 5 per cent of presentations in the same period.

Emergency department presentations that did not wait

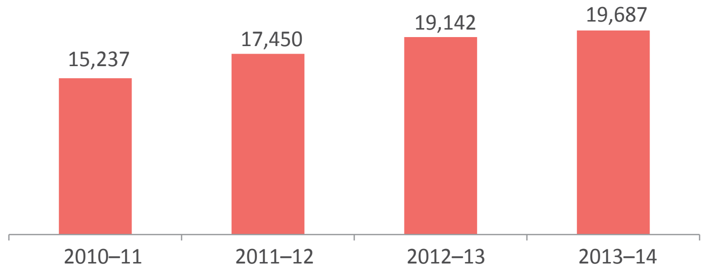
	2011–12	2012–13	2013–14	Target
Category 1	0%	0%	0%	10%
Category 2	0%	0%	0%	10%
Category 3	3%	5%	3%	10%
Category 4	11%	10%	7%	10%
Category 5	13%	12%	8%	10%
Total all categories	7%	7%	5%	10%

Australia's first Walk-in-Centre

Australia's first public, nurse-led Walk-in Centre (WiC) was opened in May 2010. Since then, the WiC has experienced 73,392 presentations to June 2014.

The WiC is designed to help people get fast, free, one-off treatment for minor illnesses and injuries. The people of Canberra are 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 to the WiC
Year-to-date June

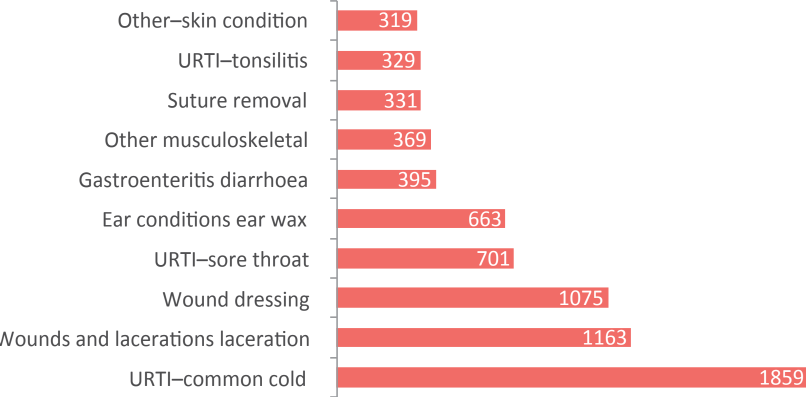


Source: WiC published dataset

Presentations to the WiC increased by 3 per cent in 2013–14 compared with 2012–13. This increase reflects the value that the service provides to the community.

The WiC nurses treat a wide range of conditions, with no significant changes in the top 10 conditions treated since last year. The common cold remains the main reason for presentation to the WiC .

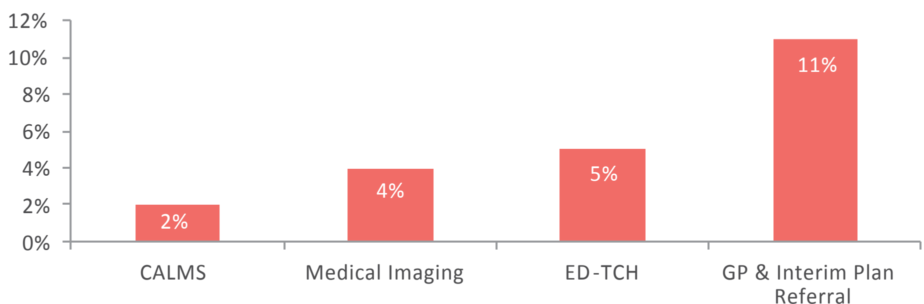
Walk-in Centre
Top 10 conditions treated at the WiC
Year-to-date June



Note: URTI in above graph is upper respiratory tract infection

If necessary, people are redirected to more appropriate services, such as their GP or the ED. Of the 19,687 presentations in 2013–14, 14,234 had a completed treatment episode by the nurse. Seven per cent of patients assessed were redirected to their GP and 5 per cent were told to present to the Canberra Hospital ED.

Walk-in Centre
Patient redirections following assessment by nurse
Year-to-date June



Source: WiC published dataset

Note: CALMS in above graph reflects Canberra After-hours Locum Medical Service. ED-TCH in above table reflects Canberra Hospital Emergency Department. GP in above table reflects General Practitioner.

The WiC 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 ED.

The WiC 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 WiC 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 GP with consent.

People in the ACT community now have access to a wide range of primary health services including their GPs, EDs, community health services, pharmacists and the WiC.

For the period of this report ACT Health operated one WiC located on the campus of the Canberra Hospital. In 2012, the ACT Government made a commitment to double the current budget for the WiC and expand the nurse-led WiCs to community locations in Belconnen and Tuggeranong.

The original WiC at Canberra Hospital closed in June 2014. A Tuggeranong WiC opened to the public on 26 June 2014, and a second WiC opened at Belconnen on 1 July 2014.

National Partnership Agreement on Improving Public Hospital Services

The National Health Reform Agreement—National Partnership Agreement on Improving Public Hospital Services was signed off by the Council of Australian Governments in July 2011. The objective of this agreement was to drive major improvements in public hospital service delivery and better health outcomes for Australians.

The agreement aimed to facilitate improved access to public hospital services, including elective surgery and emergency department services, and sub-acute care. This agreement commenced on 1 January 2012.

A set of performance targets was included in the agreement to ensure timely access to services was a priority for all health sectors across the nation. These performance indicators are measured over the calendar year.

National Emergency Access Targets

The National Emergency Access Target (NEAT) measures the percentage of patients leaving the ED within four hours, whether for admission to hospital, referral to another hospital for treatment, or discharge. Commencing from 2012, this target is phased over four calendar years, with annual interim targets increasing to 90 per cent by 2015. The ACT 2013 target required that 65 per cent of all patients within the year who presented to an ED left the ED within four hours.

For 2013, NEAT performance across ACT public hospitals was 59 per cent.

	National Emergency Access Targets – ACT	
	Target	**Total NEAT**
Dec 2012	64%	57%
Dec 2013	65%	59%

For the first six calendar months to June 2014, ACT public hospitals are reporting a NEAT result of 63 per cent. Calvary is currently at 69 per cent and Canberra Hospital 58 per cent.

ACT's NEAT performance does not compare well against other jurisdictions. This is largely due to the fact that the ACT has only two public hospitals, both of which are major centres; NSW, for example, which has 220 public hospitals, many of which are small regional facilities.

The most recent *MyHospitals* data, published December (Report: *NHPA Hospital Performance: Time patients spent in emergency departments in 2012–13*), indicates some major metropolitan hospitals in Sydney have similar results to those in the ACT. However, a number are performing at lower levels than the ACT. For the 2013 calendar year, the national peer group average performance was 60 per cent (major metropolitan hospital). ACT public hospitals are currently exceeding this figure, with a calendar year to June 2014 NEAT result of 63 per cent.

National Elective Surgery Targets

There are three components to the National Elective Surgery Targets (NEST), focusing on ensuring timely access to surgery and reducing the number of patients waiting beyond clinically recommended timeframes.

In the 2012 calendar year, ACT Health was successful in meeting all nine components of the NEST. On 30 April 2014, the AIHW released its annual report on jurisdictional performance against emergency access and elective surgery targets. The report shows that the ACT was the only jurisdiction to meet all targets in each of the three components of the NEST.

The ACT public hospitals met eight of the nine NEST targets for 2013, missing the remaining target by 0.3 per cent.

Part 1 of the NEST refers to the proportion of patients who access their elective surgery procedure within clinically recommended timeframes.

For the 2013 calendar year, the ACT met the required targets for category 1 and 3 patients accessing their surgery on time. It did not meet the target for category 2 patients, reporting a result of 65.7 per cent accessing surgery on time, against a target of 66 per cent.

Part 1 – % of patients treated within clinically recommended time						
	Target	**Category 1**	**Target**	**Category 2**	**Target**	**Category 3**
Dec 2012	95%	98%	55%	57%	82%	89%
Dec 2013	97%	98%	66%	65.7%	86%	90%

Part 2A of the NEST is based on the requirement to reduce the average overdue waiting times for each category of patients so that there are no overdue patients by the conclusion of the agreement. In calendar year 2013, ACT public hospitals met the required targets for urgency category 1, 2 and 3 patients.

	Part 2A – Average overdue days waiting	
	Category 1	**Category 2**	**Category 3**
2013 target	0	107	148
2013 calendar year result	0	107	73

Part 2B of the NEST is related to the removal of the top 10 per cent of longest waiting patients on the elective surgery waiting list each year. The Australian Government issues ACT Health with the list of long-wait patients who are to have their surgery in that year. In the 2013 calendar year, ACT public hospitals removed all of the identified longest waiting patients from the 2013 list.

	Part 2B – Removal of top 10% longest waits		
	Category 1	Category 2	Category 3
2013 target	1	64	14
2013 calendar year result	1	64	14

Sub-acute care reform

The sub-acute component of the National Partnership Agreement on Improving Public Hospital Services aims to improve 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.

Over 2013–14, the planning for growth in sub-acute care services has paid off. The ACT has now delivered more than 25 sub-acute bed-equivalents into the system, above the June 2014 target of 21 bed-equivalents.

Division of Critical Care

The Division of Critical Care is responsible for the delivery of acute and critical care as well as retrieval services. These are provided as inpatient and outpatient services at the Canberra Hospital, with a strong emphasis on accessible and timely care, delivered to a high standard of safety and quality. This is underpinned by the division’s commitment to research and training. The division includes the Retrieval Service (both road and air), Emergency Department (ED), Intensive Care Unit (ICU), Access Unit, Surgical Short Stay Unit, Surgical Assessment and Planning Unit (SAPU) and Medical Assessment and Planning Unit (MAPU).

Achievements

The Canberra Hospital ED is a tertiary service and a trauma centre with a territory-wide and regional role. The service treats adults and children. The ED at Canberra Hospital strives to provide timely, accessible and appropriate health services to people with acute illness or injury. The service is required to manage large numbers of patients presenting with a broad range of conditions that must be dealt with on a priority basis. The National Emergency Access Targets require that, by 2015, 90 per cent of patients presenting to an ED will leave the department for admission to hospital, be transferred to another hospital or be discharged to go home within four hours. While achievement of this target is a whole-of-hospital responsibility, programs are being developed by the staff within the ED to ensure that improvement in this performance indicator continues.

The performance for 2013–14 has seen improvements in the majority of categories.

With the opening of the new Emergency Medical Unit within the ED in October 2013, the model of care changed to support the introduction of streaming within the ED. This allowed patients presenting to the ED for care to be directed to either Stream A (Acute) or Stream B (Ambulant), depending on the treatment required for their presenting condition. This has resulted in an upward trend in the number of patients seen and admitted, transferred or discharged from the ED within four hours.

The Division of Critical Care has worked closely with Project Venturi (Patient Flow Project) to improve the discharge planning process for patients who are admitted to MAPU and the Medical Short Stay Unit. The multidisciplinary team has worked collaboratively with the ED to expedite the assessment and management of patients with undifferentiated medical conditions. This work is a collaborative effort with the Division of Medicine, which is responsible for the clinical unit of General Medicine. All stakeholders are focused on ensuring optimal patient outcomes, maintaining quality and efficiency of care and ensuring the efficient use of resources.

The implementation of the Medihotel in February 2014 enhances care for consumers who travel from remote or rural areas. Eight beds in hotel accommodation on the hospital campus allow consumers to be supported in their transition from the acute setting to community-based care. Family members or carers can also support consumers during their stay. This service promotes the continuity of care for consumers and enables the Canberra Hospital to optimise access and patient flow by ensuring that rural and remote consumers who require sub-acute care but who no longer require continued hospital admissions can maintain access to necessary treatment.

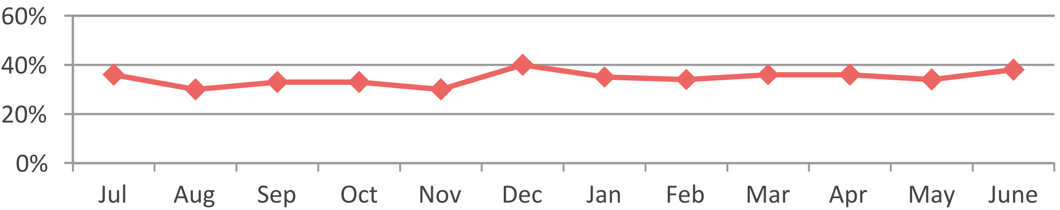
The extension of the Discharge Lounge operating hours supports consumers who no longer require acute care, and who are awaiting either transport or social support, to have access to an area that is comfortable, secure and monitored by nursing staff. This ensures consumer safety and enhances patient flow across the campus.

The expansion of the ICU has provided an additional seven beds and a larger balcony area for long-term patients to utilise. The additional capacity in ICU allows for patients requiring isolation or positioning more appropriate to their clinical needs.

Issues and challenges

The increasing number of presentations to the ED that require admission will continue to impact on the ability to meet demand in the ED. The multidisciplinary team continues to work on initiatives to enhance access as well as maintain quality and safety of care.

Percentage of admissions via ED with length of stay less than 4 hours 2013–14



Adequate intensive care coverage for a hospital that is both a major tertiary referral centre for the ACT as well as a teaching hospital has required the ICU to continue to expand in order to meet demand. This demand comes from both the emergency and trauma admissions and elective surgery.

Future directions

The ACT Government and the Commonwealth Government have committed funds to establish a dedicated service for children in the Canberra Hospital ED (a paediatric stream). The project will refurbish an area within the ED to create a more suitable family-friendly waiting, triage and treatment area and will not be provided at the expense of existing adult treatment spaces. This service will streamline and better coordinate paediatric emergency and inpatient care. It will provide early identification of paediatric patients who are waiting for care and the streamlined transfer of those patients to the appropriate services in the Centenary Hospital for Women and Children.

The Division of Critical Care's ongoing work with Project Venturi, which is assessing patient flow across the hospital, will see the expansion of the improved discharge planning process across other areas of the hospital. The processes implemented within MAPU have identified key areas that negatively impact on discharge times. Project Venturi actively promotes a multidisciplinary approach to all of the project objectives.

Division of Medicine

The Division of Medicine provides adult medicine services to the Canberra community in inpatient, outpatient and outreach settings. An emphasis is placed on accessible, timely and integrated care, which is delivered to a high standard of safety and quality.

The Division of Medicine comprises:

- Renal services
- Cardiology
- Academic Unit of Internal Medicine
- Sexual Health Centre
- Neurology
- Gastroenterology and Hepatology
- Dermatology
- Diabetes Service
- Endocrinology
- Forensic and Medical Sexual Assault Services
- Infectious Diseases
- Inpatient ward services, ambulatory clinics and clinical measurement services across many specialties
- Pharmacy Services
- Respiratory and Sleep Services
- Rheumatology.

The division has a strong commitment to teaching and research. Health students from several universities undertake practical placements within the division. Most of the division's senior medical staff hold academic appointments at the Australian National University Medical School, and there are many research programs in operation. Many members of the division's staff participate in the development of national professional guidelines and quality initiatives.

Achievements

Diabetes Service

ACT Health is committed to consumer accessibility to the Diabetes Service and has established clinics at three community health centres and Canberra Hospital.

The next ACT Health Diabetes Service Plan is being drafted in consultation with consumer representatives and the aim is to have the new plan finalised this year.

Parkinson's Disease Service

The Chronic Care Program's Parkinson's Disease (CCP PD) Service provides education, clinical support and care coordination for frequent users of the acute care sector with Parkinson's disease, multiple systems atrophy, progressive supranuclear palsy and corticobasal degeneration.

The CCP PD Service began operation in 2012 under the Chronic Disease Management Unit. It completed one year of mature operations in 2013 and is currently in its second year.

An evaluation of this service was undertaken from April to June 2014 to review its operations, identify and document its achievements and make recommendations for its evolution and improvement.

The evaluation suggested that the CCP PD Service is associated with reduced hospitalisation rates and length of stay for people with Parkinson's in the ACT and surrounding region. The service is reported to be valued by those with Parkinson's and their carers.

Stroke Unit

The demand for acute stroke care in the ACT has been rapidly increasing. To account for the increased demand for services, the Division of Medicine has implemented the following:

- creation of a transient ischemic attack (TIA) clinic
- commencement of a cross-territory stroke service between the Canberra Hospital and Calvary Hospital. The Calvary Hospital Stroke Unit commenced operations on 28 April 2014 and has four acute beds and four sub-acute beds, as well as a dedicated Stroke Liaison Nurse.

Hospital in the Home

The Hospital in the Home (HITH) Program has developed a protocol, in conjunction with the Chronic Care Program, for the Respiratory Service to identify patients in the community who are acutely deteriorating and who may benefit from a pre-emptive stay in HITH, potentially avoiding an admission to hospital.

In the second half of 2013, the introduction of a dedicated pharmacist in HITH assisted with the increasingly complex and numerous medications being used both by patients in their homes and by those receiving treatment as day-only patients.

Obesity Management Service

The Obesity Management Service (OMS) commenced taking referrals in January 2014 and saw its first patients in February 2014. It is a referral-based service for adults with Class III obesity (BMI 40kg/m^2 or more) to improve their health and wellbeing.

The service is medically led and the team includes a dietician, psychologist, physiotherapist, exercise physiologist and registered nurses. The OMS provides individual clinical care and groups for physical activity and health education. The service supports better clinical care for this patient group, community development, research and professional education. The OMS operates from the Belconnen Community Health Centre, which has specialist bariatric equipment and treatment facilities.

Cardiology

In 2013–14, the Chest Pain Evaluation Unit (CPEU) was established. This has seen a significant improvement in the management of patients presenting to the Emergency Department (ED) at the Canberra Hospital with chest pain—decreasing the time these patients spend in the ED.

The commencement in August 2014 of an additional cardiologist specialising in echocardiography will further enhance cardiology services.

Gastroenterology and Hepatology Unit

In 2013–14, refurbishment of the Gastroenterology and Hepatology Unit (GEHU) allowed for increased endoscopy and clinic capacity and reduced waiting time for patients.

In May the Endoscopic Ultrasound Service (EUS) commenced. The EUS is a medical procedure that combines with ultrasound to obtain images of the internal organs in the chest and abdomen. When combined with Doppler imaging, nearby blood vessels can also be evaluated. It allows for screening for pancreatic cancer, oesophageal and gastric cancer as well as benign tumours of the upper gastrointestinal tract.

In 2013–14 there was an increase of 9 per cent in total endoscopy procedures when compared to the 2012–13 financial year.

There were 12,473 outpatient clinic attendances in 2013–14, which is an increase of 20 per cent when compared to the same period in the 2013–14 financial year.

Issues and challenges

Gastroenterology and Hepatology Unit

The ACT Auditor-General conducted a performance audit on the outpatient services provided by the Gastroenterology and Hepatology Unit (GEHU) at the Canberra Hospital, which concluded in May 2014. The review of the unit and the recommendations fell into two categories: governance and operations.

As part of the audit, an independent expert was commissioned to review the GEHU consultant's triaging and outcomes of a selection of patients. This expert found that 'the triage category was appropriate in the vast majority of cases' and for those cases where outcomes could be assessed 'the patients were managed appropriately and in a timely manner'. While acknowledging the scope for improvement within the GEHU, ACT Health is reassured by the independent expert's assessment.

ACT Health believes that the work already undertaken, as well as the recommendations from the audit, will enable the GEHU to continue to improve and provide high-quality services to the ACT community.

Future directions

The Division of Medicine will:

- relocate Northside Dialysis Unit from Calvary Hospital to the Belconnen Community Health Centre (BCHC), where an expanded service will be offered. The move offers a number of advantages to clients accessing the service, including easy access to co-located allied health services, including dieticians and podiatry, and longer opening hours, with plans to offer nocturnal dialysis in the future. Later in 2014, dialysis services will be provided at the newly refurbished Tuggeranong Community Health Centre.
- increase endoscopy procedures to support the National Bowel Cancer Screening Program (NBCSP). Renovations to the GEHU in 2013–14 will also facilitate this increase.
- refine the Acute General Medicine model, incorporating the Medical Assessment and Planning Unit
- build on work underway in relation to the GEHU Auditor-General's report and consider the learnings from this across the division
- implement the recommendations of the CHHS Administrative Services Review, including developing a model for administrative support to the division, with specific regard to ambulatory services
- continue to support the '*What Matters to You*' Clinical Quality Improvement model, across the division
- progress more team-based models appropriate to care across the division
- facilitate more community-based services in the new community health centres in Gastroenterology, Liver and Renal Services, including the commencement of renal dialysis in the community settings in Belconnen and Tuggeranong
- participate in the rollout of Health Pathways, which will be developed in collaboration with the Medicare Local to articulate and publish pathways of care across the continuum, in collaboration with Canberra and regional general practitioners.

Division of Pathology

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 to identify the cause and severity of disease, and to monitor treatment. 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 around optimal treatment for patients.

Services are provided in the acute 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.

Achievements

Collaboration

Pathology works in close collaboration with many areas of ACT Health to provide access to accurate, timely results to assist in diagnosis, management and monitoring of patients.

In line with ACT Health objectives, Pathology supports Canberra Hospital, Calvary Hospital and the community in numerous ways, including with:

- infection control
- public health outbreaks (such as norovirus, measles, influenza, tuberculosis and meningococcal disease)
- the emergency department (priority testing for acute areas).

Pathology also performs testing for the ACT breast screening and cervical screening programs.

Performance

The tables below show the number of pathology requests received and the total number of tests performed.

	2012–13	2013–14	% increase
Total requests	569,957	571,650	0.3
Total tests	5,115,969	5,185,660	1.4

The table below shows Australian Council on Healthcare Standards (ACHS) clinical indicators that demonstrate the timeliness of reporting of results for selected Canberra Hospital Emergency Department tests. The potassium result is below target due to issues with new instrumentation that delayed the numbering and separation of blood specimens when it was introduced at the beginning of the year.

Test	2013–14	ACHS target
Potassium (% results in <60 mins)	76	82
Haemoglobin (% results in <40 mins)	87	88
Coagulation testing (% results in <40 mins)	52	51

Investments in research to promote evidenced-based practice

Pathology is a scientific discipline with research as a cornerstone. The division is participating in more than 40 research projects. Many of its 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 and contribution to the Australian National University Medical School. Members of the division, both scientific and medical, continue to publish actively in peer-reviewed journals and participate in professional meetings and workshops both in Australia and overseas.

Issues and challenges

The major challenge for the Division of Pathology in the future is dealing with increasing demand by clinicians and patients for more rapid, specific and high-tech testing for patient management, particularly in the molecular fields of cancer gene analysis and bacterial sequencing, in combination with maintaining a skilled workforce operating 24 hours a day. The future will see a significant increase in technology, including both automation and new technologies that will require a workforce that is well informed and able to adapt to changes in laboratory practice.

Future directions

Improve patient safety and quality of care

Pathology is working collaboratively with Health IT to introduce Computerised Physician Order Entry (CPOE). CPOE is an electronic ward ordering system that will improve the completion of mandatory information required for pathology testing, improve the legibility and thus accuracy of request information, and provide decision-making support information to the requesting doctor.

Pathology works closely with clinicians at Canberra Hospital to ensure accurate patient identification in specimen collection for pathology testing.

Division of Surgery, Oral Health and Imaging

The Division of Surgery, Oral Health and Imaging is responsible for delivering inpatient and outpatient surgical services, and prevention and treatment dental health programs targeting youth and adults of the ACT community and surrounding region. The aim is provide timely access to elective and emergency surgery, with a focus on quality patient-centred care, supported by evidence-based practice. The division includes the Surgical Bookings and Pre-Admission Clinic, Anaesthesia, the Pain Management Unit, operating theatres, the Post Anaesthetic Care Unit, the Day Surgery Unit, the Admissions/Extended Day Surgery Unit, Medical Imaging, various speciality surgical ward areas, outpatients departments (medical and nursing only), the Shock Trauma Service, the Trauma Orthopaedic Research Unit and the Dental Health Program.

Achievements

The ACT Government has made an ongoing commitment to support the National Elective Surgery Access Targets (NEST) and maintain services for the trauma and emergency patients who require access to surgery.

In 2013–14, the number of patients provided with access to elective surgery was 6364, which was above the target of 6300.

Performance against the NEST continued to improve, with 100 per cent of category 1 patients being provided with access to surgery within 30 days. Work is ongoing to improve access for patients in clinical urgency categories 2 and 3.

As well as contributing to the Territory's reduction in the elective surgery waiting list, the Canberra Hospital conducted more than 6300 emergency and trauma surgical procedures in 2013–14, reflecting growth of 3.2 per cent over the 6100 in the previous year.

In the ACT Budget Papers 2013–14, strategic indicator number 2 for Canberra Hospital and the division was to ensure that there was no waiting time to access emergency dental health services for eligible residents of the ACT. This performance target was set to ensure that 100 per cent of eligible clients received treatment within 24 hours of contact with the service. The ACT Dental Health Program (DHP) met this target throughout 2013–14.

The division supports the Canberra Hospital in improving the health and wellbeing of the ACT population through initiatives that focus on early intervention. With the assistance of the DHP, the division has continued to achieve the mean waiting time target for clients on the dental services waiting list, set at 12 months in accountability indicator 1.1d. The Dental Health Program improved on this target, with a mean waiting time of 3½ months at the end of June 2014. In June 2013, the mean waiting time was 11 months.

The division is also required to monitor achievement against accountability indicator 1.1h, which states that 100 per cent of category 1 elective surgery patients should receive their surgery within 30 days of registration on the waiting list. The Canberra Hospital has continued to meet this target, with 100 per cent of these patients having their procedure within the clinically indicated timeframe.

In 2012–13, the federal government provided additional funding to reduce the public dental waiting list in the ACT. This funding supported a three-year program and involved the DHP entering into a National Partnership Agreement to meet a number of key performance indicators. The DHP continues to achieve 100 per cent compliance for the number of emergency patients receiving treatment within 24 hours and has made significant improvements on the median waiting time for treatment, which has been reduced from 11 months in June 2013 to three months in June 2014.

In the 2011–12 federal budget, the Volunteer Dental and Oral Health Therapist Graduate Year Program was announced to fund new graduates in both the public and private dental sector. Funding was provided for program development, dental graduate and pro rata mentor salaries, incentive payments for dental graduates completing the program and additional infrastructure to support placements. The program will support 50 full-time dental graduate placements per year from 2013 and 50 full-time oral health therapists from 2014. The DHP has also been approved to host one dentist and one oral health therapist who commenced in early 2014.

During 2013, the DHP participated in the National Child Oral Health Survey (NCOHS), conducted in collaboration with the Australian Research Centre for Population Oral Health (ARCPOH) and state and territory public dental services. The survey was undertaken to identify more effective dental service models for children and adolescents by evaluating oral health outcomes. The DHP team (which consisted of dental therapists and dental assistants) was responsible for the administration and field work, in which more than 2200 children across 30 primary schools in the ACT were seen. Internal service delivery was maintained while the survey was being undertaken, and the ACT was the first jurisdiction to meet its response quota. ARCPOH is using the ACT as the benchmark for other jurisdictions undertaking the survey.

Issues and challenges

The elective surgery waiting list at the Canberra Hospital continues to grow, with an increase of 2.5 per cent in 2013–14. There were 8389 additions to the waiting list in the year to June, compared to 8187 in 2012–13. The high demand for elective surgery, coupled with increased trauma and emergency cases, is placing pressure on the Division of Surgery, Oral Health and Imaging.

Timely access to Outpatient Services within the division continues to be closely monitored. Strategies are being developed with Cancer, Ambulatory and Community Health Support to ensure access to reporting that will provide greater visibility in regard to waiting times and service delivery levels. This will enable effective strategies to be developed that will ensure timely access to surgical outpatient clinics.

Future directions

The division will work with other ACT services to finalise and implement the Surgical Services Plan 2014–2017. Under this plan, recommendations will be made to create more efficiencies in the management of the territory's elective surgery waiting lists. The plan has three areas of focus: the effective management of trauma and emergency surgery, the establishment of a single waiting list for the ACT, and the need for improvements and efficiencies in public hospital operating theatres to optimise access for trauma and elective surgery.

Some of the major benefits of this plan will be:

- better outcomes for patients through the streamlining of access to elective surgical services
- reduced pressure on Canberra Hospital operating theatres and inpatient beds
- improved utilisation of high-cost assets and improved efficiency in surgical services.

In early 2014, the ACT Government was provided with Commonwealth funding to increase access to dental health services for eligible ACT residents. A mobile dental clinic will be purchased to provide dental care to residential aged care facilities. Under the current system, the elderly in nursing homes receive only basic dental examinations and basic denture services and are not always able to access the complete range of dental care services, including fillings and extractions, because of their medical conditions or lack of mobility. This new service will be able to deliver the same quality of dental care to the elderly in nursing homes as would be available to any other eligible member of the community.

Through the Shock Trauma Service, the Canberra Hospital will partner with the NRMA ACT Road Safety Trust to conduct the Prevent Alcohol and Risk-Related Trauma in Youth (PARRTY) program across ACT schools. This program targets young people between the ages of 16 and 24, as this group has the highest rates of injury in the ACT. Research indicates that, between July 2007 and June 2012, 717 adolescents and young people were admitted to Canberra Hospital and Health Services suffering major life-threatening injuries. Under this program, students have the opportunity to spend a day in a hospital, talking with healthcare professionals and other staff who care for seriously injured patients. The students are able to experience some of the challenges that face mobility-impaired patients, through the use of equipment such as wheelchairs and leg braces. The final talk of the day is from an injury survivor who is living with permanent disability as a result of trauma. The speaker focuses on the choices that he or she has made in life and the impacts of those choices.

Division of Women, Youth and Children

The Division of Women, Youth and Children provides a broad range of primary, secondary and tertiary healthcare 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, in 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.

The Division of Women, Youth and Children comprises:

- maternity services, including the Continuity at the Canberra Hospital (CatCH) program, the Canberra Midwifery Program, the Maternity Assessment Unit, the Early Pregnancy Assessment Unit and the Fetal Medicine Unit
- women's health, including screening, gynaecology, programs targeting violence against women, and the Women's Health Service which prioritises women who experience barriers to accessing mainstream services
- neonatology, including the Neonatal Intensive Care Unit, Special Care Nursery, specialist clinics, newborn hearing screening and the ACT Newborn Retrieval Service
- paediatrics, including inpatient care, specialist clinics, community paediatricians
- genetics service

- Maternal and Child Health (MACH) nursing service, 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:
  - MACH Parenting Enhancement Program
  - Asthma Nurse Educator Service
  - Caring for Kids Program (care in the home for children with complex needs)
  - Child at Risk Health Unit (care for children affected by violence and abuse)
  - Integrated Multi-agencies for Parents and Children Together, which coordinates care for woman with complex care needs who are pregnant and/or have young children
  - child protection training for clinicians
  - Healthcare Access At Schools (HAAS) Program
  - school-based nursing services, including immunisation, kindergarten health checks, school youth health checks and the HAAS Program
  - nurse audiometry, providing hearing assessments to children and adults.

Achievements

Centenary Hospital for Women and Children—Stage 2 opening

The Centenary Hospital for Women and Children (CHWC) brings services for women and children together under one roof. Services include paediatrics and specialised outpatient services, maternity, birthing and specialised outpatient services, gynaecology and foetal medicine, neonatal intensive care unit and special care nursery. It has set a benchmark within Australia for women's, paediatric and newborn care.

Stage 2 of the CHWC was officially opened on 11 December 2013 after completion of the refurbishments of the previous Maternity Building and following the opening of the George Gregan Foundation Playground on 14 November 2013 and the Ronald McDonald House on 16 November 2013.

Maternity Model of Care Review

An independent review team was commissioned through Women's Health Australasia (WHA) to review the ACT CHWC Maternity Model of Care. They were tasked to examine and provide an assessment of:

- the model of care in the new CHWC Maternity Unit
- capacity of ACT Maternity Services to meet current and future demand, including commitment to expand capacity on the north side.

The WHA report was provided to ACT Health with five recommendations. ACT Health agreed in full or in principle to all recommendations. The report and ACT Health's response to the report were disseminated for public consultation, which was completed in January 2014. During the consultation period, ACT Health received four feedback submissions and after review, did not amend its response to the report.

The Maternity Leadership group is overseeing the implementation of the recommendations. This group has representation from medical and midwifery staff, as well as representation from the People, Strategy and Services Branch. The group is chaired by the Clinical Director of Obstetrics and Gynaecology and Assistant Director of Nursing and, Midwifery in Maternity. There is also consumer representation. An action plan is being developed by the Maternity Leadership group which will outline the service's plans to address the recommendations, over the next three to five years.

The Early Pregnancy Assessment Unit

The Early Pregnancy Assessment Unit (EPAU) commenced operation in October 2013 as a result of a review of the Gynaecology Assessment Service (GAS).

The EPAU has replaced the GAS and is a specialist-led service for women experiencing pain and/or bleeding in the first 20 weeks of pregnancy. This represents more than 80 per cent of all women who presented to the GAS. The EPAU model of care is based on the National Institute for Health and Care Excellence (NICE) Guidelines. The EPAU includes a midwifery role that assists with the coordination and provision of comprehensive evidence-based care to women at less than 20 weeks gestation who are experiencing early complications or pregnancy loss. The service is available from 8.30 am to 5.00 pm, Monday to Friday.

Expansion of the Continuity at the Canberra Hospital program

The expansion of the Continuity at the Canberra Hospital (CatCH) program provides a midwifery continuity model of care to all risk groups, for women who have planned to birth at the CHWC.

The CatCH program has been evaluated. The evaluation highlighted the fact that this model is effective for consumers of the service as well as the staff who operate within this model. The review encouraged continued expansion of the CatCH program and team, and confirmed that this is a safe and successful model of care.

Gungahlin Maternal and Child Health team

The Maternal and Child Health (MACH) nursing services and resources have been redistributed from two to three teams—Tuggeranong, Belconnen and the new Gungahlin team. This was in response to the increased number and changing distribution of families in the ACT with babies and young children. The restructure enables increased responsiveness and operational efficiency for this service.

Healthcare Access At School

In 2012 a project was undertaken by the Community Health Programs Unit of the Division of Women, Youth and Children in collaboration with the Disability Education section of the ACT Education and Training Directorate (ETD). The aim was to research national and international models of care that support the complex and/or invasive healthcare needs of students to enable them to attend school. This was undertaken in response to an increasing number of students with complex healthcare needs who attend mainstream ACT public schools, as well as increasing demands from parents for equitable access to an inclusive education for their children. As a result, the Healthcare Access At School (HAAS) Program was developed in partnership with the families, schools and the ETD.

The objective of HAAS is to support ACT public school students with complex or invasive healthcare needs to attend school. This can refer to care of tracheostomy, provision of nutrition and/or medication via gastrostomy, catheterisation and oxygen therapy during school hours.

The HAAS nurse role provides a link between parents and the school. Nurse-led care means a registered nurse delegates tasks, where appropriate, to a non-nursing or non-licensed school staff member. It is anticipated that most care will be provided by non-licensed school staff, as evidenced by models in other Australian jurisdictions and overseas. The non-nursing worker will be appropriately trained and will receive ongoing support from the HAAS registered nurse.

Benefits of the new model include:

- equitable access to health care for students in all ACT public schools
- individually tailored care plans developed in partnership with parents
- health needs being met with the appropriate level of care
- nurses working in specialist schools being more productive when working in HAAS across all public schools
- ongoing nurse support to schools, students and families
- a safe and sustainable model aligned with current national and international practice.

HAAS supports 20 students across eight schools to attend school. Early evaluation indicates that the program has been very successful, and a formal evaluation is planned for 2015.

Redesign of care for children with a chronic condition

Caring for Kids was a program that supported children with complex needs and their families to stay in the community and out of hospital with a range of short-term supports such as home visits, equipment, school support or overnight support. A review of the Caring for Kids program has resulted in a restructure. The services that are now offered are guided by the ACT Chronic Conditions Strategy and are based on evidence and benchmarked best practice. Feedback from consumers in the form of patient stories has contributed to the redesign.

Future directions

Paediatrics Winter Strategy

Increased admission numbers and activity levels on the paediatric ward over the winter period have created a need to develop a Paediatrics Winter Strategy. Data for this period is being collated within the division, and staffing models are being assessed for the best level of staffing to cope with the predicted increased demand.

Privately Practising Eligible Midwives at the Centenary Hospital for Women and Children

ACT Health has commenced planning for the introduction of a model of patient care which will allow privately practising eligible midwives to admit their private patients to the CHWC for birthing services. The planning process includes consultation both internally with key stakeholders in the Division of Women, Youth and Children, including midwives, managers and medical practitioners, and externally with the Australian College of Midwives, consumers and privately practising midwives. It is anticipated that this work will be completed by 2015.

Child Development System of Care

The Child Development System of Care Steering Committee (CDSC-SC) first met in November 2013 to review the way child development services are provided across the ACT. The Director, Early Intervention and Prevention Services, Community Services Directorate (CSD), and the Executive Director, Women, Youth and Children Division, ACT Health, co-chair this committee. Membership includes representation from Early Intervention and Disability (ETD), Therapy ACT, Child and Adolescent Mental Health Services (CAMHS), Community Paediatrics, Women, Youth and Child Health Policy Unit, ACT Medicare Local, the Australian Research Alliance for Children and Youth (ARACY), Marymead and the Australian Association for Infant Mental Health Inc. (AAIMHI).

The committee has been expanded to incorporate work already underway in partnership with ACT Medicare Local. The *Proposal to support an improved ACT child health and development service system* engaged the Murdoch Children's Research Institute, through the Royal Children's Hospital Melbourne, to:

- undertake a detailed quantitative and qualitative analysis of issues
- identify the strengths and assets of the current service system
- explore and define action to promote healthy childhood development and wellbeing in the immediate, medium and long term
- explore and define whole-of-system improvements.

The first of two workshops was held in March 2014 and the second is planned for late 2014. There was a willingness across sectors to strengthen the service system, with a number of key best practice elements identified for consideration. The second workshop will explore the opportunities provided from the implementation of the National Disability Insurance Scheme (NDIS) and Human Service Blueprint and plans to map out a demonstration initiative that could be trialled, for example, in one geographic area.

Family-Integrated Care—Neonatal Intensive Care Unit/Special Care Nursery project

In some models of care in neonatal intensive care units (NICU), parents spend a significant amount of time at the hospital with their babies and are encouraged to take on many aspects of their baby's care, once their baby is stable. This model is called 'Family-Integrated Care'. The Family-Integrated Care model has been successfully introduced to a small group of patients at Mount Sinai Hospital in Toronto, Canada, and is now extended to more families in NICUs across Australia and New Zealand. To understand whether this model of care is better for parents and their babies, the NICU and Special Care Nursery (SCN) at the Canberra Hospital are participating in an international, randomised trial. This study examines whether the Family-Integrated Care model improves the health and wellbeing of prematurely born babies. Parents and babies will be involved in this project from the time of enrolment until the babies are discharged from the hospital or reach 36 weeks gestational age. Parents will be given access to small-group learning sessions and some additional support, to make it easier for them to be present in the NICU for the required amount of time. There will be no change in the nurse-to-patient ratio. It is estimated that this study will commence at the end of July 2014 and will be completed after July 2015.

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. 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 clinical 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 people with appropriate assessment, treatment and care that result in improved mental health outcomes,
- providing hospital and community-based alcohol and drug services and healthcare 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 and 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, including people's homes. These services include:

Adult Mental Health Services
Adult Mental Health Unit (AMHU)
Belconnen Mental Health Team
City Mental Health Team
Gungahlin Mental Health Team
Mental Health Assessment Unit (MHAU)
Tuggeranong Mental Health Team
Woden Mental Health Team

ACT-wide Mental Health Services
Aboriginal Liaison Officer
Assertive Community Treatment Team
Brian Hennessy Rehabilitation Centre
Consultation Liaison—the Canberra Hospital (TCH) and Calvary Hospital
Crisis Assessment and Treatment Team
Dual Diagnosis
Mental Health Service for People with Intellectual Disabilities
Neuropsychology
Older Persons Mental Health Team

Justice Health Services
Forensic Mental Health Services
Justice Health Primary Health
Secure Adult Mental Health Inpatient Unit

Child and Adolescent Mental Health Services (CAMHS)
CAMHS South
CAMHS North
Dialectical Behaviour Therapy Program
Early Intervention Team
Eating Disorders Program
Perinatal Mental Health
The Cottage

Alcohol and Drug Program
Consultation and Liaison
Counselling and Treatment Services
Diversion Services
Opioid Treatment Service
Withdrawal Services

Achievements

Mental Health, Justice Health and Alcohol and Drug Services:

- exceeded its target of 100,000 occasions of service for the Adult Mental Health Services program by 15 per cent. This result reflects the response to increased demand for services and increased staff resourcing to meet this demand
- exceeded its target of 97,000 occasions of service for the ACT-Wide Mental Health Services program by 5 per cent. This higher than expected level of activity resulted primarily from the high levels of contact with the Crisis Assessment and Treatment Team
- achieved 9 per cent above its target of 103,000 occasions of service for the Justice Health Services program. This can be attributed to the increased demand related to an increased muster at the Alexander Maconochie Centre (AMC)
- met its target of 98 per cent of all new clients on pharmacotherapy treatment for opioid dependency having a completed management plan
- achieved 98 per cent against its target of 70,000 occasions of service for the Alcohol and Drug Services program
- met its target of 100 per cent of all detainees admitted to the AMC having a completed a health assessment within 24 hours of detention.
- achieved 98 per cent against the target of 100 per cent of all young people admitted to Bimberi Youth Justice Centre having a completed a health assessment within 24 hours of detention. The shortfall was the result of a refusal for the health assessment to be undertaken
- achieved 98 per cent against the target of 65,000 occasions of service for CAMHS. An increase in staffing levels will improve the ability to reach the target
- continues to be the national leader in reducing seclusion and restraint in mental health inpatient settings. In 2013 the ACT Chief Psychiatrist at the 9th National Seclusion and Restraint Forum showcased the work done with seclusion and restraint in the AMHU, which achieves the lowest rates across Australia. Seclusion reduction remains a high priority for the staff in the AMHU. There has been a continuation of the Early Support Intervention Team, a joint venture between hospital wardspersons and nursing staff that was started in 2011. Early identification of distress now invokes a supportive response to minimise the impact of the distress of the behaviour of the consumer and the general milieu of the ward environment. This work continues as part of the model of care implementation in the AMHU
- within the AMHU, continues to implement the model of care, which promotes consumer engagement at its centre. The therapy program has been extended, with activities being available after hours and on weekends. Planning is also underway to implement the High Dependency Unit activities program.

Other achievements are set out below.

- The transition clinicians embedded within the individual Adult Community Mental Health Teams now attend the Adult Mental Health Unit a half-day a week. The primary function of these clinicians is to support the transition and coordinate care for people exiting from either of the two public ACT Psychiatric Inpatient Units (Adult Mental Health Unit and Calvary Psychiatry Ward 2N) into the community setting.
- Belconnen Mental Health is now operating an extended service from the Gungahlin Community Health Centre three days a week. This service provides improved access for people who live in the most northern suburbs of Canberra.
- The Brian Hennessy Rehabilitation Centre (BHRC) Gym was opened in October 2013 as part of Mental Health Week celebrations in order to establish a health and fitness program for residents at BHRC. The gym currently provides a range of gym equipment, including bikes, a cross trainer and rowing machines. The gym also includes dedicated space for gait assessment and yoga/relaxation.

- The Scentenary Garden at Brian Hennessey Rehabilitation Centre was launched in December 2013. This was a collaborative project between ACT Health and the Centenary of Canberra through which a therapeutic garden was constructed for BHRC residents, carers and staff. Funding was provided by the Canberra Hospital Foundation and the Yulgilbar Foundation.
- The CAMHS new model of care was endorsed by the ACT Health Redevelopment Committee in 2013. Implementation has focused on establishing the Dialectical Behaviour Therapy (DBT) program, a consumer consultant within the service, and the CAMHS Bimberi liaison functions; enhancing the capacity of the Perinatal Infant Mental Health Consultation Service to respond to comorbid presentations, ultra high risk and early onset psychosis; working to build the capacity of CAMHS to provide mental health promotion prevention and early intervention across the age streams and illness continuum; strengthening partnerships with community stakeholders; and securing system responses to enhance access, effective transitions and seamless care within and at the interface of the service.
- The Eating Disorder Program provides specialised treatment for people of all ages. The service provides assessment and treatment through family-based therapy, young adult day programs and individual sessions. The program has benefited greatly from a trial of a nurse two days per week. The service also provides a significant amount of training in the community; it has provided 12 separate training sessions in 2014. A current goal for the service is to increase support for families and carers through education and support groups.
- 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 regard to 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.
- At the Hume Health Centre, Justice Health Services (JHS) now has:
  - a Suboxone withdrawal and pre-release regime. This is the first time Suboxone has routinely been used to manage opioid withdrawal and a pre-release regime in an ACT correctional facility. JHS continues to offer methadone for acute opioid withdrawal and maintenance. Currently, approximately 30 to 35 per cent of the detainee population is on opioid replacement therapy within the AMC.
  - hepatitis C treatments, through a shared care model with a referral pathway with the gastroenterology service of the Canberra Hospital. Currently, up to 12 patients can continue to be cared for through a complex treatment regime.
  - in partnership with Women's Health Service, a weekly women's counselling program, which commenced in January 2014 at the AMC
  - a High Risk Assessment Team (HRAT) convened at the AMC. This is a multi-agency forum where Primary Health and Mental Health interface with ACT Corrective Services to discuss issues related to detainees' risk.
- Forensic Mental Health Services now provides:
  - ongoing support to the Mental Health Community Policing Initiative (MHCPI)
  - a Senior Mental Health Clinician employed at the AMC to increase oversight and improve collaboration between Health and Corrections staff, and to coordinate follow-up after release from custody
  - an occupational therapist at the AMC, with the intention of developing a service within JHS
  - Dialectical Behaviour Therapy based group sessions, in collaboration with ACT Corrective Services at the AMC
  - a Consultant Psychiatrist, who liaises with magistrates to increase collaboration and understanding between Health and the judiciary
  - training and information-sharing sessions with Chief Magistrate and Forensic Mental Health staff to increase collaboration and understanding between Health and the judiciary
  - family meetings with clinicians and consultant psychiatrists at Bimberi Youth Justice Centre.
- In the Alcohol and Drug Services (ADS) program:
  - influenza vaccination clinics are now established for clients of the Opioid Treatment Service and the Inpatient Withdrawal Services
  - the ADS and the ADS Diversion team were the recipients of Aboriginal and Torres Strait Islander Reconciliation awards, recognising the work being done across the program in providing access and service delivery to people from Aboriginal and/or Torres Strait Islander backgrounds
  - the ADS Interlock Program commenced in June 2014. Alcohol interlocks are breathalysers that are wired to the ignition of a car and prevent the driver starting the engine unless they return a reading of 0.00. ADS will receive referrals from ACT Policing to provide assessments and treatment recommendations and to refer people immediately into treatment. The person is required to undertake four mandatory counselling sessions before a probationary licence will be issued.
  - the ADS Pharmacist has introduced a nicotine dependence outpatient clinic for ADS. Forty-eight clients participated in the pilot study, with 166 interventions being made. Clients report appreciation of the clinic as an alternative option for smoking cessation. Several reported they had quit smoking, and many reported reducing their smoking.
  - ADS psychotherapy and counselling is now provided from Tuggeranong, Belconnen, Gungahlin, Hume and City health centres.

- The Mental Health, Justice Health and Alcohol and Drug Services division implemented a smoke-free environment in response to concerns around passive smoking raised by consumers, carers and staff. As of 1 January 2013, all areas of the division became smoke free. Staff have completed training designed to assist people who smoke by providing education, support and access to a range of nicotine replacement therapies. The division won the 2013 Health Promotion Award for the smoke-free initiative, in the category 'outstanding achievement to address unhealthy behaviours'.
- The Mental Health Policy Unit has progressed the following initiatives:
  - The *Mental Health (Treatment and Care) Act 1994* has been under review and a draft amendment bill was tabled in the Legislative Assembly on 15 May 2014. The review has considered the relationship with the *Human Rights Act* as well as other changes in the human rights context, including the United Nations Convention on the Rights of Persons with Disabilities. The review has resulted in several changes which will increase people's control and voice in their own treatment decisions. However, the nature of mental illness and mental disorder can still at times require involuntary treatment which restricts people's human rights.
  - New provisions were introduced for treatment of the small minority of people whose mental illness leads to offending behaviour and contact with the justice system. The Human Rights Commission and a range of mental health consumer and advocacy groups have been involved in the review since its inception. The ACT Legislative Assembly's Standing Committee on Justice and Community Safety released its scrutiny report on the bill on 27 May 2014, commending the effort and skill involved in the way the bill's explanatory statement explains the provisions of the bill against human rights standards identified in a number of international instruments and, more particularly, the Human Rights Act. Debate on the bill is planned for later in 2014.
  - The most significant policy impact for people with disability in the ACT has come from the implementation of the National Disability Insurance Scheme (NDIS), which commenced in the ACT from 1 July 2014. The NDIS will provide people with disability, and their families and carers, assurances of a level of support to assist them to engage in activities of daily living, including community engagement. The National Disability Insurance Agency (NDIA) will be responsible for administering the NDIS. The NDIS will potentially have a significant positive impact in the lives of people living with serious and enduring mental illnesses and their families. The total funding associated with the NDIS will rise from an existing ACT investment of approximately $120 million per annum in 2013–14 to $342 million per annum in 2019–20. This is a doubling of the investment in disability services in the ACT, in real terms.
  - In the area of community forensic mental health, the 2013–14 ACT Budget provided funding, under Growth in Community Mental Health Service initiatives, for short-term psychosocial support to people with mental illness exiting the criminal justice system. This service will assist people to re-engage with the community and regain independence after release. In February 2014 after a public tender process, the Mental Illness Fellowship Victoria was selected as the preferred provider. The Detention Exit Community Outreach Support (DECOS) program commenced operation in March 2014. It provides up to three months intensive transitional support for individuals with a diagnosed mental illness who are exiting correctional facilities. The DECOS model ensures a continuum of care for people through a seamless case management partnership between Mental Health, Justice Health and Alcohol and Drug Services Forensic Mental Health and the Mental Illness Fellowship of Victoria.
- In the area of promotion, prevention, early intervention and suicide prevention:
  - The Let's Talk suicide prevention campaign aims to raise community awareness around suicide prevention and to provide information about where to seek help. The 2014 campaign focused on young people. Professor Diego De Leo from the Australian Institute for Suicide Research and Prevention was keynote speaker at a public forum about suicide prevention in young people, which was attended by approximately 40 parents, teachers and carers. Information about the Let's Talk campaign was also distributed at a public barbeque in Garema Place, and through a range of media outlets.
  - The Men's Mental Health and Suicide Prevention Forum, a joint initiative between ACT Health and non-government agencies, aims to promote the education and training of service providers on engaging and working with men, with a particular emphasis on suicide prevention, and was attended by 120 members of the sector. Highlights included presentations from local sporting personalities Mark Vergano, CEO of ACT Cricket, and Clyde Rathbone of the ACT Brumbies, about the efforts being undertaken in sport to enhance the wellbeing of sportspeople.
  - The 2011–12 and 2012–13 evaluation reports *Managing the risk of suicide: a suicide prevention strategy for the ACT 2009–2014* and *Building a strong foundation: a framework for promoting mental health and wellbeing in the ACT 2009–2014* were tabled in the Legislative Assembly. These reports indicate that:
    - there has been an increase in the number and range of activities agencies have embedded into their strategic plans and strategies to promote mental health and wellbeing and
    - the number of agencies providing clinical supervision for clinicians who respond to individuals who have attempted suicide or self-harm has increased to 100 per cent.

Issues and challenges

- The division is facing some challenges in finding staff to fill clinical vacancies. Strategies include the implementation of health professional officer career pathways to ensure ongoing development, mentoring and consideration of the sustainability of the health professional officers in this sector.
- The commencement of the NDIS and the associated planning and implementation requirements are significant for this division. An implementation plan has been developed to ensure appropriate services are available for eligible consumers for the transition of care arrangements to the NDIS and to support those people who may not be eligible or who may have difficulties accessing these services.

Future directions

- An Adult Mental Health Day Service (AMHDS) began operating from the Belconnen Community Health Centre in July 2014. This is an interim measure until an enhanced AMHDS is commissioned in the University of Canberra Public Hospital. The AMHDS will include treatment for adults aged 18–65 years and will offer sub-acute support services, programs aimed at preventing an acute psychiatric admission, day treatment therapies, transitional support for those people exiting acute services and reintegrating back into the community, intensive psychological therapy, and extended treatment and recovery programs.
- 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.
- JHS will conduct the 2014–15 Young Persons in Custody Health Survey.
- Forensic Mental Health Services will provide training on mental health awareness and processes to the magistrates of the ACT law courts. Preparation and organisation for the training has commenced. This initiative will be further expanded to other agencies, such as the Office of the Director of Public Prosecutions and and Legal Aid services. Forensic Mental Health Services has also continued to provide mental health awareness and education training to Bimberi youth workers as part of their training inductions.
- ADS will continue to develop the pharmacist-led Nicotine Replacement Clinic for clients of the Opioid Treatment Service and withdrawal services. This clinic will work in collaboration with the Adult Mental Health Unit and Canberra Hospital campus. The pilot program is currently being evaluated.
- The Adult Mental Health Services Model of Care project will review and develop mental health services currently provided to adults (aged 18–64 years) within the ACT. The development of this Model of Care (MoC) will inform the concept design of health infrastructure. The MoC will be developed around evidence-based practice and comply with all relevant legislations. This project includes the development of Models of Care for Adult Mental Health Rehabilitation Services and the AMHDS as well as a review of adult community mental health services, including the roles of crisis assessment and assertive outreach components of mental health care.
- Implementation of the CAMHS MoC will continue, with a focus on promoting prevention and early intervention and addressing ultra high risk and early psychosis.
- The development of the MoC for the Secure Mental Health Unit was finalised in May 2014 and is now available on the ACT Health website. The facility design process is underway. Work will commence in 2014–15 on the workforce plan for this unit.
- The business case for the expansion of the Primary Health Service at the Hume Health Centre will be undertaken to ensure that staffing levels reflect the increasing demands on that team.

Output 1.3 Public Health Services

Output description

Improving the health status of the ACT population by:

- reducing the susceptibility to illness using interventions to promote behaviour changes
- altering the ACT environment to promote the health of the population
- promoting interventions that remove or mitigate population health hazards.

This includes programs to:

- evaluate and report on the health status of the ACT population
- assist in identifying particular health hazards
- apply measures to reduce the public health risk from communicable diseases, environmental hazards and the supply of medicines and poisons.

	2013–14 targets	2013–14 actual outcome	2014–15 targets
Output 1.3: Public Health Services			
Samples analysed	7,800	10,765	8,500
Compliance of licensable, registrable and non-licensable activities at time of inspection	85%	76%[1]	85%
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%	97%	100%

Notes:
An increase in non-compliant premises identified through routine inspections, complaint-based inspections and re-inspections of non-compliant premises.

The Population Health Division is headed by the Chief Health Officer, who is appointed under the *Public Health Act 1997* and reports to the Director-General of ACT Health. The Chief Health Officer is required to report biennially on the health of the ACT population and address specific health-related topics. This is done through the Chief Health Officer's Report.

The Population Health Division has primary responsibility for the management of population health issues in ACT Health. 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.

The Health Improvement Branch (HIB) is responsible for policy and program delivery in the areas of health promotion and preventive health. The HIB also collects, analyses and disseminates information on the health status and health-related behaviours of the ACT population, which can be used to monitor, evaluate and guide health planning and policy.

The Health Protection Service manages risks and implements strategies for the prevention of, and timely response to, public health incidents. This is achieved through a range of regulatory and policy activities in areas such as food safety, communicable disease control, environmental health, emergency management, pharmaceutical products, tobacco control and analytical services.

The Office of the Chief Health Officer (OCHO) is responsible for providing public health advice, both internally and externally to the division, and undertaking high-level project and policy work on behalf of the Chief Health Officer. Policy priority areas for the OCHO include gene technology, climate change, the whole-of-government Healthy Weight Initiative, and the whole-of-government Initiative on Injury Prevention.

Achievements

- The Population Health Division fulfilled its statutory and national reporting requirements for 2013–14. These included the collection of data for, and maintenance of, the ACT Cancer Registry and Maternal and Perinatal Data Collection. The Population Health Division fulfilled national reporting requirements on public health expenditure, cancer incidence and mortality, and maternal and perinatal statistics for the ACT.
- On 20 June 2014, the Acting ACT Chief Health Officer released the *ACT Chief Health Officer's Report 2014*. The report is a legislated requirement under the *Public Health Act 1997* and profiles the health of the ACT population, including mortality, morbidity, health-service use and social factors influencing health. The report is to be tabled in the Legislative Assembly in August 2014 in accordance with the act.
- The Population Health Division published three health series publications in the reporting period:
  - *Health status of children in the ACT: Results from the 2007–10 ACT General Health Survey*
  - *Substance use and other health-related behaviours among ACT secondary students: Results of the 2011 ACT Secondary Students Alcohol and Drug Survey*
  - *Perinatal mortality in the ACT, 2006 to 2010.*

The results of these three reports are supporting informed policy and program development across the ACT.

- The Population Health Division has a survey program that supports the monitoring of ACT population health trends. Survey results are published in a number of reports and health series publications, which are used to inform health policy and program development. The survey program includes:
  - the ACT General Health Survey, a telephone computer-assisted technology household survey which collects information on a range of factors influencing health status
  - the ACT Secondary Students Alcohol and Drug Survey, a classroom-based questionnaire conducted every three years, collecting information on risk behaviours of ACT secondary school students, including alcohol, tobacco and illicit drug use
  - the ACT Year 6 Physical Activity and Nutrition Survey, a classroom-based questionnaire conducted every three years on children's weight status, physical activity and nutrition.
- In 2013–14, the Population Health Division continued to strengthen its quality systems in population health data collection and reporting. This included continuing work on the development of systems for the electronic transmission of maternal and perinatal data in the ACT and ongoing collaboration with maternal perinatal data providers to improve the accuracy, completeness and timeliness of data provision.
- The Population Health Division continued to build local capacity in data linkage between key population health data collections by updating and extending the data collections available for linkage. The division experienced a significant increase in requests for access to data for linkage projects, most likely driven by increased awareness of the facility and increased availability of data for linkage. To ensure the best practice management of access to data for linkage projects, staff received training on ethics and data linkage.
- Since 1 September 2013, all food businesses in the ACT have been required to appoint a food safety supervisor. The food safety supervisor is responsible for ensuring that hygiene and food safety standards are achieved and maintained in food businesses. This requirement ensures a trained food safety supervisor is able to provide food safety advice and guidance at each registered food business.
- In February 2014, a team of nine public health officers conducted food inspections during the three-day National Multicultural Festival. Inspections were conducted to minimise the risk to public health from poor food handling and to ensure food handlers were aware of safe food-handling processes. More than 200 inspections were conducted during the event. Public health officers routinely looked for potential breaches of the *Food Act 2001* that would give rise to unacceptable food safety risks, including inadequate temperature control, poor handwashing facilities and inappropriate food storage. A number of food safety breaches were identified, resulting in six incidents of voluntary disposal of food. No food was seized.
- Prior to the event, public health officers undertook two information sessions for community stallholders. One session provided important food safety requirements and compliance information. In the second, which was requested by the South Pacific Islander community, information was provided on food safety and the exemption granted under the *Medicines, Poisons and Therapeutic Goods Act 2008* for the consumption of kava at the National Multicultural Festival. Food safety requirements also applied to the consumption of kava, including the use of ladles and single-use cups.
- The Health Protection Service updated the food stall guidelines for the National Multicultural Festival. The guidelines help food stall organisers meet food safety requirements. The food stall guidelines include:
  - a checklist for operators
  - a fact sheet on the set-up of food stalls and facilities required
  - a fact sheet on food handling and food safety.

  The Health Protection Service has translated the documents into 11 languages to improve food stall operators' understanding of food safety requirements at future festivals.
- The Population Health Division has expanded 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 policy development on, and the assessment of, ambient air quality. The station became operational in Florey at the end of February 2014.
- The Population Health Division undertook public consultation on options to expand the Medicines Advisory Committee and change the requirements for prescribing controlled medicines under the *Medicines, Poisons and Therapeutic Goods Act 2008*. The consultation found most stakeholders supported an expansion of the Medicines Advisory Committee membership from three to seven members and the streamlining of controlled medicine prescribing through the use of a standing controlled medicines approval.
- In response to previous consultation outcomes, the Health Protection Service amended the Medicines, Poisons and Therapeutic Goods Regulation 2008 to enable the ACT to carry out Commonwealth Government initiatives for the continued dispensing of Pharmaceutical Benefits Scheme medicines in defined circumstances and the supply and PBS claiming of medicines from standardised medication charts in residential aged care facilities.

- The Health Protection Service received external funding to conduct a desktop exercise to test the public health response to a deliberate water contamination event in the ACT. The Health Protection Service formed a working group with the Australian Federal Police, ACT Policing and ACTEW Water to develop the exercise concepts. The exercise was conducted on 16 May 2014 at the National Museum of Australia and was attended by representatives from the Population Health Division, Canberra Hospital and Health Services, Calvary Healthcare ACT, ACTEW Water, the Australian Federal Police, ACT Policing, the ACT Ambulance Service and stakeholders from the ACT Government. A number of issues were raised and lessons learnt from the exercise, and the report highlighted issues and made recommendations to strengthen future responses.
- In June 2014, the Health Protection Service responded to a case of meningococcal disease in an Australian Defence Force Academy Officer Cadet. In accordance with national guidelines, the Health Protection Service worked closely with Australian Defence Force Academy personnel to identify close contacts of the case and distribute information about meningococcal disease to the broader Australian Defence Force Academy community. Twelve contacts were provided with clearance antibiotics. Since 2004, there have been 40 notifications of meningococcal disease in the ACT, including this case. Prior to this case, the last case in the ACT was in July 2013. There has been a significant reduction in the incidence of invasive meningococcal disease in the ACT since the introduction of the meningococcal C vaccine in 2003.
- In 2013–14, two cases of measles were notified in the ACT. One person acquired their infection overseas and the other case was linked to an overseas-acquired case. An increase in overseas-acquired measles cases was also observed nationally in 2013–14, highlighting the importance of measles vaccination, especially prior to overseas travel. The Health Protection Service investigates and implements disease control measures for each confirmed case of measles under national guidelines. Since the beginning of 2009, 25 cases of measles have been notified in the ACT, of which 13 were associated with an outbreak linked to a school in late 2011.
- The Health Protection Service hosted a forum for the staff of aged care facilities on 8 May 2014. The primary aim of the forum was to provide the facilities with information to increase their preparedness for influenza season. It covered topics such as infection control measures, surveillance data and outbreak management. Presenters at the forum included staff from the Health Protection Service and Canberra Hospital. More than 22 people from ACT aged care facilities attended the forum.

Issues and challenges

- The Population Health Division implemented new confirmation methods for food pathogens. In recent years, there have been major food-borne outbreaks of gastrointestinal illness. The introduction of these new confirmation methods will help to reduce testing turnaround times, deliver better responsiveness, and provide the community and businesses with an improved outcome.
- Since 1 September 2013, all food businesses in the ACT have been required to appoint a food safety supervisor. Some non-profit community organisations were adversely affected by this regulation due to the costs associated with training a food safety supervisor. On 21 November 2013, the Minister for Health, Katy Gallagher MLA, announced that community organisations operating temporary food stalls selling lower-risks foods, such as barbeque foods, would be exempt from the requirement to register as a food business and have a food safety supervisor.
- The 2011 Auditor-General's Report identified the need to address a shortage of skilled environmental health officers in the ACT. ACT Health collaborated with the University of Canberra to establish a local accredited environmental health course. However, due to insufficient enrolments, the Bachelor of Environmental Health course did not proceed. Students who had enrolled in the course were transferred to other science-based courses at the university.
- A large-scale public health response was required to comply with a national Therapeutic Goods Administration directive issued on 1 May 2014 to quarantine batches of the anaesthetic Propofol. The national quarantine was called due to suspected contamination of certain batches of Propofol with the bacteria *Ralstonia pickettii*. The Health Protection Service coordinated the ACT response to the national directive through activation of the Emergency Operations Centre from 2 to 6 May 2014. Significant liaison and coordination with stakeholders was required to identify potential users and stock holdings among ACT hospitals, dental surgeries and day procedure units. Ongoing liaison was required to determine territory holdings of the quarantined batches and stock holdings of usable alternatives to ensure surgical service provision was not adversely affected. A multi-agency after-action review was conducted at the Health Protection Service on 14 May 2014. A number of recommendations arose from the review. The Health Protection Service will work with stakeholders to address the issues raised to improve arrangements for future responses.
- A multi-agency health response was required to investigate and manage cases of a toxicological syndrome consistent with ingestion of death cap mushrooms, *Amanita phalloides*, that occurred in a family group between 24 and 30 April 2014. The public health investigation into the source of the poisoning was undertaken by the Health Protection Service in conjunction with the Australian Federal Police and ACT Policing. Clinical case management was undertaken by Calvary Health Care ACT and the Canberra Hospital and Health Services division. A multi-agency after-action review was conducted on 13 May 2014 at the Health Protection Service. A number of recommendations arose from the review. The Health Protection Service will work with stakeholders to address the issues raised to improve arrangements for future responses.

Future directions

- Development work for a website featuring air quality data has been ongoing. The aim is to give the public access to ambient air quality data for the Canberra region, with a view to having an Air Quality Index to provide an overall rating of ambient air quality.
- The Health Protection Service is progressing with amendments to the Medicines, Poisons and Therapeutic Goods Regulation 2008 to allow the prescription of controlled medicines under a standing controlled medicines approval. The changes are aimed at minimising the regulatory burdens imposed on health professionals responsible for the safe supply of controlled medicines and at providing patients with timely access to therapy. The changes will be supported by the real-time collection of pharmacy dispensing data to minimise the harms of controlled medicine abuse, misuse and diversion.
- The changes announced on 21 November 2013 to the regulation of food sold by certain non-profit community organisations require amendments to the *Food Act 2001* and subordinate legislation. These amendments include the removal of registration, notification and food safety supervisor requirements for temporary non-profit community organisations. The Health Protection Service expects this body of legislative work to be completed in 2014.
- The Health Protection Service continues to work on developing and improving enforcement strategies for food safety in the ACT. The Health Protection Service is working towards greater engagement with industry by increasing regulatory transparency and establishing an industry–stakeholder reference group. The Health Protection Service is developing regulatory tools—for example, guidelines, manuals and procedures—for public health officers to support the inspection process and to improve regulatory consistency and industry confidence in food safety regulatory activities. The Health Protection Service will systematically publish regulatory tools such as inspection forms and manuals to facilitate increased regulatory transparency. The Health Protection Service continues to work on improving data integrity and the efficiency and effectiveness of food safety services.
- ACT Health has a dual role in emergency management. Under the ACT Emergency Plan, ACT Health is the lead agency for some types of emergencies and a supporting agency for all of the others. Section 148 of the *Emergencies Act 2004* directs that an ACT Emergency Plan be prepared and that the Emergency Plan include provision for a disease or epidemic emergency. The ACT Emergency Plan directs that ACT Health prepare sub-plans covering communicable disease and pandemic emergencies and a generic Health Emergency Plan.
- The Population Health Division commissioned an independent external review of the effectiveness of ACT Health's organisational approach to emergency management. The objective of the review was to provide ACT Health with independent, external analysis and opinion on the effectiveness of the directorate's current approach to emergency management and make recommendations for improvement. The review was conducted between May and June 2014. It included analysis of current legislation, plans and policy, and interviews with executives and managers who execute emergency management arrangements. A report with eight recommendations was provided to the Population Health Division at the end of the process. The division will now work to develop a formal response to the review report and liaise with the ACT Health Executive Council in 2014–15 to implement the agreed recommendations and strengthen organisational arrangements.
- The Health Improvement Branch is developing a new web platform to report on national and local indicators, as well as other population health priorities. At 30 June 2014, the project was at the proof-of-concept phase. It is due to be completed by 30 June 2015. The project aims to increase the utility of population health information for stakeholder groups.
- An independent review of the ACT Cancer Registry will be undertaken in 2014. Recommendations will be made on various aspects of the registry to inform future directions.

Output 1.4 Cancer services—Cancer, Ambulatory and Community Health Support

Output Description

Cancer, Ambulatory and Community Health Support (CACHS) 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 cancer meet targets, ensuring that waiting times for access to essential services such as radiotherapy are consistent with agreed benchmarks, and increasing the proportion of women screened through the BreastScreen Australia program for the target population (aged 50 to 69 years) to 70 per cent over time.

In November 2012, the Nous Group was engaged to review the 2011 restructure of the ACT Health Directorate. From this review, 36 recommendations arose to inform future strategy and organisational design, including in March 2014 the renaming of the division from the Capital Region Cancer Service to Cancer, Ambulatory and Community Health Support (CACHS). The new name reflects the activity and staff of the division, providing and/or supporting the provision of ambulatory and community health services across Canberra Hospital and Health Services.

The CACHS 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 in the form of screening, inpatient and outpatient services and community-based psychosocial support services. The division also manages and coordinates clinical outpatients administrative support, Health Centre Administration, Community Health Intake and Transcription Services.

CACHS ensures a continuum of care for consumers ranging from prevention and screening through to diagnosis, treatment, rehabilitation and palliative care.

Achievements

Cancer Services provided care for 1352 new radiotherapy patients in 2013–14. This is a 2 per cent increase on the 1,330 patients beginning radiotherapy services when compared to the same period last year.

Despite the increase in demand for radiation therapy services, waiting times have maintained the excellent record of recent years, with 100 per cent of all urgency categories receiving access within the standard timeframes.

Waiting times for breast screen appointments have improved as a result of the engagement of additional permanent radiographers (in 2011) as well as locum and casual radiographers. The BreastScreen ACT program no longer provides services to South East New South Wales and this has freed up radiography staff to provide services to women of the ACT. However, women who reside in NSW and who currently work in the ACT are still able to access BreastScreen services in the ACT.

In 2013–14, 97 per cent of women waited less than 28 days for their screening appointment. This is a marked improvement on the 24 per cent reported in 2010–11. Waiting times for the proportion of women who receive an assessment within 28 days has also maintained an excellent record in 2013–14, with a result of 93 per cent, compared to 76 per cent reported for the same period in 2010–11.

Despite ready availability of appointments, recruitment of women into the program to attend for screening is proving difficult. To improve the numbers, BreastScreen ACT has commenced an active recruitment campaign using multiple strategies, such as contacting lapsed attendees and sending letters to general practitioners to encourage women to have a breast screen. These new initiatives appear to be working, as there has been a 17 per cent increase in screenings performed in 2013–14. A total of 16,379 breast screens were performed for ACT residents over 2013–14, compared with the 14,017 screening procedures reported for the same period last year.

Other achievements over the reporting period are set out below.

- In November 2013, BreastScreen ACT was awarded four years accreditation by BreastScreen Australia.
- On 16 June 2014, the ACT Minister for Health signed the Commonwealth's National Partnership Agreement for the expansion of the BreastScreen Australia program to include women aged 70 to 74 years in the target age group.
- An Open Day and Women's Luncheon was held on 9 May 2014 to celebrate 21 years of screening in the ACT. Funding from the Canberra Hospital Foundation was granted for these events.
- BreastScreen ACT is screening more women than ever before. In the 24 months to 30 June 2014, BreastScreen ACT screened 30,396 ACT women. The estimated resident population for the target age group has increased by 2 to 3 per cent per year and in order to maintain the participation rate the program has been required to screen additional women.

- The Stereotactic Radiosurgery (SRS) program commenced clinical operation on 12 July 2013 for cranial techniques. SRS is a highly precise form of radiation therapy where treatment delivery is accurate to within one or two millimetres. This procedure delivers targeted radiation at much higher doses in fewer treatments, providing maximum dose delivery to the cancer while minimising the dose to surrounding healthy tissue.
- To date, 12 patients have received SRS treatment for single and multiple brain metastases. Recent developments have seen extension of the service to provide treatment for non-malignant acoustic neuroma.
- Radiation Oncology was recently credentialed to participate in a Trans-Tasman Radiation Oncology Group study in which patients can be randomised to receive stereotactic body radiotherapy. Treatment will be given initially in the context of the study but will be available to all eligible patients in the near future.
- Radiation Oncology has commenced the following clinical projects:
  - Rapid Access Clinic for palliative care patients
  - development and implementation of a simplified mono-isocentric breast technique
  - Information Technology Networking Group focusing on the upgrade of the ARIA Oncology Information System
  - expansion of verification imaging capabilities, including development of a credentialing program
  - development of respiratory gating, including deep inspiration breath hold to reduce the radiation dose to critical organs
  - development of the expanded application of intensity modulated radiation therapy to include treatment for prostate and anal canal cancers in addition to brain, head and neck cancers.
- The Radiation Oncology Administration team won the ACT Health Administration Excellence Award in 2013 for work undertaken to improve billing processes for patients.
- Following the successful recruitment of three clinical haematologists, the service has achieved significant reductions in waiting times for initial referrals. This has enabled expansion of the haemophilia and bleeding disorders service, and the establishment of the multidisciplinary lymphoma clinic.
- A grant was received from Novo Nordisk for a multidisciplinary approach to further develop and improve haemophilia services for the ACT and surrounding region. The project, Changing Possibilities in Haemophilia, is being led by Dr Nalini Pati.
- The Rapid Assessment Clinic commenced in September 2013, providing assessment for oncology and haematology patients who have symptomatic issues during treatment. The service is aimed at providing patients with access to immediate care by oncology and haematology specialists and diverting patients from presentation to the emergency department.
- In November 2013, Anastasia Wilson RN; Maria Burgess RN; Dr Philip Crispin, Haematologist; and Professor Matthew Cook, Immunologist, developed and implemented a program to support the change made by the National Blood Authority to make available subcutaneous immunoglobulin replacement products. This transition to subcutaneous therapy represents a significant advance for the management of patients with antibody deficiency to self-administer immunoglobulin at home.
- Cancer Psychosocial Services developed and consolidated processes to assist with more timely and effective delivery of services. This included a rollout of a formal referral process, including indicators to triage patients and formalisation of the intake process for the community-based services.
- The Care of the Dying Patient Pathway pilot was implemented in Ward 11A, Ward 14B and Ward 10A. The pathway reflects a shift from acute life prolonging treatment to acute palliative care. This enhances comfort and acknowledges the need to actively make decisions that promote sensitive and appropriate care for the patient in the last predicted days of life. This pilot has produced excellent feedback to date.
- Dr Matthew Cook was awarded an academic promotion to full professor level, effective January 2014.
- The Cancer Outreach Team, the Palliative and Supportive Services Team and the Oncology Pharmacy Team won Australia Day Achievement Medallions in 2014. In January 2014 a single administration/reception model of care was introduced across all health centres in the ACT. This involved the consolidation of front-line administration teams from all services within the centres into one team under the management of Community Health Support.
- The outpatient administration service has continued to redesign processes to address increasing demands and improve responsiveness for people accessing the services. Activities have included: formalised audit processes for waitlists in each specialty; communication strategies for patients, GPs and key stakeholders; changes to referral registration processes; and improved management of booking and scheduling processes.

Issues and challenges

- The new Canberra Region Cancer Centre is to open in August 2014. This is an exciting time for staff, including challenges for ongoing transition of services in the new centre.
- Achieving a 60 per cent BreastScreen participation rate for women aged 50 to 74 years will involve establishing a process to recruit women using electoral roll data and to increase capacity when the screening service opens at the Belconnen Community Health Centre. Of particular emphasis is the need to increase the number of women from Aboriginal and Torres Strait Islander and culturally and linguistically diverse backgrounds attending regular screening.
- Continued review of models of service is occurring across all specialties to meet the increasing demand for cancer services.
- Immunology is developing strategies to improve waiting times due to the demand for clinical services. Plans to expand the department are in place and will be implemented in 2015.
- Technology capabilities are a critical component of future service delivery in cancer, ambulatory and community health services. To help meet growing demand, ongoing enhancement and adoption of electronic medical record systems is underway, ranging across cancer management information systems and health centre operations, and incorporating client and patient support, such as queue management, Telehealth, better appointment scheduling, replacement of legacy systems and reduction of reliance on paper records.

Future directions

- The opening of a breast screening clinic at Belconnen Community Health Centre will ensure the service is able to accommodate the expansion of the target age group to include women aged 70 to 74 years, and increase access to breast screening for women living in Belconnen and Gungahlin.
- Using electoral roll data, ACT women in the target age group will be invited to attend breast screening.
- To increase survivorship support options:
  - a post-treatment group is being developed and will be rolled out in October–November
  - co-facilitation of the TRUCE group will take place with CanTeen for adolescents and young people who have a parent with a cancer diagnosis
  - to facilitate involvement in the survivorship model, a survey will identify psychosocial care questions to help inform service delivery
  - art therapy will complement psychosocial services for both inpatients and outpatients.

Other future directions include:

- the establishment of research agendas across the clinical departments and a working relationship with the new Centenary Cancer Chair at the John Curtin School of Medical Research
- further development of disease-streamed clinics and multidisciplinary meetings with clinical haematology
- partnership with University of Canberra (UC) and the New South Wales Survivorship Clinic (UNSW) to progress development of a Cancer Survivorship Centre at the UC campus
- development of a business plan with Molecular Oncology, ACT Pathology, for transition of the cancer molecular testing service to the next generation sequencing platform. Cancer molecular testing refers to the detection of so-called driver DNA mutations within cancer cells. This testing will assist with enhancing the diagnosis and detection of the important mutants in tumour samples using next generation sequencing technology, leading to more effective targeted therapies for ACT patients.
- plans to build on research efforts in genomics to begin to implement personalised medicine in routine patient care in immunology
- refurbishment of the central outpatient area at the Canberra Hospital campus to improve access and flow and provide a comfortable, calming environment for patients and their families waiting for a specialist appointment.

Output 1.5—Rehabilitation, aged and community care

Output description

The provision of an integrated, effective and timely service 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,
- ensuring that access is 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 healthcare needs of the community.

The Rehabilitation, Aged and Community Care (RACC) Division integrates public health system rehabilitation, aged and community care, 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 covering the range of 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, sub-acute and community healthcare services while fostering professional development and promoting best practice in rehabilitation, aged and community care.

RACC services are delivered at a broad range of sites throughout the ACT, including hospitals, community health centres and the homes of clients. This includes health care and support for people with acute, post-acute and long-term illnesses.

Achievements

- In August 2013, the Aged Care and Assessment Team (ACAT) took back the responsibility of managing all referrals to ACAT from initial point of contact through to assessment end. The changes to the process of referral acceptance, triage and processing have improved the service's capacity to manage referrals in a timely manner. ACAT has met ACT Health requirements to respond to public hospital-based assessments within two working days of acceptance of an appropriate referral. From June 2013 to June 2014, there was a 90 per cent decrease in the number of ACAT priority 3 referrals waiting to be actioned by ACAT.
- ACAT responded to changes in legislation planned for 1 July 2014 with further upgrades to the national software database and 100 per cent completion of mandatory training as set by the Commonwealth.
- The Transitional Therapy and Care Program provides goal-focused care to facilitate the transition of elderly clients from hospital to the home. The improved average occupancy rate of 81.81 per cent across the first two quarters of 2013–14, up from 55.42 per cent in 2012–13, can be attributed to improved identification of suitable patients and intake processes with the introduction of the access officer role, coupled with the provision of extensive education to hospital staff about the program.
- Community Allied Health Services exceeded the established activity target (22,000 occasions of service), providing 24,789 occasions of service. The improvement was made by increasing the staffing levels in podiatry and physiotherapy, which included the establishment of a physiotherapy clinical educator position.
- Community nursing services were expanded at Belconnen Community Health Centre and Tuggeranong Community Health Centre with the opening of the new and refurbished health centres under the ACT Health Infrastructure Program. Additional ambulatory care clinics, providing mostly wound and continence care, post-chemotherapy monitoring and medication administration, have been established at the health centres and have improved access to care.
- The community nursing service has also expanded the Self Management Chronic Conditions Program with the implementation of additional Living a Healthy Life with Long-term Conditions courses for community participants across the ACT. This self-management course is patient- and family-centred and empowers the patient to take more responsibility for their health, monitor and manage their symptoms, adhere to treatment regimes and work collaboratively with their health providers. This course educates patients and carers on a variety of self-management strategies, including the management of pain, fatigue, anxiety and depression, healthy eating, exercise, dealing with difficult emotions and working with health professionals to assist in managing conditions optimally.
- The Exercise Physiology Department is also placing greater emphasis on self-management through behaviour change and goal setting. The department will continue to work with multidisciplinary chronic disease and rehabilitation programs that are already established within the department.

- A research project aimed at improving services for patients with recurring venous leg ulcers was funded through a Nursing and Midwifery Practice Development Scholarship. As part of the project, monthly compression stocking clinics with a nurse practitioner in wound management commenced at Gungahlin Community Health Centre. Interim results indicate improved outcomes for participants. This clinic provides improved patient assessment for suitability for ongoing compression therapy, prescription of correct pressure gradient stockings, improved monitoring of skin integrity, better support and advice for ongoing care, access to a clinic for ongoing expert advice and monitoring by a nurse practitioner.
- Stroke education groups within the Community Rehabilitation Team (CRT) were developed and established during 2013–14. A Vestibular Rehabilitation Clinic has also been established at Phillip Health Centre and Belconnen Health Centre (as part of the CRT). The CRT is also now providing services from the expanded Belconnen Community Health Centre.
- RACC inpatient nursing services successfully introduced assistants in nursing into the Acute Care of the Elderly team (Ward 11A), to improve the quality of service while reducing reliance on short-term agency nurses.
- In collaboration with food services and nutrition services at the Canberra Hospital, the RACC inpatient nursing services team introduced initiatives to improve the nutritional intake of patients. Initiatives include coloured meal mats to denote which patient requires assistance, monthly themed lunches and a move towards a protected mealtime. Protected mealtimes allow patients to eat their meals without disruptions (for example, a ward round or medication round) and enable staff to focus on providing support and assistance to patients.
- The Walk-in Centre in Tuggeranong Community Health Centre opened on 26 June 2014 following the closure of the Walk-in Centre at the Canberra Hospital on 25 June 2014. The Walk-in Centre at Belconnen Community Health Centre opened on 1 July 2014.
- The Prosthetics and Orthotics Service has added the manufacture of custom medical-grade footwear to its range of services. Following necessary recruitment, set-up and training, the service commenced manufacturing custom medical-grade footwear for clients in January 2014.
- The Domiciliary Oxygen and Respiratory Support Scheme renegotiated the contract with the current supplier and commenced purchasing continuous positive airway pressure (CPAP) machines outright, which has resulted in minimising the rental cost of the scheme. At 30 June 2013, 777 clients were receiving support through this scheme. In 2013–14, 971 clients were receiving assistance, an increase of 25 per cent.
- A number of RACC staff received awards during 2013–14:
  - Hazel Hurrell, Assistant Director of Nursing, RACC was awarded the 2014 Manager of the Year at the ACT Nursing and Midwifery Excellence Awards; Emma Whitehead, Allied Health Assistant with CRT, was awarded Allied Health Assistant of the Year; and Kerryn Maher, Manager of the RACC Podiatry Service, was awarded Allied Health Professional of the Year and the Allied Health Award for Management and Leadership for Excellence.
  - RACC staff member Margaret Hemsworth was nominated in the 2013 ACT Health Awards for Administrative Excellence, as was the Village Creek Centre administration team.
  - The Community Care quality activity titled ‘Improving Documentation of Clinical Interventions’ won the 2013 ACT Quality in Healthcare Award, safety category through demonstrating improvement to documentation of clinical intervention.
  - The Community Care Podiatry Team won the Allied Health Award for Excellence.
  - At the Australian Wound Management Association Conference in May 2014, the Nurse Practitioner for Wound Management, Judith Barker, was presented with a fellowship that recognises her outstanding contribution to the Australian Wound Management Association (AWMA) committee activities and her clinical leadership. She is the first AWMA Fellow from the ACT.
- The Exercise Physiology Department received an allied health funding grant to develop two posters about the multidisciplinary Cardiac Rehabilitation Program and six-minute walk test data.

Issues and challenges

- A number of RACC services will be impacted by the commencement of the ACT trial of the National Disability Insurance Scheme (NDIS) on 1 July 2014. Preparations for the service delivery, financial, IT and communications issues have been undertaken but work will continue as the trial progresses.
- RACC is actively involved in the establishment of the University of Canberra Public Hospital (UCPH). The staging and decanting of Building 3, TCH will impact on RACC services.
- ACAT will need to support the delivery of online assessment and a centralised support system as determined by the Commonwealth through the My Aged Care System. The national framework will ensure a centralised entry point which will make it easier for older people, and their families and carers, to access information on ageing and aged care, have their needs assessed, make referrals and be supported to locate and access services available to them. This will be supported by a central client record.
- Reduced access to residential aged care beds has continued to impact on the average length of stay and separations in the inpatient wards. In November 2012, RACC contracted eight beds at Goodwin Aged Care Service at Monash for inpatients waiting for permanent placement in a residential aged care facility. The current contract with Goodwin Aged Care Service will cease on 30 September 2014, and these inpatients will be transferred back to Canberra Hospital under the bed realignment project.

Future directions

- RACC will continue to be heavily involved in the design and development of the new UCPH.
- RACC is participating in the NDIS pilot, and continues to work closely with Community Service Directorate and the National Disability Insurance Authority locally.
- Tuggeranong Community Health Centre is expected to expand its weekend nursing clinic services to meet ongoing clinical demand now that more clinic space is available in the new health centre.
- RACC community-based services are expected to expand its services and increase number of staff positions in 2014–15. This will include additional allied health and nursing services, including the creation of a clinical nurse consultant for stoma therapy to assist with increasing demand in this area.
- The CRT is expected to provide additional rehabilitation services to community patients with neurological diagnoses as a result of additional funding attached to community health services.
- The introduction of the community electronic clinical record in 2015 will improve real-time access of clinical information for staff working in domiciliary and clinic settings in the community health centres, including the Walk-in Centres.
- During 2014–15, ACAT will develop processes to allow for referrals, assessment services, referrals for service delivery from other agencies and maintenance of a central client record.

Output 1.6—Early intervention and prevention

Output Description

Improving the health and wellbeing of the ACT population through a range of programs, services and initiatives, focused on early intervention, prevention and health promotion. The key strategic priorities for early intervention and prevention include encouraging and promoting healthy lifestyle choices to decrease the rates of conditions like obesity and diabetes and reducing risky health behaviours such as smoking and alcohol consumption and maintaining high levels of immunisation.

ACT Health undertakes several activities aimed at increasing the focus on initiatives that provide early intervention to health conditions that may result in major acute or chronic health care burdens on the community.

Early intervention is managed in many ways, including ACT Health screening programs such as BreastScreen, Cervical Screening and Newborn Hearing Screening, as well as immunisation programs.

ACT Health supports a comprehensive range of programs aimed at primary prevention to reduce the onset, causes and complications of chronic diseases.

ACT Health primary prevention programs are aimed at quantifying and preventing chronic disease across the ACT population.

Achievements

- The ACT maintained its position as the jurisdiction with the highest life expectancy in Australia. In 2012, the life expectancy of ACT residents was 81.2 years for males and 85.1 years for females. Cancer, mental disorders and cardiovascular disease are the leading contributors to the total burden of disease in the ACT, contributing nearly half of the total disease burden.
- ACT Health continued to work to the National Partnership Agreement on Preventive Health (NPAPH). This was a funded initiative from 2010 due to run until 2018. However, the Federal Budget for 2014–15 ceased the funding from 1 July 2014. Aimed at stimulating action in preventing chronic disease, the NPAPH funded the delivery of five different initiatives. NPAPH-funded initiatives progressed during 2013–14 were:
  - Healthy Children: ACT Health delivered programs aimed at reducing the rates of overweight and obesity in children aged 0–18 years. These included:
    - *Kids at Play (Active Play):* contributes to an increase in active play by children aged three to five years in Early Childhood Education and Care (ECEC) services in the ACT. The 2013 Kids at Play (KAP) Repeat Impact Evaluation undertaken with the Heart Foundation reported that during phase 3 of Kids at Play (June 2012 to September 2013) 156 educators from 39 ACT ECEC services were involved in 17 KAP training sessions, and 104 activity van visits were delivered to 62 Long Day Care (LDC) services, three Family Day Care (FDC) schemes, one independent preschool, eight playschools and 12 ACT Government preschools.
    - *Fresh Tastes: healthy food at school*: aims to increase knowledge and availability of healthy food and drinks in ACT primary schools. Twenty-four schools signed up to the three-year Fresh Tastes program in the first six months of recruitment. Fifty-nine schools undertook a menu assessment, with 17 of these having had an annual menu review showing a 34 per cent decrease in 'red' or unhealthy foods and a 20 per cent increase in 'green' or healthy foods.
    - *Ride or Walk to School (RWTS)*: encourages primary school students across the ACT to ride or walk to school. Twenty schools developed action plans. Physical Activity Foundation received an ACT Health Healthy Canberra Grant to implement the RWTS program in 30 more schools. Four cycling related professional development workshops were implemented for 49 teachers. The Health Improvement Branch continued to work across government to increase the number of children able to ride or walk to school , including developing RWTS maps for eight schools, with another 10 maps under development.
    - *It's Your Move ACT*: this research intervention with Deakin University targets high schools to increase physical activity and healthy eating and aims to reduce unhealthy weight gain in young people aged 12–16 years. Results of this research are expected by the end of 2014. Across the three implementation schools there are significant changes to improve health and wellbeing of students and staff, including an increase in physical activity opportunities, changes to the food environment in the schools, and policy guidelines written to restrict 'red' or unhealthy food and drink availability in school.
    - *Healthy Food@Sport:* aims to increase healthy food choices available to children and young people through sporting canteens. The program worked with 19 clubs in 2013–14. An evaluation of the pilot clubs is currently underway.

- Healthy Workers: ACT Health delivered programs to promote and support healthy lifestyles in and through ACT workplaces.
  - *Healthier Work*: ACT Healthier Work undertook site visits to 42 individual ACT workplaces. The external evaluation of Healthier Work continues to inform service strategies. To further enhance workplace engagement, a Healthier Work Recognition Scheme was developed along with additional capacity-building activities, such as networking sessions and health and wellbeing training.
  - *Public sector health promotion*: ACT Health continued to support the ACT whole-of-government Workplace Health and Wellbeing Policy through the implementation of a comprehensive staff health and wellbeing program known as 'my health' for ACT Health employees. A key achievement was the endorsement in December 2013 of the Healthy Food and Drink Choices Policy for ACT Health staff, volunteers and visitors to ACT Health facilities. The policy is being implemented gradually, so that by March 2015 staff, food outlet operators and vending machine suppliers will have had time to make the necessary changes.
- Healthy Communities Initiative (HCI): The initiative aimed to reduce the prevalence of overweight and obesity among adults not in paid employment in the Inner North of Canberra and received its final funding under the NPAPH for the year ended 30 June 2014. Achievements included:
  - delivering the Australian Red Cross FOODcents program in partnership with Community Health Dietitians to service providers and community members through a mix of training, education sessions and development of resources. This builds the capacity of this workforce to provide nutrition advice to clients they work with.
  - increasing the number of people participating in active recreation.
  - neighborhood gardens in public housing complexes providing improved access to fresh produce as well as increasing social connectedness and community safety.
  - providing outreach mini-health checks for marginalised communities, including flu vaccinations and improved referral pathways to primary health care.

- Social marketing: Achievements included the ongoing promotion of the ACT-developed campaign, 'Beyond Today... it's up to you' to encourage healthy lifestyles and smoking cessation among the Aboriginal and Torres Strait Islander community.
- The refocused ACT Health Promotion Grants Program opened its two new funding opportunities for applications on 24 August 2013. Healthy Canberra Grants focus on tackling obesity across the population and on improving children's health, including improving eating habits through school canteens and food education. The Health Promotion Innovation Fund focuses on the same priorities as the Healthy Canberra Grants and offers smaller value grant funding opportunities several times per year.
- The *Towards Zero Growth: Healthy Weight Action Plan* was launched by the Chief Minister on 14 October 2013. Since then, implementation groups comprising representatives from all ACT Government directorates, key non-government organisations and academic institutions have been working collaboratively to implement the actions in the plan.
- Responsibility for the coordination and oversight of the Healthy Weight Initiative and implementation of the actions listed in the action plan was formally transferred from ACT Health to the Chief Minister and Treasury Directorate in May 2014.
- The Health Protection Service undertook consultation from 21 March to 12 May 2014 as part of Future Directions for Tobacco Reduction in the ACT. Submissions were welcomed on options for restricting access to tobacco through increased tobacco licence fees and changes to licensing schemes. Section B.3 Community engagement in this report contains more information on the consultation.
- 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 2013–14, ACT childhood immunisation coverage rates remained above the national target of 90 per cent for 12-month-old children. ACT Health's target of 92 per cent of one-year-old children being fully immunised was exceeded in all quarters (92.7 per cent, 93.3 per cent, 92.7 per cent and 93.4 per cent).
- The National Partnership Agreement on Essential Vaccines 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:

  i. maintaining or increasing vaccine coverage for Indigenous Australians

  ii. maintaining or increasing coverage in agreed areas of low immunisation coverage

  iii. maintaining or decreasing wastage and leakage

  iv. maintaining or increasing vaccination coverage for four-year-olds.

  The ACT cannot be assessed against benchmark 2, as the ACT does not have any identified areas of low immunisation coverage.

  In 2013–14 the ACT achieved three of the three assessable benchmarks (benchmarks 1, 3 and 4).

- Implementation of the ACT Immunisation Strategy 2012–2016 continued, with work targeted at maintaining ACT immunisation coverage rates and reaching vulnerable community members.
- The Human Papillomavirus Vaccination Program for boys commenced in 2013 for boys aged 12 to 13 (in Year 7) through a school-based immunisation program, with a two-year catch-up component for boys in Year 9.

  Preliminary data on HPV vaccine delivered through the school immunisation program indicates the following uptake rates for the 2013 calendar year:

  – Year 7 girls: 80.2 per cent
  – Year 7 boys**:** 78.7 per cent
  – Year 9 boys**:** 68.7 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 2014, the ACT participation rate for the target population was 58.04 per cent. The Australian Institute of Health and Welfare (AIHW) report *Cervical screening in Australia 2010–2011* puts the ACT in the top three jurisdictions in Australia for participation in cervical screening and first overall in Australia for the five-year participation rate.
- During 2013–14, the Cervical Screening Program actively promoted an updated message about regular cervical screening to community groups and to reflect the change recommended by the Australian Government Medical Services Advisory Committee (MSAC) in late April 2014. Several print media campaigns were implemented to promote the updated screening message among women in the community. Brochures were also updated to reflect this change. Program staff attended notable women's health events in the ACT to promote screening, including the Women's Health Information Forum organised by Women's Centre for Health Matters (WCHM) and the Control and Choice Expo 2014 organised by Advocacy for Inclusion for people with disabilities.
- During 2013–14, Population Health Division commenced a partnership with the Australian National University, after winning an Australian Research Council grant in 2012. This grant will enable the development of methods for policymakers to better use research in population health. In 2013–14 the academic partners held interviews with decision-makers and policy advocates and implemented an online survey to identify barriers to the uptake of research evidence in population health and to develop a training model to improve processes by which researchers and policymakers work together. Tools to assist policymakers to use evidence will be developed following this study. As part of this study, a PhD student commenced a Research Translation Internship placement in the Population Health Division.
- ACT Health is a founding funding partner in the National Health and Medical Research Council's The Australian Prevention Partnership Centre (TAPPC). TAPPC focuses on the interrelation of health and non-health systems with regard to primary prevention and chronic health problems and will undertake an integrated program of work designed to enable policy and program developers to make better decisions about the strategies and structures to prevent lifestyle-related chronic conditions in Australia. The work of TAPPC aligns well with the key ACT Government initiative Towards Zero Growth: Healthy Weight Action Plan.
- BreastScreen ACT is part of a national population breast screening program that is aimed at reducing deaths from breast cancer through early detection. Further information can be found in the section Output 1.4 Cancer Services on page 52 of this report.
- School-based nursing programs:
  – Immunisations: From the beginning of 2013, the HPV vaccine, Gardasil, was offered to boys in Year 7 as well as girls, with the catch-up program for male Year 9 students ending at the end of 2014. The average uptake of this vaccine in the male student population has been 80 per cent.
  – Kindergarten health checks: For the first time in 2014, the results of the kindergarten health check are being sent to the family's GP (if nominated on the consent form) for ongoing support.
  – The School Youth Health Nurse works in high schools with a preventive focus, including early identification, brief intervention and harm minimisation activities. The nurse is often the first point of contact for young people, their families and school community members seeking information, advice and support in health matters. Further information can be found in section B.2 under Division of Women, Youth and Children on page 68 of this report.
- The Asthma Nurse Educator Service provides asthma education and support to children, young people, families and community groups. The focus is on clients understanding and managing their asthma to prevent acute episodes. The demand for this service has increased by 60 per cent in the last five years.
- Newborn Hearing Screenings are provided to every newborn in the ACT and 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 68 of this report. As part of the Commonwealth-funded National Bowel Cancer Screening Program, endoscopy services are provided to patients. Further information can be found in section B.2 under Division of Medicine on page 34 of this report.
- Well Women's Checks were provided to 42 per cent of women from culturally and linguistically diverse communities. This is above the target of 30 per cent, and an increase of 2 per cent from the 2011–12 period.
- 100 per cent of children aged 0 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. This is above the target of 80 per cent, and an increase of 10 per cent from the 2011–12 period.

- In May 2013, the ACT Minister for Health endorsed the *ACT Chronic Conditions Strategy—Improving Care and Support 2013–2018,* building on the previous strategy. The strategy sets the direction of care and support for those living with chronic conditions in the ACT and outlines a collaborative approach to this vitally important area of health care. Implementation and evaluation of the strategy is being overseen by the ACT Primary Health and Chronic Condition Steering Committee (PH&CCSC).
- The ACT Minister for Health launched the *ACT Primary Health Care Strategy 2011–2014* on 14 December 2011, building on the previous Primary Health Care Strategy and setting the direction for primary health care into the future. The strategy aims to improve integration between general practice and the wider healthcare sector in provision of primary health care. The strategy has been developed within the context of the outcomes of the Council of Australian Governments (COAG) health reforms and a range of existing health-related strategies and plans. Implementation of the strategy is being overseen by the ACT Primary Health and Chronic Condition Steering Committee (PH&CCSC).

Issues and challenges

The very low numbers of Aboriginal and Torres Strait Islander children in the ACT means that ACT Aboriginal and Torres Strait Islander coverage data should be read with caution, as the immunisation coverage rates can fluctuate greatly. Coverage rates can vary dramatically between cohorts and between reporting periods.

- Increasing and maintaining high immunisation coverage rates in Aboriginal and Torres Strait Islander children will continue to be a challenge. The Health Protection Service is actively pursuing different strategies to increase immunisation rates for Aboriginal and Torres Strait Islander children, including phone contact with parents of children identified as overdue for immunisations, discussions with stakeholders, liaising with Winnunga Nimmityjah Aboriginal Health Service and investigating immunisation promotion opportunities with the Aboriginal and Torres Strait Islander community. The Health Protection Service has been working collaboratively with the ACT Medicare Local Closing the Gap unit on the production of immunisation resources and education for relevant communities.
- The Health Protection Service undertakes a quarterly mail-out to parents of children who are recorded in the Australian Childhood Immunisation Register as overdue for immunisation, either because they have not been vaccinated or because their vaccination has not been recorded on the register by their immunisation provider. This letter advises parents or guardians that their child is overdue for immunisation, reminds them of the importance of vaccination and enables any administered but unrecorded vaccinations to be entered onto the register.

Future directions

- Health Promotion will continue to focus population-based health promotion initiatives on contributing to the ACT Government Healthy Weight Initiative in both children’s settings and workplace settings. This will include the launch of a social marketing campaign targeting parents of children to increase engagement in healthy lifestyle behaviours.

B.3 COMMUNITY ENGAGEMENT

ACT Health recognises that building an effective healthcare system requires genuine collaboration between consumers, carers and ACT Health staff. ACT Health is committed to providing opportunities for consumers and carers—those who are most affected by healthcare services—to influence the development, delivery and review of services. Increasing the participation of consumers and carers in health care is fundamental to building strong partnerships. The quality of care ACT Health provides is higher as a result of meaningful consumer and carer involvement in policy development and planning of health services.

The *ACT Health Consumer and Carer Participation Framework* aims to assist consumers, carers and ACT Health staff to work in genuine collaboration in order to:

- increase consumer and carer participation in health care
- facilitate joint decision-making at all levels and
- improve the development, delivery and evaluation of ACT's public health services.

Opportunities for consumer participation within the health system exist at many levels and at many points within the continuum of care and delivery of services. These include, but are not limited to, participation at:

- the level of **individual care***,* where there are interactions between the consumer, patient and/or carer and the healthcare providers
- the **service level***,* where consumer and carer participation is focused on contributing to service delivery guidelines and procedures
- the **organisational level***,* where the level of participation is focused on broader strategic and policy development activity.

ACT Health already has in place an extensive range of established practices and initiatives that demonstrate its ongoing commitment to consumer and carer participation. Examples of these include:

- Listening and Learning: Consumer Feedback Policy and Standards
- implementation of the *Australian charter of healthcare rights* and *Charter on the rights of children and young people in healthcare services in Australia*
- Consumer, Carer and Community Representative Reimbursement Policy
- relationships with consumer advocacy agencies through service funding agreements
- Respecting Patient Choices program
- Patient- and family-centred care framework.

ACT Health has actively engaged with the community on a range of matters, as indicated below.

Population Health Division

The Health Protection Service undertook a public consultation on options to expand the Medicines Advisory Committee and change the requirements for prescribing controlled medicines under the Medicines, Poisons and Therapeutic Goods Regulation 2008. The Health Protection Service published an online consultation paper for comment and hosted two face-to-face discussion forums for key stakeholders, in August and October 2013. The Health Protection Service received 33 stakeholder submissions in response to the consultation. The majority of submissions favoured the option to expand the Medicines Advisory Committee and streamline the prescribing of controlled medicines through use of a standing controlled medicines approval process. The Health Protection Service is currently exploring regulatory amendments to further the consultation outcomes.

The Health Protection Service undertook consultation on restricting access to tobacco as part of Future Directions for Tobacco Reduction in the ACT. The consultation, between 21 March and 12 May 2014, included options for restricting tobacco through increased tobacco licence fees and changes to licensing schemes. The discussion paper was distributed to more than 260 stakeholders, including tobacco licensees, public health advocacy groups and industry groups. The paper was also placed on the ACT Government Time to Talk consultation website and the ACT Health website. Sixty written responses were received. The majority of submissions were from tobacco licensees from both small and large ACT businesses. Issues raised by submitters are currently being reviewed to create a summary report. Where the submitter agreed, submissions are expected to be published in the near future on the ACT Government's Time to Talk consultation website. All received submissions and views expressed during the consultation process will be considered as part of any future regulatory development.

Newspoll was contracted to conduct an omnibus survey of 1000 Canberra adults to gauge and benchmark community attitudes to vending machines and drinking tap water. Qualitative focus testing was undertaken to test the potential effectiveness of creative concepts promoting tap water as the drink of choice, which resulted in development of a new marketing brand that was launched in June 2014.

To inform the development of the 'ways to wellbeing' social marketing campaign, parents of children aged 8 and under were consulted in a quantitative online survey of 100 people, qualitative focus group testing involving 28 people, and in-depth interviews with Aboriginal and Torres Strait Islander parents. The social marketing campaign promotes healthy lifestyle messages to parents of children in this age group and will be implemented in 2014–15.

From November 2013 to January 2014, the ACT Government undertook a public consultation process regarding the future of the *Gene Technology (GM Crop Moratorium) Act 2004*. A consultation paper was placed on the Time to Talk website and advertised in the Community Noticeboard section of *The Canberra Times* in line with the ACT Government Guide to Community Engagement. No submissions were received.

The Health Protection Service undertook a targeted consultation in June 2014 with the medical community and select health advocacy groups on making changes to the guidelines for prescribing amphetamines for attention deficit hyperactivity disorder. Approximately 500 doctors were invited to provide comment during the consultation. The Medicines Advisory Committee independently reviewed all 13 stakeholder submissions received and agreed to change the guidelines in order to provide patients with greater access to therapy, and to ensure consistency with other jurisdictions.

Health Infrastructure and Planning branch

Secure Mental Health Unit model of care

The draft model of care (MoC) for the ACT's Secure Mental Health Unit was released for public and stakeholder comment in November 2013. The availability of the draft MoC on the ACT Government's Time to Talk consultation website, and the opportunity to provide comment, was promoted through press advertising, social media, a project web page, posters, internal staff notices, and a project newsletter delivered to mental health staff, consumer and carer representative groups, and more than 3000 households located within approximately 1.5 kilometres of the site of the new facility.

A community information session about the draft MoC was held in December 2013. Approximately 30 people attended the session that was facilitated by Dr Norman Swan, ABC Radio National *Health Report* presenter, and included a Q&A panel discussion with experts in mental health service delivery. Feedback on the draft MoC was received through formal submissions, focus groups and at the public information session.

Overall, the MoC received positive feedback. As a result of the feedback, the sections on physical health needs, the need for outdoor spaces and occupational rehabilitation needs were expanded. The feedback showed that the community on the whole wanted to see a more therapeutic environment for people with moderate to severe mental illness.

Secure Mental Health Unit preliminary sketch plan

In May 2014, the preliminary sketch plan for the Secure Mental Health Unit was released for public and stakeholder comment. A preliminary sketch plan is the first stage of the design phase and illustrates what the final building may look like at the final sketch plan stage.

The plan was made available on the ACT Government's Time to Talk consultation website. The opportunity to comment was promoted through press advertising, social media, a project web page, posters, internal staff notices and a project newsletter.

A community information session, similar to one held as part of the unit's MoC consultation, was held in May 2014. An audience of just under 40 people comprising ACT Health employees, mental health sector workers, consumer and carer representatives, and residents of homes near the site of the facility received presentations from experts in mental health service delivery and from the unit's architect before a Q&A panel discussion took place.

The Health Infrastructure Program received 12 formal submissions. Although there remains some opposition to the site for the new facility, and concerns about consultation during site selection process, in general the design plans were well received by most stakeholders. Overall comments on the plan were supportive of the new facility with most of the comments received simply seeking further information or clarification.

The comments received during the consultation period are welcomed and valued by the project team and will be used to guide the development of the final sketch plan, prior to the lodgement of a development application in the second half of 2014.

Belconnen Community Health Centre open day

Before the new Belconnen Community Health Centre was opened, Canberrans were given the opportunity to take a look through the new building and engage in the final stage in the facility's development before it became operational. The community open day was held in November 2013 and was advertised through print and radio outlets, an eight-page lift-out in the *Canberra Times*, social media and printed promotional material. The open day drew a large crowd, in excess of 750 people. The feedback about the new facility was overwhelmingly positive.

Tuggeranong Community Health Centre open day

Before the newly expanded and refurbished Tuggeranong Community Health Centre was opened, Canberrans were invited to walk through the completed building before it opened its doors to its first clients. The open day, held in March 2014, was advertised through print and radio outlets, an eight-page lift-out in the *Canberra Times*, social media and printed promotional material. Around 300 people attended the open day, many of whom were past clients of the centre, who offered glowing compliments about its refurbishment and expansion.

University of Canberra Public Hospital service delivery plan

In June 2014 the service delivery plan for the University of Canberra was released for comment. The service delivery plan outlines the range of services that will be offered from the University of Canberra Public Hospital (UCPH). It also sets out the technical and environmental issues that need to be considered in the design, and outlines the design concept.

The plan was made available on the ACT Government's Time to Talk consultation website. The opportunity to comment was promoted through press advertising, social media, a project web page, posters, internal staff notices and a project newsletter delivered to key stakeholders and residents of homes near the site of the new facility.

At 30 June 2014 the consultation period for the service delivery plan remained open. Thirteen submissions had been received by that date. Health Infrastructure and Planning Branch had also begun working with the Health Care Consumers Association of the ACT (HCCA) to plan a forum, to be held in early July 2014, for HCCA members and interested community stakeholders. The HCCA will consolidate comments and prepare a formal submission.

University of Canberra Public Hospital environment assessment

Development of the new UCPH on its planned site is considered a 'controlled action' under the *Environmental Protection and Biodiversity Conservation Act 1999*. This means that it is considered to have a significant environmental impact and therefore requires assessment and approval before construction can proceed.

Documentation and reports relating to impacts on box gum woodland, golden sun moths, and flora and fauna were made available for public comment in May 2014. The documentation was made available on the ACT Government's Time to Talk consultation website and in hard copy at Macarthur House in Lyneham and the Belconnen Library. Opportunities to comment were promoted through the ACT Government Community Noticeboard, social media and the UCPH project web page.

At 30 June 2014 the consultation period for the environmental assessment remained open. Only one submission, a supportive letter from the Friends of Grassland, had been received.

Rehabilitation, Aged and Community Care

Future options for ACT Health Aged Day Care Program

Rehabilitation, Aged and Community Care (RACC) undertook a consultation in October and November 2013 on the Belconnen Aged Day Care Program. The objective was to explore a proposal that the Aged Day Care Program would be more appropriately delivered by a non-government provider co-located with other community services, rather than by ACT Health from a health centre.

An external consultant, Rob Allaburton, was engaged to conduct the consultation, which consisted of meetings with senior ACT Health staff; daytime and evening open forums available to approximately 50 program clients, carers and families; consultation with 15 staff; invitations to 10 community and consumer advocacy groups to make submissions; and a meeting with senior staff of the community-based organisation which took over the care of the clients of Tuggeranong Aged Day Care Program when it was transferred to another provider in 2011. Twenty-five individual submissions and 125 individual emails were received. The program transitioned to a non-government provider in July 2014.

Mental Health, Justice Health, Alcohol and Drug Service

Mental Health Services

Child and Adolescent Mental Health Services redesign

Child and Adolescent Mental Health Service (CAMHS) has a commitment to develop and strengthen collaborative practice with key stakeholders and to support the participation of people and carers at all system levels. CAMHS partners with and provides secondary consultation, psycho-education sessions, conjoint group work and networks with multiple and diverse stakeholder groups within the mental health sector, education sector, primary health care environment and children services. CAMHS engages and seeks the participation of parents, young people and children in many ways. Some examples of this are consumer and carer feedback, the consumer and carer feedback survey, participation in the routine evaluation of group programs and the participation on reference groups. Another example is the Perinatal Mental Health Consultation Service providing numerous education sessions to key stakeholders over the past 12 months. It has provided support for a former client to speak about her experience with postpartum psychosis, at the International Marce Society conference in Melbourne on 10 and 11 October 2013. It also provided support for a former client to speak about her lived experience with postpartum psychosis, at Queen Elizabeth II Family Centre on 7 April 2014.

A CAMHS consumer consultant has been employed full-time. CAMHS continues to regularly report to the CAMHS consultative committee, which includes constituents from across the mental health, education, justice and children services sectors.

Adult Mental Health Model of Care Steering Committee

The Adult Mental Health Model of Care Steering Committee was established to provide leadership to the development of an Adult Mental Health Service model of care (AMHS MoC), including the UCPH Health Infrastructure Project (HIP). Key partners in this steering committee include the peak bodies ACT Mental Health Consumer Network, Carers ACT and the Mental Health Community Coalition of the ACT. One of the main functions of this committee is to ensure community members and consumers are engaged in the development of the AMHS MoC. Representatives from over 20 consumer, carer and community agencies have been involved in a number of the working groups for the AMHS MoC.

National Disability Insurance Scheme Implementation Steering Committee

In preparation for the commencement of the National Disability Insurance Scheme (NDIS) in the ACT on 1 July 2014, Mental Health, Justice Health Alcohol and Drug Service established an NDIS Implementation Steering Committee to develop pathways to assist those NDIS-eligible and non-eligible consumers post implementation and to identify any issues that may arise for the people accessing these services, as well as potential impacts on service delivery. Key partners in this steering committee include the peak bodies ACT Mental Health Consumer Network, Carers ACT and the Mental Health Community Coalition of the ACT. There has already been one MHJHADS-led workshop, on 10 June 2014. A large number of community sector agency representatives were present to share their knowledge and resources to help identify and assist consumers in accessing the NDIS.

University of Canberra Public Hospital user groups and working groups

As part of the planning for the UCPH, user groups and working groups have been established for the development of both the MoCs and the building plans for both the Adult Mental Health Day Service and the Adult Mental Health Rehabilitation Unit. These groups meet monthly and include representatives from the peak bodies ACT Mental Health Consumer Network, Carers ACT and the Mental Health Community Coalition ACT. Internally, consumer consultants have also been involved in these groups. As part of this planning, forums were also held in April and October 2013 for Brian Hennessy Rehabilitation Centre (BHRC) staff, consumers and carers to discuss the transition of rehabilitation services from BHRC to UCPH.

Havelock Housing Association

A Memorandum of Understanding (MOU) was signed in May 2014 between MHJHADS and Havelock Housing Association (HHA) to further develop the collaborative relationship between the services. This MOU recognises the complementary role these services play in the provision of care and support for people who experience mental health issues. Provisions within the MOU assist AMHS to work with HHA in facilitating medium-term accommodation options for clients through the HHA program after they are discharged. These people will continue to be clinically supported by AMHS. HHA will assist with applications to Housing ACT for long-term housing options.

General practitioner liaison

A registered nurse commenced in the newly-created role of MHJHADS General Practitioner Liaison (GP Liaison) on 23 June 2014. This position will play a key role in clients' transitions from mental health services to community-based primary care services. The GP Liaison will promote and foster relationships between AMHS and GPs and Medicare Local. AMHS community teams will be supported in identifying people who may be suitable to transition to primary care and community support systems, and it is hoped that linkages with GPs and other providers will be better facilitated. In addition, the GP Liaison will be well placed to contribute to the work being undertaken with clients, and their families and support systems, to assist in the transition to primary care, including providing information and education on appropriate community-based services.

Alcohol and Drug Services

Alcohol and Drug Service forums

Consumers are actively involved in the clinical governance, business planning meeting and smoke-free environment implementation group. Six representatives from alcohol and other drug sector organisations, including consumer advocacy groups, attend. Good working networks and rapport have been established, with consumer voices having an influence on business, service delivery models and policy planning.

Alcohol overdose smart phone app development

Following the development of the Alcohol Overdose business card, this information has been incorporated into a smart phone application. Client groups have provided feedback in sessions (approximately 15 clients in total) and focus groups with the Youth Coalition are being arranged.

Drug Action Week 2014 survey

A survey was conducted during a barbeque for Drug Action Week, to seek client suggestions for future Health Promotion activities. Thirty-eight responses were received. This is an important process for opportunistic client engagement.

Justice Health Services

Forensic Mental Health Services

The Forensic Mental Health Services team engages with and supports clients in the community setting in a number of ways. The service seeks to support those clients in the community with a forensic history to remain mentally well and help minimise the risk of recidivism due to mental illness.

Clinicians at the Alexander Maconochie Centre (AMC) follow up with clinically-managed clients within seven days of their release into the community, and liaise with community mental health teams, justice and community services and non-government organisations for continuation of care. The Senior Clinician AMC fulfils the role of steward for the Detention Exit Community Mental Health Outreach Program (DECMHOP). DECMHOP is a newly-contracted program facilitated by the Mental Illness Fellowship of Victoria in conjunction with ACT Health, which offers mentally ill clients three months of intensive community support upon release from custody.

Bimberi Youth Justice Centre

Clinicians at Bimberi follow up with clinically-managed clients within seven days of their release into the community, and liaise with community mental health teams, Canberra Youth Justice, Care and Protection Services, non-government organisations and families for continuation of care.

A framework has been established for meetings with clinicians, consultant psychiatrists and young people's families at Bimberi. To date approximately 20 meetings have taken place.

Court Assessment and Liaison Service

The Court Assessment and Liaison Service provides mental health assessment services for the ACT Magistrates Court. Clinicians are available to assess those before the Court to ascertain the need for immediate psychiatric treatment and care or the requirement for community mental health follow-up.

Forensic Mental Health Services provides court-ordered psychiatric and psychological forensic reports for the ACT courts' consideration. This service is open to both those in custody and those in the community. In 2013–14, 138 forensic court reports were completed.

Forensic Community Outreach Service

The Forensic Community Outreach Service (FCOS) provides comprehensive risk assessment for clients of ACT community mental health teams. In 2013–14, 39 risk assessments were completed. FCOS also has a limited capacity to provide community clinical management for clients with moderate to severe mental illnesses who are (or who are at risk of being) in contact with law enforcement agencies because of aggressive or violent behaviour. The service seeks to support those clients in the community with a forensic history to remain mentally well and help minimise the risk of recidivism due to mental illness. In 2013–14, 383 clinical reviews were conducted. The service includes providing ACAT with clinical reports and documentation when considering community psychiatric treatment or restriction orders.

Justice Health Primary Health Service

The Chronic Diseases Nurse from the AMC Primary Health Service has begun to run a nurse-led Hepatitis C clinic on a fortnightly basis for detainees after their release, at the withdrawal unit located at the Canberra Hospital.

The Clinical Director for Justice Health Services participates in a fortnightly teleconference with Directions, Hepatitis ACT and Winnunga Nimmityjah Aboriginal Health Service to discuss issues and to provide a regular communication forum with Primary Health Services about detainee health and wellbeing issues.

Secure Mental Health Unit

As part of the development of the Secure Mental Health Unit MoC and preliminary sketch plans, there has been extensive community engagement, including a number of forums with peak stakeholders, community information sessions and regular newsletters. Thirteen submissions were received, and all feedback and questions from the information forums and focus groups were documented on a register and themed. Feedback relevant to the MoC was incorporated in the final version. The MoC on the ACT Health website and the invitation to provide feedback have been promoted through newspaper advertisements and ACT Health social media.

A document was developed to include all of the received feedback and was placed on the ACT Health website.

Division of Women, Youth and Children

Maternity Services model of care review

Over 2012–13, the growth in demand for birthing services at Centenary Hospital for Women and Children (CHWC) outweighed the overall birthing demand across the Territory. The period of high demand placed significant pressure on capacity within the hospital and resulted in some women raising concerns about the MoC. These concerns largely related to the approach under the MoC for well women to go home within 24 hours after giving birth.

An independent review team was commissioned through Women's Healthcare Australasia to review the CHWC Maternity Services MoC. It examined and provided an assessment of:

- the MoC in the new CHWC maternity unit and
- the capacity of ACT Maternity Services to meet current and future demand, taking into account recent changes to service demand as well as the MoC including a commitment to expand capacity on the north side of Canberra.

The report on the review of the MoC and ACT Health's response to the report were placed on the ACT Government Time to Talk website, and submissions were invited from the public between 28 November 2013 and 10 January 2014. Extensive internal consultation occurred in relation to the MoC during the review period. No feedback was tabled by staff during the consultation process. Australian Nursing and Midwifery Federation ACT, Friends of the Birth Centre, Health Care Consumers Association and one ACT consumer provided feedback on the report. Their submissions were also published on the Time to Talk website. After submissions were received, ACT Health's response to the report did not change.

The Maternity Leadership Group will oversee the implementation of the recommendations. This group has broad representation from medical and midwifery staff in the service, as well as a representative from the People, Strategy and Services branch. The meeting is chaired by the Clinical Director and Assistant Director of Midwifery. There is also consumer representation.

The Maternity Leadership Group is developing an action plan for the next three to five years, which will outline the service's plans to address the recommendations. This will be reviewed by senior management on an ongoing basis.

Community health programs

Healthcare Access at School

Healthcare Access at School (HAAS) provides nurse-led care to students with complex or invasive healthcare needs, while they are at school. This service is provided by the ACT Health Directorate's Women Youth and Children Community Health Program in partnership with the ACT Education and Training Directorate.

Following four community forums across the ACT in November 2012 and a successful pilot program during 2013, this MoC is now being implemented across all ACT Government schools, including the specialist schools. For school staff and parents of students attending Black Mountain, Cranleigh and Malkara schools, where a nurse has previously been based at the school, the move to nurse-led care is a significant change. It was important to communicate the changes to all concerned.

Black Mountain School (BMS) was the first specialist school to transition to the HAAS MoC. Information about the new model was delivered at meetings with school staff and parents, in the school newsletter, in letters and brochures sent to parents, and by phoning affected parents. More than 100 staff members attended the staff meetings, and five parents attended the community meetings. Individual phone discussions with parents about the new HAAS model were the most successful, as the discussion could be tailored to their child and how the transition would affect them. Parents and staff voiced concerns but were supportive of the new model. Since the implementation of HAAS at BMS, parents and staff members have shown good support. Some school staff members have been, or are being, trained as HAAS workers.

Nursing and Midwifery Office

The nursing and midwifery professions engage with and involve the community through a range of mechanisms to ensure that issues and concerns are understood and considered as part of the decision-making process. This is highlighted with membership on the ACT Nursing and Midwifery Network, the peak forum for nurses and midwives across all sectors in the ACT. As a member of this peak forum, the unit participates in decision-making on strategic and professional issues relating to the ACT nursing and midwifery profession and builds community awareness and understanding of issues challenging nurses and midwives in the ACT.

Each year during Nurses and Midwives Week celebrations in May, a Remembrance and Thanksgiving service is held at the Australian War Memorial. The defence force community, veterans and the broader ACT community are invited to honour nurses and midwives of the defence force who have served their country.

Through the Research Centre for Nursing and Midwifery Practice, HCCA members represent the ACT community to provide consumer input to research projects that have a direct impact on patient care and outcomes.

Cancer, Ambulatory and Community Health Support

Review into ambulatory care administration support services

A HCCA forum and workshop was undertaken on 20 March 2014 to engage with consumer representatives on the review into ambulatory care administration support services across Canberra Hospital and Health Services which commenced in 2013–14. The half-day activity involved roundtable discussions, led by consultants, about the need to redesign and expand administrative support services to meet increasing demand on ambulatory services. The workshop, attended by about 10 representatives, sought views on how ambulatory care services can best be supported by administration and how service access can improve to ensure approaches are patient- and family-centred with a focus on quality and safety.

Insights from the workshop, as well as client and patient needs, informed the review findings, which went on to recommend a model to provide best practice administration support to clinical services providing ambulatory care services. The model will be progressively implemented during 2014–15.

BreastScreen ACT

This advisory committee provides a forum for major stakeholders in the ACT region to discuss issues and provide feedback and advice to BreastScreen ACT and the Executive Director of Cancer, Ambulatory and Community Health Support on matters relating to the service provided to women in this region.

Meetings are held quarterly with representatives from Cancer Council ACT, Breast Cancer Network Australia, Bosom Buddies, radiography, ACT Medicare Local, pathology, radiology, breast surgery, epidemiology, Women’s Health Service, Winnunga Nimmityjah Aboriginal Health Service and Canberra Multicultural Community Forum. Feedback has been provided on program priorities and deliverables, stakeholder engagement, promotional activities and quality projects.

The **State Accreditation Committee** oversees accreditation activities within BreastScreen ACT and to work with members of the State Coordination Unit (SCU) and service providers to support the provision of quality services within BreastScreen Australia.

The **Community Reference Group** provides a forum for representatives of women of the ACT to discuss issues and provide feedback, support and advice to the breast screening program about its services. Two meetings are held each year with 10 representatives from HCCA, Women With Disabilities ACT, Cancer Council ACT, Women’s Health Service, Winnunga Nimmityjah Aboriginal Health Service, Canberra Multicultural Community Forum, Country Women’s Association and Bosom Buddies.

The **BreastScreen Information System and Digital Mammography Project Steering Committee** gains feedback and suggestions from consumers regarding the implementation of the BreastScreen Information System.

To celebrate 21 years of breast screening in the ACT and promote BreastScreen ACT to women living in Canberra, an open day and morning tea was held and attended by 70 people. The Chief Minister publicly acknowledged the contribution made by BreastScreen ACT and the achievements made over the last 21 years. Utilising funding provided by the CHF, a luncheon was held for women who have regularly been screened over the 21 years, and for their friends who have not yet participated in the program. Around 80 people attended, about half of whom were women who had not yet had a mammogram. The celebrations were promoted through newspaper and radio outlets, community noticeboards, other printed material and breast cancer networks.

Community education sessions were provided to community members on the early detection of breast cancer, and the aims of the BreastScreen program, through face-to-face education sessions and at information stalls at community events. Almost 300 people attended three of these events, which provided the opportunity for contact with community members and networking with community groups.

Policy and Government Relations Branch

Multicultural Health Policy Unit

Comments were sought on a proposed ACT Health strategic framework intended to improve the organisation's responsiveness to the health needs of culturally and linguistically diverse communities. The draft strategic framework drew on previous community consultation in 2011–12 relating to a review of the Canberra Hospital Migrant Health Unit. A guided feedback form was used to gather comments from organisations active in the multicultural sector. Feedback was received from the Canberra Multicultural Community Forum, which sought comments from member organisations, including the ACT Chinese Australian Association, ACT Chinese Aged Care Information and Referral Service, Ethnic Disability ACT, Australian Muslim Voice, and the Integrated Women's Network. In addition, comments were received from ACT Human Rights Commission, Centre for Culture, Ethnicity and Health (Victoria), HCCA, ACT Multicultural Mental Health Network, Companion House, ACT Council of Social Service, Public Health Association of Australia (ACT Branch), ACT Medicare Local and the ACT Office of Multicultural Affairs.

The comments received informed the development of a final draft. ACT Health Executive Council subsequently endorsed the document *Towards Culturally Appropriate and Inclusive Services: a Co-ordinating Framework for ACT Health, 2014–2018*. Letters were sent to all participating organisations providing responses to the comments made and indicating what amendments to the document had been made as a result.

Chronic and Primary Health Care Policy Unit

During 2012 ACT Health developed the *ACT Palliative Care Services Plan 2012–2017*. This plan incorporated the development of strategies for new and emerging models of care in palliative service provision and the development of more integrated services across acute, sub-acute and community health, and addressed service gaps. The development of this plan also involved an examination of likely demand projections, workforce needs now and in the future, community education and support for non-government organisations, and identified possible future models of care. The plan was released by the Minister for Health on 28 October 2013. It was very well received by the ACT Health sector, ACT palliative care stakeholders and the broader ACT community.

The **ACT Ministerial Advisory Council on Sexual Health, HIV/AIDS, Hepatitis C and Related Diseases** (SHAHRD) conducted a community consultation forum in May 2013 entitled 'The Future of HIV Prevention in the ACT'. Specific aims of the forum were to share research results with a broader community, to develop an understanding of the changing ACT context for HIV prevention and to provide an opportunity for networking in the sector. Approximately 25 interested community members attended. Guest speakers from the University of New South Wales Ian Down, Assoc. Prof. Garrett Prestage and Dr Martin Holt shared their respective research on the Canberra Gay Community Periodic Survey and the HIV Seroconversion Study. An associated HIV clinical care meeting with the same guest speakers was held for local clinicians. The aim of this meeting was to encourage ACT-based clinicians to discuss and translate ACT-based HIV research results into practice. Approximately 25 clinicians attended this meeting.

Mental Health Policy Unit

Men's Mental Health and Suicide Prevention Conference

In June 2013–14, the Mental Health Policy Unit was part of a planning committee that developed a conference focusing on men's mental health and suicide prevention. Other partners included the Australian Federal Police, OzHelp, Menslink and Lifeline. The fourth annual Men's Mental Health and Suicide Prevention Conference heard from Professor John MacDonald of the University of Western Sydney about men's mental health and the challenges men face. A number of seminars were aimed at particular stages in a man's life. The overriding intention of the conference was considering ways to increase the numbers of men attending services and those who seek help. The conference was attended by around 105 people, largely from community organisation service provision backgrounds. Feedback was very positive, and consideration is underway as to whether a similar event will be held in 2014–15.

Mental Health (Treatment and Care) Amendment Bill

Public consultations following the release of the second exposure draft of the *Mental Health (Treatment and Care) Amendment Bill* continued in 2013–14. Early in the review it was agreed that proposed amendments to the act would go through a two-stage exposure draft process so that the community and stakeholders could be confident that their contributions had been considered. The process was complemented by meetings with stakeholder groups, briefings to members of the Legislative Assembly and an iterative process with the review's advisory group, which included over 40 key stakeholders, including the ACT Human Rights Commission, consumer and carer representatives, advocacy groups from the mental health and disability areas, clinicians and other participants from the Health, Justice and Community Services directorates. Despite a great diversity of views and interests, a spirit of cooperation prevailed on the advisory group and a high level of consensus was achieved.

The Mental Health (Treatment and Care) Amendment Bill 2014 was formally tabled in the ACT Legislative Assembly on 15 May 2014. The bill reflects significant changes occurring internationally, with the inclusion of decision-making capacity as a criterion to decide whether people make their own decisions about treatment. The bill also seeks to reflect developments in human rights law in the ACT over recent years.

Aged and Community Care

Executive planning forum

The executive planning day explored the potential impact of the NDIS on the delivery of community care services in the ACT and specifically considered those clients who may not be eligible for access to services under the NDIS. The key objectives of the forum were to:

- increase understanding of potential gaps in service delivery for clients not covered by aged care reform and the NDIS
- seek input from stakeholders into what type of ACT program could best address these service gaps in the future and
- identify the pathway forward to developing a new or revised ACT community support program.

Approximately 45 representatives from 19 community organisations attended the forum. Participants identified a number of potential support needs that may not be addressed by the NDIS, including complex case management, advocacy, information and carer support, and responsive services in areas of palliative care, hospital discharge and clients with chronic health conditions. Participants demonstrated a commitment to continue to work collaboratively towards developing an appropriate range of services and an associated service delivery framework within the ACT, to address any gaps left after the introduction of the NDIS. Further consultation will take place in 2014–15.

Aboriginal and Torres Strait Islander Health Unit

Antenatal Care, Pre-pregnancy and Teenage Sexual and Reproductive Health (APTSRH) Project

The Antenatal Care, Pre-pregnancy and Teenage Sexual and Reproductive Health (APTSRH) Project is an initiative under element 2 of the Council of Australian Governments National Partnership Agreement on Indigenous Early Childhood Development. The project aims to increase provision of sexual and reproductive health services, antenatal care and early parenting support for Aboriginal and Torres Strait Islander young people.

In 2013–14, the APTSRH Project included broad consultation, community engagement and support with a range of stakeholders, including schools and community organisations such as the Tedd Noffs Foundation, Canberra College Cares, the Indigenous Social Inclusion Company and Bimberi Youth Justice Centre.

The project is also monitored by the APTSRH Advisory Group, which includes representation from The Junction Youth Health Service, Gugan Gulwan Youth Aboriginal Corporation, West Belconnen Child and Family Centre, Canberra Sexual Health Centre, Sexual Health and Family Planning ACT, and Winnunga Nimmityjah Aboriginal Health Service. Two advisory group meetings were held in 2013–14, with additional out-of-session consultation via email. In that time, the APTSRH Project also included:

- 53 Core of Life (COL) sessions, delivered to 12 organisations, with approximately 611 participants across all sessions
- a COL network meeting, held in October 2013, attended by nine participants
- distribution of two COL newsletters
- a COL facilitators training workshop, held in October 2013, attended by 13 participants
- approximately 27 sexual health youth outreach sessions, across 10 organisations, with approximately 270 participants

- a COL and sexual health information and testing stall as part of the NAIDOC on the Peninsula event in July 2013, attended by approximately 4500 people and
- extensive consultation with local stakeholders on the development of resources for young Aboriginal and Torres Strait Islander people, including two DVDs: *Give it a go*, a breastfeeding resource, and *Young Parenting, a new beginning*.

The project will continue in 2014–15 with funding under the new Commonwealth Indigenous Teenage Sexual and Reproductive Health and Young Parenting Support program.

Tobacco control

ACT Health, through its Aboriginal and Torres Strait Islander Tobacco Control Advisory Group (ATSITCAG), continued to engage and consult with local Aboriginal and Torres Strait Islander communities and relevant stakeholders on the issue of smoking cessation and tobacco control. ATSITCAG includes representatives from a range of organisations, including Gugan Gulwan Youth Aboriginal Corporation, Winnunga Nimmityjah Aboriginal Health Service, Alcohol Tobacco and Other Drug Association ACT, ACT Medicare Local, Australian Institute of Aboriginal and Torres Strait Islander Studies, University of Canberra, ACT Cancer Council, and the Centre for Excellence in Indigenous Tobacco Control. Three ATSITCAG meetings were held in 2013–14.

ACT Health has also continued to develop and implement its 'Beyond Today...it's up to you' smoking cessation and healthy lifestyles social marketing campaign. This has included face-to-face consultations with more than 20 Aboriginal and Torres Strait Islander health, education and sporting organisations. Beyond Today messages and materials were also included as part of Winnunga Nimmityjah Aboriginal Health Service's World No Tobacco Day event held on 30 May 2014.

Women, Youth and Child Health Policy Unit

Whole-of-government Commitment to Children and Young People

Community engagement was sought to develop a whole-of-government commitment to children and young people in the ACT, which is being developed in partnership with the Community Services Directorate.

Consultation has included an online survey on the Time to Talk website, along with two paper surveys for children and young people. Through the different engagement activities, there were more than 1200 responses to the survey.

More than 65 non-government partners were invited to undertake the survey. ACT Health staff spoke to children, young people and their parents and carers in the paediatric ward, high-care paediatric ward, paediatric outpatient clinic and hospital school within the Centenary Hospital for Women and Children. These conversations led to 27 surveys being completed. Twenty-four surveys were completed at a second community engagement activity, at the Civic Bus Interchange.

The outcome of the community consultation and engagement will inform the first draft of the Whole-of-government Commitment to Children and Young People. The draft commitment will then be sent out for a second round of community consultation later in 2014.

Table of Grants

In 2013–14, ACT Health funded activities related to the promotion of health across the ACT population. Grants provided to community groups are listed in the tables following.

Grants provided under 2013–14 community funding round

Recipient	Project	Project Purpose	Amount
Alcohol Tobacco and Other Drug Association ACT	Implementing Cross Cultural Validated Screening and Brief Intervention to Address Alcohol, Tobacco and Other Drug Related Harm Project	Embed the only cross cultural validated screening and brief intervention services working with people at risk of alcohol, tobacco and other drug-related harm	$50,000
Alcohol Tobacco and Other Drug Association ACT	Under 10% Project (stage 2)	Support ACT to be the first jurisdiction in Australia with a smoking prevalence under 10%	$57,000
Australian Breastfeeding Association ACT & Southern NSW Branch	Implement elements of the ACT Breastfeeding Strategic Framework 2010–2015	Implement elements of the ACT Breastfeeding Strategic Framework 2010–2015	$67,028
Australian Drug Foundation	Good Sports ACT	Assist sporting clubs to promote a smoke-free environment and a culture of responsible drinking	$49,000
Australian Red Cross	Eat Smart, Shop Smart	Provide training, support and advice to community organisations to set up a FOODCents program	$48,876
Belconnen Senior Citizens Club Inc.	Fun and fitness program	Conduct a fun and fitness program	$2,000
Companion House Assisting Survivors of Torture and Trauma Inc.	Nurturing Wellbeing	Support identification of mental health and wellbeing issues and develop ways to maintain mental health and wellbeing	$37,800
Companion House Assisting Survivors of Torture and Trauma Inc.	Nutrition and Exercise for Healthy Future	Improve healthy nutrition and physical activity for children and carers	$48,800
Companion House Assisting Survivors of Torture and Trauma Inc.	Young People Safe and Strong	Address alcohol misuse in young people	$47,000
Council on the Ageing (ACT) Inc.	POP – Positive Outcomes Program: the benefits of making healthy lifestyle choices	Educate ACT seniors on the benefits of making healthy lifestyle choices	$34,340
David Wirrpanda Foundation	Deadly Sista Girlz	Encourages positive health choices	$92,310
Football United – University of New South Wales	Empowered for Healthier Communities – a Football United Canberra Project	Provide regular physical activity and leadership/lifeskills training	$49,903
Health Care Consumers Association	Health Literacy for all: building an inclusive community of support with empowered health consumers and their families and friends across a lifetime	Develop a series of health literacy modules	$31,914
Hello Sunday Morning	Hello Sunday Morning	Change the drinking culture in the ACT by supporting individuals to make positive behavioural changes	$100,000
Multiple Sclerosis Ltd t/a MS Australia – ACT/NSW/VIC	Eating well for people living with multiple sclerosis	Provide information and cooking workshops on nutrition and healthy eating	$6,200
Nutrition Australia	Project Dinnertime – Communities in the Kitchen	Provide cooking workshops to improve knowledge, skills and confidence in the kitchen	$51,015
Reclink Australia	Bega Court Neighborhood Garden Project	Manage, facilitate and complete the construction of sustainable neighborhood vegetable garden	$98,621
SHINE for Kids Co-operative Ltd	Building resilience in a uniquely vulnerable group: children of prisoners	Increase the understanding of, and outcomes in, the health and wellbeing needs of children of prisoners	$107,200
Society of St Vincent de Paul Pty Ltd	Homeground	Provide support for homeless families through engagement in gardening, including growing healthy food	$59,859
Southside Community Services Inc.	Southside Flats Health Promotion Program	Promote healthy lifestyle options for residents of medium- and high-density housing areas	$42,424
Ted Noffs Foundation	Active lifestyle program	Improve physical and recreational activity and increase capacity to live healthy lifestyles	$30,000
Warehouse Circus Inc.	Spin Out! circus program	Provide weekly circus classes to young people, to improve physical activity outcomes	$35,514
YMCA of Canberra	Eat, Play, Love Life!	Enhance nutritional skills and confidence in parents of young children	$19,900
YWCA of Canberra	Healthy Learning=Healthy Eating	Improve healthy eating attitudes in children aged 7–12 years	$10,756

Multi-year grants continuing from 2012–13 Health Promotion Sponsorship Funding Round

Recipient	Project	Project Purpose	Amount
YMCA of Canberra Inc.	YMCA Senior Sports Carnival	Support the annual YMCA Senior Sports Carnival, designed for people who are residents or attendees of aged care facilities.	$10,000

Grants provided under 2014 Healthy Canberra Grants

Recipient	Project	Project Purpose	Amount
ACT Medicare Local	Connect Up For Kids	Improve pathways for obesity prevention for children while guiding families through health promotion advice, child health assessments, primary healthcare services and community-based programs	$148,969
Gordon Primary School	Lanyon Cluster of Primary Schools Every Chance to Dance	Implement the Kulturebreak program to the Lanyon cluster of primary schools	$18,000
Heart Foundation ACT	Live Lighter	Population-based education campaign encouraging adults to make healthier lifestyle choices to improve overweight and obesity outcomes	$139,751
Physical Activity Foundation Ltd	Ride or Walk to School	Build the capacity of schools to encourage students to use active modes of transport for school travel	$291,480
YMCA of Canberra	Take Off! with the Y and Bluearth	Enhance healthy lifestyle options for 2,500 children	$142,000

Grants provided under 2014 Health Promotion Innovation Fund (Round 1)

Recipient	Project	Project Purpose	Amount
Australian Federal Police (ACT Policing)	Constable Kenny Koala Stay OK on the Road program (high-visibility vest initiative)	Implement the use of high-visibility vests to help facilitate children riding to school	$10,000
Fraser Primary School	Paddock to Plate @ Fraser	Enable students to learn about healthy food in creating healthy meals	$15,000
Koomarri	Fit for Life	Support employees to improve health and fitness outcomes through the workplace	$14,750
Rob de Castella's SmartStart for Kids!	SmartStart PLAY (Physical Literacy and Activity for Youth)	Enable the delivery of a healthy living physical activity and nutrition program to children and families	$14,989
West Belconnen Child and Family Centre	Koori Kids: Health Messages	Encourage Aboriginal and Torres Strait Islander children to grow fresh food and create healthy meals	$3,680
West Belconnen Child and Family Centre	Sudanese Health	Improve the health and wellbeing of the Sudanese community through healthy cooking and education activities	$3,650
Youth Coalition of the ACT	Youth Work – It's More Than Pizza	Influence the youth sector to engage with young people and model positive behaviours towards food and nutrition	$15,000

Grants provided under 2014 Health Promotion Innovation Fund (Round 2)

Recipient	Project	Project Purpose	Amount
Australian Red Cross	Set for Life – addressing food insecurity for families and children in the ACT	Address food insecurity for families and children in the ACT	$10,550
Nutrition Australia ACT Inc.	Food&ME Years 5 & 6	Review and update nutrition resources to align with the Australian Curriculum – Health and Physical Education	$11,000
Ainslie School P&C	Ainslie Organic Kids (AOK) – Ainslie School Sustainable Garden Program	Encourage vegetable garden activity and increase healthy eating habits	$15,000
Lake Tuggeranong College	Eat and Thrive@LTC	Provide a nutrition and lifestyle program for students	$2,212
House with No Steps	Crunch Time	Provide healthy living education to young people with a disability/ mental illness	$14,922
Nutrition Australia ACT Inc.	Project Dinnertime – Take the Nutrition Week Challenge	Promote affordable healthy eating and positive culture change around healthy eating	$15,000
North Belconnen Day Centre	See and Do for a Healthier You	Improve eating habits and physical fitness in the local community	$4,207
Gungahlin Jets Australian Football Club Inc.	Jets Top Guns Project	Educate around the value of good nutrition, particularly for physical training	$13,400
Foundation for Alcohol Research and Education Ltd	Pregnant Pause	Provide support and raise awareness around Fetal Alcohol Spectrum Disorders	$15,000
Special Olympics Australia – ACT	SO ACT Get Fit	Increase awareness of healthy eating and regular exercise for athletes with a disability	$12,305
Campbell Primary School	Unlocking Potential of Campbell Primary Students	Encourage key movement experiences to support students to reach their physical and academic potential	$7,300
Skateboarding Australia	Skateboarding Hubs Program	Increase and improve physical activity outcomes among children and young people	$15,000

B.4 ECOLOGICALLY SUSTAINABLE DEVELOPMENT

ACT Health is committed to sustainable development and encourages staff to practise sustainability in all aspects of their daily activities. ACT Health has developed policies, programs and an action plan to promote ecologically sustainable development (ESD), including economic, social and environmental considerations in decision-making processes, as required by the *Climate Change and Greenhouse Gas Reduction Act 2010* and the *Environment Protection Act 1997*.

ACT Health participates in the ACT Government Carbon Neutral Implementation Committee and reports on sustainable initiatives.

ACT Health is committed to recording and closely monitoring its contributions to ESD. Measures being taken to limit its environmental impact are as follows.

ACT Health is working towards establishing Green Teams, which will work to instil a sustainability culture across the Directorate.

ACT Health has a Sustainability Strategy—Action Plan 2010–2015 which contains short-, medium- and long-terms actions aimed at limiting the impact on the environment. An update on the implementation of these actions is as follows:

- Short-term 97 per cent completed
- Medium-term 31 per cent completed (due to be finalised December 2014)
- Long-term 29 per cent completed (due to be finalised December 2015).

Energy

- Continuous review and assessment of ageing infrastructure and replacement through the Capital Upgrades Program, with consideration of sustainable alternatives when replacement is due.
- Monthly trending analysis of utility bills to identify energy spikes and make adjustments to reduce energy usage.
- Infrastructure audits to identify potential energy savings, using the ACTSmart Green Team Kit and assessment booklet, and implementation of LED lighting.

Water

- Continuous monitoring of water consumption, using the Environmental Sustainable Platform.
- Implementation of water-saving strategies, such as water tanks, water-saving fixtures and fittings, swipe off–on taps.
- Use of hand sanitiser instead of constant handwashing (also an infection control measure).

Waste

- Analysis of Waste Policy and Waste Management Plan key performance indicators.
- Waste audits and internal benchmarking activities.
- Waste streaming (landfill, mixed recyclables, clinical waste, metals, batteries, fluorescent tubes and toner cartridges).
- Organics recycling in approved areas.
- Participation in the ACTSmart accreditation and training programs.
- Continuous contract variations to the Waste Management Contract in 2013–14 to ensure the delivery of high-standard services to new developments.
- Receipt of an EA rating for waste and environmental management from the Australian Council on Healthcare Standards (ACHS) accreditation process.

Transport

- Procurement of low-emission, economically sustainable vehicles, including two electric vehicles in 2013–14, as directed by the Chief Minister's Directorate.
- Assessment of alternative sustainable options each time a vehicle's leasing arrangement ceases, rather than automatic replacement of vehicles.
- Consideration of vehicles with low emissions, such as those which run on diesel fuel.

Sustainable development performance 2012–13 and 2013–14

Indicator as at 30 June	Unit	2012–13	2013–14	Percentage change
Agency staff and area				
Agency staff	FTE	5,749.1	5,979.9	4.01%
Agency staff	Headcount	6,540	6,797	3.93%
Workplace floor area	Area (m^2)	228,090[1]	259,504[2]	13.77%
Stationary energy usage				
Electricity use	Kilowatt hours	34,664,956	31,978,303[3]	–7.75%
Renewable electricity use	Kilowatt hours	3,328,618	N/a[4]	-
Natural gas use	Megajoules	111,060,000	110,109,684	–0.86%
Transport fuel usage				
Total number of vehicles	Number	322	321	–0.31%
Total kilometres travelled	Kilometres	4,046,311	3,882,625	–4.05%
Fuel use – Petrol	Kilolitres	228	221	–3.07%
Fuel use – Diesel	Kilolitres	134	126	–5.97%
Fuel use – Liquid Petroleum Gas (LPG)	Kilolitres	-	-	-
Fuel use – Compressed Natural Gas (CNG)	Kilolitres	-	-	-
Water usage				
Water use	Kilolitres	194,088	220,317.30[5]	13.51%
Resource efficiency and waste				
Reams of paper purchased	Reams	48,259	48,781[6]	1.08%
Recycled content of paper purchased	Percentage	4.95	3.76	–24.04%
Waste to landfill	Litres	19,805,577	21,282,888[7]	7.46%
Co-mingled material recycled	Litres	1,892,880	4,120,160[8]	117.67%
Paper & Cardboard recycled (incl. secure paper)	Litres	1,194,348	976,396[9]	–18.25%
Organic material recycled	Litres	0	8,012[10]	100%
Greenhouse gas emissions				
Emissions from stationary energy use	Tonnes CO2-e	40,666	40,958[11]	0.72%
Emissions from transport	Tonnes CO2-e	975	936.15	–3.98%
Total emissions	Tonnes CO2-e	41,641	41,894.15	0.61%[12]

Explanatory Notes:

The move to centralised sustainability data.

In June 2014, the Government established an Enterprise Sustainability Platform (ESP), to provide a consistent approach to reporting sustainability data in future years. The ESP provides continuously updated, accurate and auditable water, energy (electricity and gas), and greenhouse gas (GHG) emissions data and utility billing cost information for its assets and agencies, a function which has not previously been available. The ESP was used to provide data for 2012–13 and 2013–14 in this Annual Report. For some directorates this will result in data that is different to that published in the 2012–13 report, as more comprehensive reporting is now available.

GreenPower purchased for 2013–14.

ACT Property Group purchased 7,530 MWh (Mega Watt hours) of GreenPower on behalf of the ACT Government, representing 5 per cent of the ACT Government's energy consumption for 2013–14.

Notes:

1. *Net lettable area.*
2. *Total Workplace Floor Area refers to the combined floor areas of all facilities, whether for the provision of operations or services, for which a directorate has administrative responsibility in accordance with the Annual Reports (Government Agencies) Act 2004.*
3. *TCH meter readings in the first five months 2013–2014 reading 4,680,842kwh or 35 per cent less than reported in 2012–2013 due to electrical meter irregularity.*
4. *Not being reported at the Directorate level; only reported at WoG level.*
5. *Increase due to Women's & Children's Hospital Stage 2, Building 19 Canberra Region Cancer Centre and the Belconnen Community Health Centre becoming operational.*
6. *Figure reflects a 1 per cent per cent increase of paper reams purchased associated with increased headcount/activity growth across all Health.*
7. *2013–14 landfill litres represents an increase of 1,477,311 litres (7.5 per cent) when compared to 2012–13. This is due to increased growth (TCH only).*
8. *2013–14 co-mingled recycled litres represents an increase of 2,227,280 litres (117.6 per cent) when compared to 2012–2013. This is due to improved recycling systems and increased growth (TCH only).*
9. *2013–14 paper-recycled litres represents a decrease of 217,952 litres (18.2 per cent) when compared to the 2012–2013. Due to diversion of some paper/cardboard into comingle stream (note significant co-mingle increase) – across all Health sites.*
10. *Commencement of organics recycling at 1 and 11 Moore Street.*
11. *The emissions figure does not reflect electrical meter irregularity, and the m^2 difference between the ESP database and ACT Health's actual m^2 for 2013–14.*
12. *ACT Health reduced overall emissions across all scopes in 2013–14 against a 14 per cent rise in workplace floor space.*

GOVERNANCE AND
ACCOUNTABILITY REPORTING
SECTION C

C.1 INTERNAL ACCOUNTABILITY

Senior executive and responsibilities

The organisational chart on page 6 shows the structure of ACT Health at 30 June 2014. This chart includes the names of the senior executives responsible for each of the organisation's output areas.

Executives in the ACT Public Service are engaged under contract for periods not exceeding five years. Their remuneration is determined by the Australian Capital Territory Remuneration Tribunal.

Senior executive and organisational changes

In 2014 ACT Health contracted Governance Plus to undertake a gap analysis against the National Safety and Quality Health Service Standards to assess its preparedness for accreditation. The report recommended that, to ensure effective oversight of the organisation's progress towards meeting the requirements for accreditation and patient safety, resources associated with safety and quality be realigned to sit within a single clinical governance structure.

To this end, a proposal was put forward to move resources from the Quality and Safety Branch (with the exception of the Workplace Safety section) and Quality and Safety Officers (QSOs) within Canberra Hospital and Health Services (CHHS) to HealthCARE Improvement in CHHS. The consultation period for the proposal commenced on 31 March 2014 and ceased on 28 April 2014.

There was general support for the opportunities the restructure could create, including coordinated oversight and progression of accreditation and patient safety requirements, minimisation of duplication, improved efficiencies, enhanced and open communication, creation of a culture of quality and service improvement, and provision of a clear, well-articulated quality and safety system that holds all staff to account.

From 1 July 2014, positions from the Quality and Safety Branch will be realigned to the Healthcare Improvement Branch, CHHS. Staff from Workplace Safety will remain as part of the Strategy and Corporate Divisions.

Senior executive

ACT Health is organised into groups and operational areas which report directly to the Director-General. The four groups—Canberra Hospital and Health Services, Strategy and Corporate, Health Infrastructure and Planning, and Population Health—are led by Deputy Directors-General. Canberra Hospital and Health Services employs the majority of staff working in ACT Health.

Senior executive positions across the organisation are as follows:

- Dr Peggy Brown — Director-General (DG)
- Stephen Goggs — Deputy Director-General (DDG), Strategy and Corporate
- Ian Thompson — Deputy Director-General (DDG), Canberra Hospital and Health Services
- Dr Paul Kelly — Chief Health Officer, Population Health Division
- Jacinta George — Acting Deputy Director-General, Health Infrastructure and Planning
- Dr Frank Van Haren — Director, DonateLife ACT
- Elizabeth Trickett — Executive Director, Quality and Safety Branch
- Ron Foster — Chief Finance Officer
- Judy Redmond — Chief Information Officer, E-health and Clinical Records Branch
- Phil Ghirardello — Director, Performance Information
- Rosemary Kennedy — Executive Director, Business and Infrastructure Branch
- Ross O'Donoughue — Executive Director, Policy and Government Relations Branch
- Judi Childs — Director, People, Strategy and Services
- Veronica Croome — ACT Chief Nurse
- Karen Murphy — Chief Allied Health Advisor
- Prof Frank Bowden — Chief Medical Administrator
- Dr Marianne Bookallil — GP Advisor

- Professor Charles Guest — Director of Research
- Barbara Reid — Executive Director, Division of Surgery, Oral Health and Imaging
- Elizabeth Chatham — Executive Director, Division of Women, Youth and Children
- Denise Lamb — Executive Director, Division of Cancer, Ambulatory and Community Health Support
- Linda Kohlhagen — Executive Director, Division of Rehabilitation, Aged and Community Care
- Katrina Bracher — Executive Director, Division of Mental Health, Justice Health and Alcohol and Drug Services
- Prof Peter Collignon — Executive Director, Division of Pathology
- Rosemary O'Donnell — Executive Director, Division of Medicine
- Adrian Scott — Executive Director, Clinical Support Services
- John Woollard — Director, Health Protection Service
- Joanne Greenfield — Director, Health Improvement Branch
- Barbara Reid — Acting Executive Director, Division of Critical Care

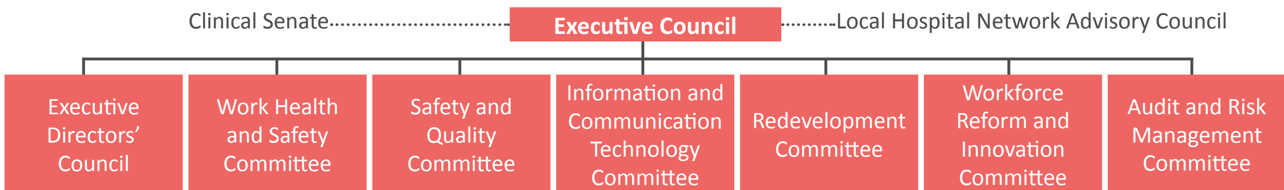
Senior management committees, roles and membership

ACT Health committees are established at the following levels:

- Tier 1—directorate level
- Tier 2—division/branch level and Tier 1 subcommittees
- Tier 3—unit/team level.

Information within the organisation is cascaded down from Tier 1 committees, and similarly information and issues can be raised at the Tier 3 level and reported and managed up through the higher committee tiers.

The overarching governance committee for ACT Health is the Executive Council.



Name of committee	Role of committee	Membership
Executive Council	At the centre of ACT Health's governance model is the Executive Council. Its role is to: • support the Director-General to meet responsibilities outlined in the *Health Act 1993* and other relevant legislation • make recommendations on the strategic direction, priorities and objectives of the organisation and endorse plans and actions to achieve the objectives • oversee finance, performance and human resources • set an example for the corporate culture throughout the organisation. • The Executive Council is chaired by the Director-General and meets twice monthly; one of these meetings each month is focused on finance, performance and other matters, and the other is focused on other business. A number of subcommittees report to the Executive Council, each dealing with different areas of accountability across the directorate.	Director-General (Chair) Deputy Director-General, Canberra Hospital and Health Services Deputy Director-General, Strategy and Corporate Chief Health Officer, Population Health Chief Finance Officer Chief Allied Health Advisor ACT Chief Nurse Chief Medical Administrator Consumer Representative Academic Representative
Executive Directors Council	This council provides an opportunity for all executive members to communicate and collaboratively work in partnership with other areas of ACT Health to deliver patient-focused, high-quality care by influencing policy and strategic direction, managing policy governance and risk, and maximising operational effectiveness. The Executive Directors Council meets monthly and reports to the Executive Council on strategic operational matters and risk management.	Director-General (Chair) Deputy Director-General, Canberra Hospital and Health Services Deputy Director-General, Strategy and Corporate Acting Deputy Director-General, Health Infrastructure and Planning Chief Health Officer, Population Health Senior Manager, Executive Coordination Unit GP Advisor Chief Medical Administrator Executive Director, Mental Health, Justice Health and Alcohol and Drug Services Executive Director, Women, Youth and Children Director, People Strategy and Services Executive Director, Quality and Safety Executive Director, Pathology ACT Chief Nurse Chief Finance Officer Director, Performance Information Director of Research Executive Director, Business and Infrastructure Executive Director, Rehabilitation, Aged and Community Care Manager, Internal Audit and Risk Management Executive Director, Cancer, Ambulatory and Community Health Support Patient Experience Leader Manager, Canberra Hospital Foundation Chief Allied Health Adviser Executive Director, Medicine Executive Director, Policy and Government Relations Chief Information Officer, E-health and Clinical Records Executive Director, Surgery, Oral Health and Imaging Executive Director, Critical Care Director, Clinical Support Services Director, Strategic Projects Acting Senior Manager, Communications and Marketing Director, DonateLife ACT

Name of committee	Role of committee	Membership
Safety and Quality Committee	This committee provides high-level advice to the Executive Council on all matters regarding quality and safety and ensures impacts on patient safety are considered in decision making. This committee: • sets the strategic direction, priorities and objectives for safety and quality across the organisation • provides oversight of clinical practice improvement, quality improvement, accreditation, clinical governance matters (including sentinel events), consumer engagement and clinical policy.	Director-General (Chair) Deputy Director-General, Strategy and Corporate Deputy Director-General, Canberra Hospital and Health Services Clinical Director, Clinical Governance Unit Executive Director, Quality and Safety Branch Manager, Internal Audit and Risk Chief Health Officer, Population Health Executive Director, E-Health and Clinical Records Director, Performance Information Executive Director, Business and Infrastructure Acting Deputy Director-General, Health Infrastructure and Planning Executive Director, Policy and Government Relations Chief Allied Health Advisor Chief Medical Administrator ACT Chief Nurse Health Care Consumer and Carer Representatives (2) Patient Experience Leader Executive Director, Surgery, Oral Health and Imaging Executive Director, Women, Youth and Children Executive Director, Critical Care Executive Director, Cancer, Ambulatory and Community Health Support Executive Director, Rehabilitation, Aged and Community Care Executive Director, Mental Health, Justice Health and Alcohol and Drug Services Executive Director, Pathology Executive Director, Medicine Medical Advisor, Clinical Governance Director, DonateLife ACT
Work Health and Safety Committee	This committee comprises executive members, health professional members and health and safety representatives. Its role is to: • facilitate cooperation between ACT Health and staff to instigate, develop and carry out measures designed to ensure the health and safety of staff • assist in the development of standards, rules and procedures relating to health and safety that are to be complied with in the workplace • provide work health and safety advice and recommendations on strategies, allocation of resources and legislative arrangements • address whole-of-agency work health and safety issues unable to be resolved at division or branch level.	Director-General (Chair) Director, Workplace Safety To achieve a quorum, at least half of the members of the committee must be staff who are not nominated by ACT Health. Two representatives from each division/branch Tier 2 Health and Safety Committee—one manager and one Health and Safety Representative. Other members as co-opted.

Name of committee	Role of committee	Membership
Information Communication and Technology Committee	The role of this committee is to: • oversee the development of Health Directorate information management and information and communications technology (IM&ICT) plans, policies and frameworks, as required, ensuring whole-of-government issues are considered • monitor lifecycle ICT asset management frameworks, strategies and policies consistent with best practice • monitor portfolio IM&ICT risks • monitor, review and manage ICT assets, services and delivery and financial performance and infrastructure risk across the Health Directorate • ensure whole-of-ACT Government and Health Directorate IM&ICT policies and standards are implemented across the organisation • prioritise IM&ICT initiatives • evaluate proposed IM&ICT initiatives and recommend supported business cases for all major IM&ICT projects to Executive Council • review and report the status of ICT projects under development and, if required, recommend strategies to rectify significant variances of these.	Deputy Director-General, Strategy and Corporate (Chair) Deputy Director-General, Canberra Hospital and Health Services Deputy Director-General, Health Infrastructure and Planning Chair, Clinical Working Group or representative Chief Information Officer, E-health and Clinical Records Director, Performance Information Executive Director, Business and Infrastructure Executive Director, Policy and Government Relations Chief Health Officer, Population Health Chief Nurse Chief Medical Administrator Executive Director, Critical Care Executive Director, Cancer, Ambulatory and Community Health Support Executive Director, Rehabilitation, Aged Care and Community Care Executive Director, Surgery, Oral Health and Imaging Executive Director, Women, Youth and Children Executive Director, Mental Health, Justice Health and Alcohol and Drug Services Executive Director, Pathology Executive Director, Medicine Executive Director, Shared Service ICT or representative Chief Executive, Calvary Public Hospital or representative Health Care Consumer representative ACT Medicare Local representative
Redevelopment Committee	This committee is the chief decision-making body for the ACT Health Infrastructure Program (HIP). It is responsible for providing advice, monitoring progress and monitoring risk in the HIP.	Director-General (Chair) Deputy Director-General, Canberra Hospital and Health Services (Chair) Deputy Director-General, Strategy and Corporate Chief Finance Officer Deputy Director-General, Health Infrastructure and Planning Chief Information Officer, E-Healh and Clinical Records Executive Director, Business and Infrastructure Director, People Strategy and Services Representative of Director, People Strategy and Services Chief Executive Officer, Calvary Health Care ACT Chief Minister's Representative, Chief Minister, Treasury and Economic Development Directorate Director-General, Commerce and Works Directorate Budget Management and Analysis Branch, Chief Minister, Treasury and Economic Development Directorate (Treasury representative) Executive Director, Shared Services ICT ACT Health Care Consumers' Association Infrastructure Finance and Advisory, Chief Minister, Treasury and Economic Development Directorate Executive Construction and Program Director, Health Infrastructure and Planning Senior Finance Manager HIP, Health Infrastructure and Planning Director, HIP Branch, Shared Services Procurement Principal Solicitor, ACT Government Solicitor's Office Senior Manager, Health Infrastructure Business Support Acting Senior Manager, Health Services Planning Unit, Health Infrastructure and Planning

Name of committee	Role of committee	Membership
Workforce Innovation and Reform Committee	This committee provides executive leadership on the implementation of the ACT Health Workforce Plan 2013–2018 and other aligned workforce plans as an organisational priority. The committee: • receives six-monthly reporting against the endorsed actions of the plan and documents progress • determines further ACT Health workforce reform in line with the national agenda and the broader objectives of ACT Health and the ACT Government.	Deputy Director-General, Strategy and Corporate (Chair) Director, People Strategy and Services Executive Director, Clinical Support Services Director, Workforce Policy and Planning Unit Senior Manager, Health Services Planning Executive Director, Mental Health, Justice Health and Alcohol and Drug Services Executive Director, Surgery, Oral Health and Imaging Executive Director, Women, Youth and Children Executive Director, Cancer, Ambulatory and Community Health Services Executive Director, Critical Care Executive Director, Rehabilitation, Aged and Community Care Executive Director, Pathology Executive Director, Medicine Chief Medical Administrator ACT Chief Nurse Chief Allied Health Advisor Additional attendees are co-opted as required for specific issues.
Audit and Risk Committee	This committee provides independent assurance, assistance and advice to the Director-General regarding audit, risk control and framework, external accountabilities and responsibilities, and appropriate internal controls.	The committee consists of five members: • Chairperson—external and independent of the directorate • Deputy Chairperson—external member, appointed for a fixed period • two Deputy Directors-General • an ACT Health senior executive. The Director-General and the Manager, Internal Audit and Risk Management, are invited to all meetings. The secretariat role is performed by the Internal Audit and Risk Management Branch.

As well as these committees, governance meetings are established at the Tier 2 level within the Strategy and Corporate group and the Canberra Hospital and Health Services group, Population Health, and Health Infrastructure and Planning. Senior staff from divisions and branches are involved in these meetings and key information is cascaded down from the Tier 1 level via groups, divisions and branches to unit level across ACT Health.

A range of forums provide the opportunity for stakeholder input into health services. Some of these include:

- Medical Staff Council (monthly)—ongoing
- Nursing and Midwifery Leaders meeting (monthly)—ongoing
- Allied Health Forum (monthly)—ongoing
- Director-General Forums (six-weekly)—ongoing
- Leadership Network (three times a year)—ongoing
- ACT Region Integrated Regional Clinical Training Network—ongoing
- Private Hospitals Liaison Committee—ongoing
- Healthcare Consumers Liaison Committee—ongoing
- GP Liaison Network—ongoing
- Southern Local Hospital Network District Liaison Cross-Border Operational Meeting—ongoing
- ACT Medicare Local/ACT Health Liaison Committee
- ACT Health/Community Services Directorate Liaison committee (quarterly)—ongoing
- ACT Health/Human Rights Commission (annual)—ongoing
- Health Emergency Management Sub-Committee (quarterly)—ongoing
- Alexander Maconochie Centre—Health Policies and Advisory Group—meets quarterly
- Aboriginal and Torres Strait Island Health Forum.

ACT Local Hospital Network Council

In 2011, the ACT Local Hospital Network Council was established under amendments to the *Health Act 1993.* It is responsible for providing strategic advice to the Director-General of ACT Health on matters critical to the ACT Local Hospital Network's success. The council meets at least six times a year.

Each financial year the council is required to present to the Minister for Health a report on the state of the local hospital network and any recommendations relating to the improvement of health services by the local hospital network that the council considers necessary.

Clinical Senate

The Clinical Senate provides a forum for a multidisciplinary group of clinicians, health experts and consumers with diverse perspectives to share their collective knowledge in discussing strategic clinical issues. The Senate is required to provide evidence-based advice and recommendations to the Director-General of ACT Health and the Chair of the ACT Medicare Local, with the aim of improving patient care outcomes. Meetings are held three or four times a year.

The Clinical Senate reports to the Director-General of ACT Health and the Chair of ACT Medicare Local, who consider and respond formally and transparently to all recommendations.

The membership of the Senate reflects the range of views that would be encountered across the full breadth of the community on significant clinical strategic issues. Members are appointed following due consideration of clinical skills and/or knowledge, capacity to make a contribution, clinical influence, consumer input and multidisciplinary coverage.

The Senate comprises up to 40 members, the majority of whom are clinicians with direct clinical duties. In addition to ex-officio members, membership consists of specialist medical practitioners, specialist dental practitioners, nursing and midwifery representatives, academic staff, allied health professionals and consumer representatives.

C.2 RISK MANAGEMENT AND INTERNAL AUDIT

ACT Health's Audit and Risk Management Committee Charter governs the operation of the Audit and Risk Management Committee, which provides assurance to the Director-General on ACT Health's governance and oversight in relation to risk management, internal systems and legislative compliance. It objectively considers the internal control environment, governance and risk management activities.

The committee consists of five members: an independent chair, three senior executives from within ACT Health and one external member. Observers from ACT Health and the ACT Auditor-General's Office also attend meetings. The committee is supported by ACT Health's Manager, Internal Audit and Risk Management.

The Audit and Risk Management Committee held five meetings in 2013–14. Attendances are set out below:

Name of member	Position	Duration on the committee	Meetings attended
Geoff Knuckey	Independent Chair	3 years	4
Jeremy Chandler	External member and Deputy Chair	1.5 years	5
Ian Thompson	Member	7.5 years	5[1] *
Katrina Bracher	Member	1.1 years	5[1] **
Stephen Goggs	Member	1.7 years	5[1] ***

Note:

*1 * represents another person acting in the member's substantive position having attended the meeting. The number of stars shows the number of times this occurred.*

ACT Health's Internal Audit and Risk Management Branch promotes and improves ACT Health's corporate governance by conducting and coordinating internal audits and investigations and making recommendations for improvements. In 2013–14, nine internal audit assignments were completed. One special review was also commissioned, as one audit topic from the Strategic Internal Audit Program was split into two audits.

Audit findings and recommendations are rated in line with ACT Health's *Integrated Risk Management Guidelines.* Throughout the year, the Manager, Internal Audit and Risk Management reported developments in implementing the Strategic Internal Audit Program and implementation of audit recommendations to the Executive Directors' Council and the Audit and Risk Management Committee. The committee is also kept informed on implementation of recommendations made by the ACT Auditor-General's Office, where these apply to ACT Health.

The ACT Health Risk Management Policy and Guidelines are maintained in full compliance with the International Standard for risk management, AS/NZS ISO 31000. The documents clarify the governance arrangements and include clear responsibilities and measurable key performance indicators.

Executive Risk Management workshops are held regularly to review the directorate's organisational level risks. ACT Health's Executive Directors' Council is responsible for:

- monitoring timely, effective management of organisational level risks and
- managing escalation of risks to organisational level.

C.3 FRAUD PREVENTION

The ACT Health Fraud Management Framework, Policy and Plan govern fraud management and prevention work across ACT Health. Divisions of ACT Health regularly undertake fraud risk assessments together with integrated risk assessments. Mitigating controls are put in place to address identified fraud threats and risks. The executive directors are responsible for managing fraud risk in their respective divisions. A review of the framework was conducted in 2013–14.

The ACT Health Senior Executive Responsible for Business Integrity Risk undertakes analysis on trends and risk assessments with respect to fraud and other integrity breaches, and provides reports to the Audit and Risk Management Committee bi-annually.

Staff receive fraud control and prevention training during orientation and through an e-learning program entitled Ethics, Integrity and Fraud Prevention. Managers are provided with further fraud control and prevention information and training during the managers' orientation program. This is supported by targeted information provided to alert staff to responsibilities and protocols intended to improve systems or to mitigate identified fraud threats and risks.

One allegation of fraud was made against an ACT Health employee in 2013–14. This allegation was referred to the Australian Federal Police for investigation, the outcome of which is yet to be determined. The matter has resulted in a review and upgrade of an IT system and additional compliance training of staff.

C.4 LEGISLATIVE ASSEMBLY INQUIRIES AND REPORTS

Committee	Report Title	Date Tabled
Standing Committee on Health, Ageing, Community and Social Services	Report 3—Annual and Financial Report 2012–2013	April 2014

Report purpose

To inquire into and report on matters related to the ACT Health Annual Report 2012–13.

Recommendations

The following recommendations related to ACT Health:

Recommendation 11 – The Committee recommends that the ACT Government's Immunisation Strategy includes data on a varied range of target groups to ensure high rates of immunization for all sectors of the community.

Recommendation 12 – The Committee recommends that the ACT Health continue efforts in the area of preventative health and in particular programs such as Towards Zero Growth.

Government response

Recommendation 11 – Agreed. The ACT Immunisation Strategy 2012–2016 includes the collection of data for numerous targeted groups in the community. This data collection is ongoing and progress for the targeted groups is monitored and evaluated on a regular basis. Evaluation of the specific datasets collected and recommendations for future data to be collected will be undertaken with the review of the strategy.

Recommendation 12 – Agreed. The Healthy Weight Action Plan was completed and launched in October 2013. Implementation is progressing, with a focus on community engagement.

Implementation

Recommendation 11 – Implementation is ongoing.

Recommendation 12 – On 14 October 2013 the Chief Minister launched the Towards Zero Growth Healthy Weight Action Plan, which sets the goal of zero growth in rates of obesity in the ACT. Towards Zero Growth focuses on strategies that will make active and healthy lifestyle choices easier. The Government has adopted a whole-of-government Healthy Weight Initiative governance model, managed by Chief Minister, Treasury and Economic Development Directorate.

Committee	Report Title	Date Tabled
Select Committee on Estimates 2013–2014	Inquiry into Appropriation Bill 2013–2014 and the Appropriation (Office of the Legislative Assembly) Bill 2013–2014	6 August 2013

Report purpose

To examine the expenditure proposals contained in the Appropriation Bill 2013–2014, the Appropriation (Office of the Legislative Assembly) Bill 2013–2014 and any revenue estimates proposed by the Government in the 2013–2014 Budget and prepare a report to the Parliament.

Recommendations

The following recommendations related to ACT Health:

Recommendation 53 – The Committee recommends that the ACT Government consider reporting Health and Community Care and ACT Local Hospital Network accountability indicators together in future budgets.

Recommendation 55 – The Committee recommends that the ACT Government advise the Assembly on why the ACT is the worst or near worst performing jurisdiction in elective surgery achievements.

Recommendation 56 – The Committee recommends that the ACT Government advise the Assembly about when the ACT will achieve national average or better than the national average in elective surgery performance.

Recommendation 57 – The Committee recommends that the ACT Government advise the Assembly why the ACT has the longest emergency department waiting times in the country and why ACT waiting times have deteriorated so significantly.

Recommendation 58 – The Committee recommends that the ACT Government provide details to the Assembly on the key lessons learnt from Western Australia's successful implementation of the emergency department four-hour length of stay rule.

Recommendation 59 – The Committee recommends that the ACT Government advise the Assembly of the outcomes from the action plan that was developed in response to the ACT Auditor-General's 2012 report into *Emergency Department Performance Information* and the PricewaterhouseCoopers report into the *integrity of Emergency Department records and processes at the Canberra Hospital*.

Recommendation 60 – The Committee recommends that the ACT Government advise the Assembly why it has taken so long to backfill the Executive Director for Critical Care position.

Recommendation 61 – The Committee recommends that the ACT Government develop strategies to educate older Canberrans on the dangers of alcohol use in relation to the risk of falls and subsequent injuries.

Recommendation 62 – The Committee recommends that the ACT Government provide a quarterly report to the Assembly outlining the progress, scope and budget and delivery date of the Aboriginal and Torres Strait Islander Alcohol and other Drug Rehabilitation centre.

Recommendation 63 – The Committee commends the staff of the QEII for providing a wonderful service over the last 50 years.

Committee	Report Title	Date Tabled
Select Committee on Estimates 2013–2014	Inquiry into Appropriation Bill 2013–2014 and the Appropriation (Office of the Legislative Assembly) Bill 2013–2014	6 August 2013

Government response

Recommendation 53 – Not Agreed. It is a requirement of the Financial Management Act, 1996 (section 12) that all Directorates have accountability indicators.

Recommendation 55 – Not Agreed. The ACT was the only jurisdiction to meet its targets under the National Elective Surgery Target (NEST) in 2012. Over the last three years the Government has provided additional funding which has resulted in record levels of access to Elective Surgery in the ACT over the past three years.

Until there is a nationally consistent approach for elective surgery categorisation it is not possible to measure jurisdictions against jurisdictions or national averages. In a report published in July 2013, The Australian Institute of Health and Welfare (AIHW) and the Royal Australian College of Surgeons (RACS) provided evidence about the inability to measure performance between jurisdictions due to considerable variations in classifications of elective surgery patients. The report found that 49 percent of ACT elective surgery patients are classified as category two patients, against the NSW figure of 32 percent.

This identifies major variations between jurisdictions, and as such it is not possible to judge the relative performance of states and territories in meeting elective surgery waiting times.

The AIHW and RACCS propose a national approach for elective surgery categorisation to provide for more simple definitions for each category rather than the current national definitions. Also all jurisdictions should have the same end target to ensure that all elective surgery patients are admitted within established timeframes.

Recommendation 56 – Not agreed. Until all jurisdictions adopt the same methodology for elective surgery categorisation it is not possible to compare against the same targets.

Recommendation 57 – Noted. The ACT Government tabled in March 2013 its Emergency Access Plan for 2013–2017 which detailed actions to be implemented over the next four years to improve waiting and treatment times within our public hospital emergency departments. The plan recognises that improvements to emergency department times must include changes to the way the whole hospital works and improved partnerships between hospitals and community services.

Recommendation 58 – Agreed. Key lessons learnt from Western Australia include:

- The key objective should be on quality of patient care to drive whole of hospital change and not target focused. This is imperative to engage clinician support;
- Executive leadership, support and accountability is vital;
- Dedicated resources in the area of Clinical Service Redesign (CSR), together with proven redesign methodologies imperative;
- 3 years of hard work and commitment to progress changes using a sound change management approach;
- Improvement solutions based on true root causes supported by robust data;
- Ongoing training and education provided to Executives and project teams to ensure change management and leadership are sustained;
- Ongoing evaluation of redesign projects; and
- Key organisational changes to ensure ongoing evaluation and strategy development to meet KPIs.

ACT Health continues to address quality of patient care initiatives including:

- Through the Patient Flow Steering Committee to provide advice and oversight the patient flow project;
- Senior clinicians and other staff have visited Western Australia to gather knowledge;
- The Chief Minister is planning to visit Queensland Health in the near future to see at first hand how they have managed big improvements in a short amount of time; and
- Embedding staff with redesign skills within the hospital and health service areas to bring them closer to clinical areas.

Recommendation 59 – Agreed. A Progress report was provided to the ACT Legislative Assembly.

Recommendation 60 – Agreed. An unsuccessful recruitment round was held in February 2013. A second round of recruitment is currently underway.

Recommendation 61 – Agreed in Principle. ACT Health will examine more closely the degree to which alcohol may be a contributing factor in relation to falls injuries and, if required, how current efforts in the area of falls prevention and early intervention may be strengthened.

Recommendation 62 – Not Agreed. In addition to responding to questions at the select committee hearings and to questions on notice, the ACT Government also publishes a quarterly report on capital works projects which includes information on the Aboriginal and Torres Strait Islander Alcohol and other Drug Rehabilitation Centre. In addition, the Government reports on progress of capital works projects in the annual mid year review.

Recommendation 63 – Noted.

Committee	Report Title	Date Tabled
Select Committee on Estimates 2013–2014	Inquiry into Appropriation Bill 2013–2014 and the Appropriation (Office of the Legislative Assembly) Bill 2013–2014	6 August 2013

Implementation

Recommendation 53 – No further action required.

Recommendation 55 – No further action required.

Recommendation 56 – No further action required.

Recommendation 57 – No further action required.

Recommendation 58 – In March 2013, the Government tabled the Emergency Access Plan for 2013–2017, which detailed actions to be implemented over the next four years to improve waiting and treatment times within our public hospital emergency departments.

There has been an improvement in ED NEAT performance (59 per cent for the 2013 calendar year) since the Emergency Access Plan was tabled.

Some of the initiatives to be undertaken over the next four years include:

- the development of streams for acute and ambulatory patients who present to the ED, that will enable streamlined triage and admission processes
- the development of an expanded paediatric area that will enable streamlined triage and admission processes, as well as enhancing the patient experience through more a appropriate child- and family-friendly environment
- employing new doctors and nurses within our emergency departments to manage increasing demand, including four new specialist senior emergency physicians
- increasing the focus on improved and coordinated discharges to enable patients to leave the hospital in the most efficient manner, with all their discharge needs catered for thereby enhancing patient flow and allowing access to ward beds for ED patients who require admission
- ensuring both public hospitals continue to plan effectively for seasonal changes in demand patterns, such as the annual establishment of a winter strategy which provides for changes in the way hospitals operate during peak periods and how hospitals and community services can work better in high-demand periods.

The Chief Minister visited the Princess Alexandra and Royal Brisbane Women's Hospital on 23 September 2013 to look at different ways of responding to increasing demand for emergency care. The visit confirmed that improved Emergency Department access is a whole-of hospital-issue. A new streaming approach introduced in October 2013 at Canberra Hospital is also very similar to the approach at Royal Brisbane.

Recommendation 59 – In July 2014 the Chief Minister provided a final update to the Standing Committee on Public Health for each of the recommendations in the Auditor-General's Report No 6: Emergency Department Information Progress Report which also included the PricewaterhouseCoopers report. The majority of recommendations have been completed and the remainder should be completed by the end of 2014.

Recommendation 60 – National and international advertising for the second round of recruitment for this position occurred in September 2013 under contract with Hardy Group International. The first ranked candidate for the position was unable to take up the position due to problems experienced in relation to obtaining a visa that could not be overcome. The second ranked candidate has been offered the position and is due to commence in the role in September 2014.

Recommendation 61 – Currently there is limited data available to determine the extent to which alcohol may contribute to falls in the elderly in the ACT.

It is known that falls are increasingly over-represented in permanent residents of aged care facilities, that less than 5 per cent of the ACT population resides in these facilities, and that they and are unlikely to have access to alcohol.

ACT Health is unable to reliably determine the underlying cause of falls based on diagnoses from Admitted Patient Care data. Emergency Department data is also limited. However, these data sources could be investigated further. New methods of data collection and surveillance may have to be costed and implemented before it is possible to determine whether alcohol as a cause of falls is a significant public health issue across the elderly population.

If it is determined that this is a significant issue at the population level, strategies will be implemented to incorporate the risks of alcohol and falls in educational materials and health promotion activities related to falls.

If appropriate, alcohol use and its risk in relation to falls will be incorporated in the assessment of individuals reviewed at the falls prevention program.

As part of the assessment in the Falls and Falls Injury Prevention Clinic, information is obtained in relation to the consumption of alcohol and whether this has been a contributing factor to a person's fall.

If appropriate, information is then provided from the 'Reduce Your Risk' document published by the Australian Government Department of Health on the national recommendation for alcohol consumption and fact sheets from the Department of Human Services, Victoria on Alcohol intake.

Recommendation 62 – No further action required.

Recommendation 63 – No further action required.

Committee	Report Title	Date Tabled
Select Committee on Estimates 2014–2015	Inquiry into Appropriation Bill 2014–2015 and the Appropriation (Office of the Legislative Assembly) Bill 2014–2015	Ongoing as at 30 June 2014

Report purpose

To examine the expenditure proposals contained in the Appropriation Bill 2014–2015, the Appropriation (Office of the Legislative Assembly) Bill 2014–2015 and any revenue estimates proposed by the Government in the 2014–2015 Budget and prepare a report to the Assembly.

Recommendations

As at 30 June 2014 the inquiry was ongoing.

Government response

Not applicable.

Implementation

Not applicable.

Committee	Report Title	Date Tabled
Standing Committee on Public Accounts	Auditor-General's Report No. 4 of 2014: Gastroenterology and Hepatology Unit, Canberra Hospital	Presented 6 June 2014

Report purpose

This report presents the results of a performance audit on the effectiveness of administrative and triaging practices of outpatient services provided by the Gastroenterology and Hepatology Unit (GEHU) at Canberra Hospital.

Recommendations

The Auditor-General recommended ACT Health should improve the governance of the GEHU and develop and implement an action plan to reduce the GEHU outpatient waiting list and guide GEHU in providing the best possible patient care.

As at 30 June 2014 the report was under consideration by the Standing Committee on Public Accounts.

Government response

Not applicable.

Implementation

Not applicable.

Committee	Report Title	Date Tabled
Standing Committee on Public Accounts	Auditor-General's Report No 5 of 2014: Capital Works Reporting	Presented 27 June 2014

Report purpose

This report presents the results of a performance audit of reporting on the capital works program.

Recommendations

The audit made eight recommendations to address the audit finding in this report. Recommendation 6 relates to Health – All Directorates should quality control information to be included in capital works reports to the Chief Minister and Treasury Directorate and the Budget Committee of Cabinet, and have documented quality control procedures.

As at 30 June 2014 the report was under consideration by the Standing Committee on Public Accounts.

Government response

Not applicable.

Implementation

Not applicable.

C.5 AUDITOR-GENERAL AND OMBUDSMAN REPORTS

Reports by the ACT Ombudsman and ACT Auditor-General's Office during 2013–14 relating to ACT Health are set out below.

ACT Ombudsman

ACT Health responds to complaints that are referred from the ACT Ombudsman Office. In 2013–14 ACT Health received and investigated one complaint referred from the ACT Ombudsman.

Some matters that are referred to the ACT Ombudsman regarding ACT Health are not within the jurisdiction of the ACT Ombudsman and are referred to the Health Services Commissioner in the Human Rights Commission or referred back to ACT Health.

ACT Auditor-General*

Office	Report title	Date tabled
ACT Auditor-General	Report 8 of 2013 : Management of Funding for Community Services	20 December 2013
ACT Auditor-General	Health Directorate—Final Audit Management Report	November 2013

**Note:*
Two performance audits conducted by the ACT Auditor-General's Office under consideration by the Public Accounts Committee and responses are expected to be included in the 2014–15 Annual Report.

Progress on the implementation of recommendations from these reports can be seen in the table below.

Implementation status of ACT Auditor-General Reports

Report 8 of 2013 : Management of Funding for Community Services (5 of 10 recommendations applied to ACT Health)

Response—All agreed.
Implementation status/outcome—20% completed; 80% in progress.

Recommendation 2
The Funding Managers' Network should be promoted across Government and its terms of reference expanded to include grant programs.

Recommendation 3
The Health Directorate should include in its grants procedures a requirement to undertake a risk assessment of grant recipients and reflect the level of risk in payment instalment arrangements.

Recommendation 6
The Health Directorate should enhance its service delivery and design for its Mental Health Services through formalising its consideration of service design.

Recommendation 7
Service Funding Agreements should be amended to include a standard reporting template which, among other things, specifies the relationship between key performance indicators, outputs and outcomes.

Recommendation 10
The ACT Government should assess the appropriateness of extending the use of a web-based grant program to manage all grant applications across Government.

Health Directorate—Final Audit Management Report – (Of the 18 previously reported audit findings, 12 were resolved, 2 were partially resolved, 4 were not resolved and 2 were new, leaving a balance of 8 audit findings.)

Response—All agreed.

Implementation status/outcome—38% completed; 62% in progress.

Findings related to:

- category 1 elective surgery patients (measurement and supporting documentation)
- business continuity plans—various revenue systems
- fraud management framework, control plan and policy
- business continuity arrangements
- data quality policy
- support agreements for revenue systems
- review of daily revenue reconciliations at Canberra Hospital
- review of credit card acquittals.

In addition, nine audits were completed by the ACT Health Internal Audit and Risk Management Branch in 2013–14. For further information, contact the Manager, Internal Audit and Risk Management Branch, on 6207 5755.

SECTION D
LEGISLATION-BASED
REPORTING

D.1 PUBLIC INTEREST DISCLOSURE

Public interest disclosure is managed in ACT Health in accordance with the *Public Interest Disclosure Act 2012*. Public interest disclosures received by ACT Health are managed in accordance with the Commissioner for Public Administration's guidelines. ACT Health's public interest disclosure policy and procedures were retired following adoption of the Commissioner's guidelines. The Senior Executive Responsible for Business Integrity Risk receives disclosures and determines the appropriate action in accordance with the Act.

Two potential public interest disclosures were referred to ACT Health in 2013–14. One related to misconduct and employment practices. It was determined that the matter did not constitute a public interest disclosure, and the complaint was subsequently referred to the entity concerned for investigation and appropriate action, as ACT Health did not have the authority to pursue the matter. The other related to alleged misconduct and is currently being investigated under the provisions of the relevant enterprise agreement, as it did not meet the criteria for progression under the Act.

D.2 FREEDOM OF INFORMATION

The *ACT Freedom of Information Act 1989* gives citizens a legally enforceable right of access to official information in a documentary form held by ACT ministers and agencies, except where an essential public interest requires confidentiality to be maintained. It also requires information about the operations of ACT agencies to be made publicly available, particularly rules and practices affecting citizens in their dealings with those agencies.

Section 7 statement

Section 7 of the *ACT Freedom of Information Act 1989* requires all agencies to prepare and publish a statement setting out the structure, operation and categories of documents. This is set out below.

Organisation

ACT Health is responsible to the Minister for Health, who appoints the Director-General. The agency is responsible for policy development, planning and the provision of a range of health services to best meet the needs of the community within the policy framework and budget parameters set by government.

Powers

ACT Health holds a wide variety of statutory powers relating to health services in the ACT. A comprehensive list of legislation under which ACT Health exercises statutory powers can be found on the *ACT Legislation Register*.

The agency has the authority to do all things that are necessary for the performance of its functions, including the purchase, sale and lease of buildings and equipment, the provision of financial assistance, and to enter into arrangements with people or authorities for the provision of health services.

The Chief Health Officer has the authority to grant, deny, vary and revoke applications for the supply of prescription drugs of dependence under the *Drugs of Dependence Act 1989*. The Chief Health Officer also holds powers to license and inspect hairdressers, boarding houses, eating houses, private hospitals and other establishments.

The *Health Records (Privacy and Access) Act 1997* enables consumers of health services to gain access to their medical records.

The Health Services Commissioner holds power under the *Human Rights Commission Act 2005* to investigate and conciliate complaints about providers of health services. Consumers can contact the Commissioner's office by telephoning 6205 2222 or calling in person at Level 4, 12 Moore Street, Canberra City, ACT.

Categories of documents

ACT Health holds several basic categories of documents, including:

- those that are freely available on request and without charge
- those available for sale, including those that are part of a public register
- those that are exempt under the *Freedom of Information Act 1989* (the Act)
- all other kinds of documents that may be made available under the Act.

Documents available on request

Documents in this category include publications produced by the directorate on various aspects of its activities. These are distributed from public counters and libraries throughout the Territory and may also be available on the ACT Government's web site at *www.act.gov.au*, or the ACT Health web site at *www.health.act.gov.au*.

Documents of other kinds that may be available under the Freedom of Information Act are:

a. general files, including internal, interdepartmental and public documents, minutes of meetings of management and other committees, agendas and background papers, policy statements, financial and staffing estimates
b. diaries, rosters and work sheets
c. program and policy files
d. records held on microfilm, computer or paper in connection with specialised divisional functions
e. photographs, videos and films
f. financial and accounting records
g. details of contracts and tenders
h. files on applicants and clients
i. records of government, including the machinery of government
j. leases and deeds of agreement
k. databases relating to personnel administration, assets registers, in-patient morbidity statistics and accounting systems
l. maps and plans of ACT Health facilities, such as hospitals and health centres, working plans and drawings for proposed buildings or facilities under alteration or construction and maps of the ACT and surrounding region used for planning and delivery of services.

ACT Health may hold medical and client records within its many functional units. These include inpatient and outpatient records at the Canberra Hospital and health centres' medical records and dental records. Access to these records may be gained under the *Health Records (Privacy and Access) Act 1997.*

The Directorate also produces for public distribution a number of pamphlets and brochures relating to health matters in the ACT and the surrounding region.

ACT Health will make available for purchase documents covered by section 8 of the *Freedom of Information Act 1989.*

Freedom of Information procedures and initial contact points

ACT Health's Freedom of Information (FOI) officer receives, monitors and coordinates all requests for documents held by the agency. The FOI officer is located at Level 3, 11 Moore Street, Canberra City (phone 02 6205 1340). The FOI officer is available to members of the public from 9.00 am to 4.00 pm Monday to Friday (excluding public holidays) for the lodgement of requests. Electronic requests can be sent to HealthFOI@act.gov.au. Copies of documents to which access has been granted under the FOI Act may be forwarded to the applicant or may be inspected under supervision during office hours.

Processing guidelines

A copy of ACT Health's FOI processing guidelines is provided to the FOI Decision Maker to assist in their deliberations. The FOI officer is able to assist decision makers in all aspects of processing applications in accordance with the Act.

In accordance with the whole-of-government policy, the Decision Letter, Schedule of Documents and the documents are to be made available in PDF format on the open government website within 15 days. The decision maker will identify 'certain information' that is not to be published in accordance with the Act.

No application fees are charged for FOI requests; however, the directorate applies processing fees, in accordance with the Attorney-General (Fees) Determination, for applications that require more than 10 hours processing time and/or 200 pages of documents.

Section 8 statement

Section 8 of the *Freedom of Information Act 1989* requires the principal officer to prepare and make available each year a statement (which may be in the form of an index) specifying the documents that are provided by the directorate for the purposes of an enactment or scheme administered by the directorate. The statement can be made available to members of the public by contacting the principal officer.

Section 79 statement

Fees and charges

In the 2013–14 financial year, $3,341.28 was received in payment for processing fees for FOI requests received by ACT Health.

The following tables summarise the results of FOI requests across ACT Health and the time taken to finalise requests.

Description	
Initial applications lodged	40
Partial access	12
Access refused	3
Full release	14
Technical refusal	3
Withdrawn	5
Transferred	1
Not yet finalised (as at 30 June 2014)	2
Reviews lodged (under section 59 of the Freedom of Information Act 1989)	3
Number upheld	3
Number given partial access	0
Number overturned	0
Number not yet finalised (as at 30 June 2014)	0
Applications to ACT Civil and Administrative Tribunal	0
Requests to amend records	0
Time taken to finalise requests	
Less than 31 days	16
31–45 days	10
46–60 days (third party consultation)	8
61–90 days	4
More than 90 days	3

D.3 HUMAN RIGHTS ACT 2004

It is essential that policy writers and staff at or above manager level be educated about the *Human Rights Act 2004*. The Staff Development Unit facilitates human rights training for managers. In consultation with the ACT Human Rights Commission, an e-learning program has been developed to allow a more flexible method of training. Face-to-face sessions are also delivered by internal trainers. In 2013–14, three sessions were attended by 41 staff, including two senior officers, 11 health professionals, five administration officers, 35 nurses, one dentist and one scientist. A total of 246 staff completed the e-learning module, including staff specialists, senior officers, health professionals and senior nurses. Participants' course evaluations indicate that the training increased the participants' awareness of their obligations under the *Human Rights Act 2004.* In total, 287 staff completed human rights training in 2013–14.

In 2013–14, ACT Health distributed 300 copies of a brochure about healthcare rights and 4000 copies of a brochure about the Mental Health Charter of Rights.

In 2013–14, ACT Health continued its major review of the *Mental Health (Treatment and Care) Act 1994*, and an extensive amendment bill was introduced into the Legislative Assembly on 15 May 2014. The review considered the Act's relationship with the *Human Rights Act 2004* as well as other changes in the human rights context, including the UN Convention on the Rights of Persons with Disabilities. The review has resulted in several changes which will increase people's control over their own treatment decisions. The Human Rights Commission and a range of mental health consumer and advocacy groups have been involved in the review since it commenced.

The Standing Committee on Justice and Community Safety released its scrutiny report on the bill on 27 May 2014, commending the effort and skill involved in the way the bill's explanatory statement explains the provisions of the bill against human rights standards identified in a number of international instruments and the *Human Rights Act 2004*.

Litigation arose from the administration of electroconvulsive therapy without the consumer's consent. The application claimed general damages, aggravated damages and exemplary damages for false imprisonment, assault and battery, and a breach of section 18 of the *Human Rights Act 2004*. The matter was settled out of court.

Another application before the ACT Supreme Court arose from a wrong site surgery incident at the Canberra Hospital. As was reported in the *Canberra Times*, the family of the patient claimed that the deceased was treated in a cruel, inhumane and degrading way and was subjected to medical treatment without her free consent. The family also sought a declaration that the deceased was a victim of a contravention of the *Human Rights Act 2004*. The Supreme Court dismissed the claim (the judgment can be found at www.courts.act.gov.au/supreme/judgment/view/7838/title/chaloner-and-anor-v-australian). The plaintiff is applying to the Supreme Court to appeal the decision.

D.4 TERRITORY RECORDS ACT

Records Management Program

ACT Health's Records Management Program was approved by the Chief Executive of ACT Health in June 2009 and lodged with the Director of the Territory Records Office. It continues to be the instrument under which ACT Health works. ACT Health Records Management Program has responsibility only for administrative records of ACT Health, not clinical or patient records.

The ACT Health Records Management Program comprises policy statement, detailed procedures, and nominated functional disposal schedules. The Records Management Policy incorporates the requirements of the *Territory Records Act 2002*, under which the agency must have, and comply with, a records management program. That details how the agency adheres to the requirements of the Act. All ACT Health staff make and maintain accurate records of their administrative activities in accordance with this policy.

Public access

The Records Management Program is available for inspection by the public upon request in writing to the agency principal officer.

Access to administrative records that are less than 20 years old is available only under the provisions of the *Freedom of Information Act 1989*. These records are not available through the Reference Archivist and an application must be lodged through the ACT Health Freedom of Information Officer to gain access.

Public access to Territory records

In 2013–14, Health Records Management staff liaised closely with the Territory Records Office's Reference Archivist in response to public access requests under part 3 of the *Territory Records Act 2002*, Access to Records. During this period, five requests were received for access to records.

Records management procedures

The Administrative Recordkeeping Manual provides a framework for ACT Health to create, systematically capture, register, classify, use, store, dispose of and retain records.

The Administrative Recordkeeping Manual is available for all staff to view and refer to on the Records Management intranet site. The intranet site is updated regularly and includes links to the Territory Records Office's standards and guidelines.

Records disposal schedules

A list of nominated approved Records Disposal Schedules appears below.

Records disposal schedule name	Effective	Year and number
Community Relations	8 March 2012	NI2011–84
Compensation	11 March 2012	NI2012–183
Equipment and Stores	13 April 2012	NI2912–186
Establishment	11 September 2009	NI2009–437
Financial Management	2 September 2011	NI2011–482
Fleet Management	13 April 2012	NI2012–187
Government Relations	8 March 2011	NI2011–88
Health Treatment and Care	23 December 2013	NI2013–589
Industrial Relations	8 March 2011	NI2011–90
Information Management	8 March 2011	NI2011–92
Legal Services	11 September 2009	NI2099–443
Occupational Health and Safety	11 September 2009	NI2009–444
Patient Services Administration	8 May 2009	NI2009–210
Personnel	8 March 2011	NI2011–97
Population Health Care Management and Control	8 May 2009	NI2009–209
Property Management	11 December 2009	NI2009–625
Publication	11 September 2009	NI2009–450
Strategic Management	11 September 2009	NI2009–453
Technology and Telecommunications	11 September 2009	NI2009–454

Training

Throughout 2013–14, the policy and Administrative Recordkeeping Manual were promoted to staff through formal and in-the-workplace training and education sessions regarding compliance with legislation across all ACT Health sites.

A Records Management module has been incorporated in ACT Health's Managers Orientation Program, run monthly by the Staff Development Unit.

Records Management staff offer on-the-job training to ACT Health staff. An e-learning package has been developed and is available to ACT Health staff to reinforce awareness of the requirements for compliant record keeping and management.

A TRIM user manual and fact sheets are available to all staff through the intranet. This information is currently under review.

In 2013–14, a number of quality improvement initiatives were undertaken to evaluate the training provided. A number of improvements to the training program were implemented. Training provided will continue to be evaluated and adjusted as required.

Compliance schedule

As reported in the annual Assurance on Compliance e-System (ACeS) compliance report, ACT Health, under section 16 (1) of the *Territory Records Act 2002*, makes, maintains and disposes of records in a systematic manner and controls the quality of its records and the facility, and responds appropriately to applications for access to health information. Records are kept and stored appropriately in ACT Health facilities.

Preservation of Aboriginal and Torres Strait Islander information

Administrative records containing content about Aboriginal and Torres Strait Islander people mainly belong to the general record series about health community programs, health and welfare issues and policy.

All Records Management staff understand the sensitivities relating to records about Aboriginal and Torres Strait Islander people and the need for these records to be preserved for possible future access and reference.

The current disposal schedule has identified a small selection of records for Aboriginal and Torres Strait Islander people for permanent retention.

D.5 LEGAL SERVICES DIRECTIONS

The Health Directorate is committed to upholding the principles of the Model Litigant Guidelines by acting honestly, fairly and with propriety in the conduct of all civil claims and litigation, arbitration and other alternative dispute resolution processes.

The Health Directorate understands its role as a model litigant and places significant emphasis on maintaining effective communication with healthcare consumers who have complaints about, or have suffered adverse outcomes as a result of, treatment in the public health service. Open communication may also minimise the need for consumers to seek resolution of complaints or claims through formal legal avenues.

The Health Directorate is committed to responding to complaints about public sector health services in a timely and systematic manner. Complaints are a valuable part of the quality improvement system, which aims to optimise patient care and safety, promote positive system changes and ensure resolution of the complaint to the satisfaction of the consumer, where possible.

Consumers are invited to provide feedback about the care they received at the point of service, or by telephone, letter or email, or through the Health Directorate internet site. The Health Directorate has a independent Consumer Feedback and Engagement Team (CFET) and ensures that all consumer feedback is responded to and resolved, where possible, in a timely manner. The CFET acknowledges consumer complaints within five working days, coordinates investigations and aims to inform the consumer of the outcome within 35 calendar days. If the consumer is not satisfied with the response to their complaint, the consumer is advised of assistance available though the ACT Human Rights Commission (HRC). The HRC provides an independent means for dealing with complaints about health services, through the Health Services Commissioner.

In some instances, an alternative method of dispute resolution such as conciliation is considered. This involves the HRC acting as an impartial third party to help the consumer and health staff clarify issues and resolve matters raised in a complaint. Sometimes, in resolving a complaint, a financial settlement may be considered and agreed to in a formally binding agreement, reducing the risk of complaints developing into legal claims and thereby reducing claim costs for both parties.

The Health Directorate acknowledges that early resolution of a claim not only can have benefits for the plaintiff's health and wellbeing but also reduces the costs associated with litigation. The Health Directorate is committed to working with the ACT Government Solicitor (ACTGS) to ensure that its conduct in matters that progress to litigation is timely, efficient, effective and in accordance with the Model Litigant Guidelines.

It is important to note that, while the obligation to comply with the Model Litigant Guidelines is conferred on the agency, the ACTGS acts on behalf of the Health Directorate in all litigation and provides advice in accordance with the obligations applying under the *Law Officers Act 2011*. The ACTGS has advised that it is not aware of any breaches of the *Law Officers (General) Legal Services Directions 2012* or Model Litigant Guidelines 2010 in Health Directorate matters during 2013–14.

D.6 NOTICES OF NON-COMPLIANCE

Dangerous Substances Act 2004

In 2013–14, ACT Health did not receive any notices of non-compliance under section 200 of the Act (infringement notice offences).

Work Health and Safety Act 2011

Four notices of non-compliance were issued in 2013 in relation to the *Work Health and Safety Act 2011*.

The four improvement notices issued to ACT Health on 27 November 2013 related to expired plant registration. The boilers (plant) were subsequently inspected and registered on 16 December 2013. The improvement notices were effectively lifted on 2 January 2014. All plant has since been registered.

New systems have been established to track registration for all registrable plant across ACT Health. This has been undertaken by the Business and Infrastructure Division to ensure legislative compliance is maintained.

In 2013–14, ACT Health did not receive any prohibition or non-disturbance notices in relation to the *Work Health and Safety Act 2011*.

D.7 BUSHFIRE RISK MANAGEMENT

In 2013–14, the following ACT Health facilities in varying stages of development were located in rural zones that require plans to mitigate risks associated with bushfire-prone areas:

- Miowera (Ngunnawal Bush Healing Farm)
- Secure Mental Health Unit at Symonston.

Ngunnawal Bush Healing Farm

The following reports have been prepared for the Ngunnawal Bush Healing Farm and issued to the Emergency Services Authority (ESA):

- Bush Fire Assessment and Compliance Report—May 2013
- Bushfire Action Plan (BAP)—May 2013
- Bushfire Operations Plan (BOP)—May 2013.

These reports have been finalised and cover the extent of the group or organised camp area:

- A Firewise Plan was developed for the site in October 2008, which may require updating for the new facility pending advice from the ESA.
- The current land management agreement includes strategies for the reduction of fire fuel loads over the entire property through agistment. Annual licence agreements are in place to comply with this strategy.

Secure Mental Health Unit

A bushfire risk assessment was undertaken of the Secure Mental Health Unit at Symonston. It is currently in draft form. Consultation with the ESA (rural and urban firefighting units) is underway and the finalisation of this report is anticipated in July or August 2014.

ESA feedback has been incorporated in the preliminary sketch plan design for the facility. A BOP and BAP may be required for the facility and will be prepared during the final sketch plan stage of the project, pending ESA advice.

D.8 COMMISSIONER FOR THE ENVIRONMENT

ACT Health is responsible for reporting against the following recommendations from the *State of the Environment Report 2011*:

- Recommendation 9—To improve knowledge of our indoor air quality, the Chief Health Officer should consider the health impact of indoor air quality in the ACT in the *Chief Health Officer's Report 2014*.

Progress: The Chief Health Officer decided against including health impact of indoor air quality in the ACT in the *Chief Health Officer's Report 2014.* It is not considered a health priority at present.

- Recommendation 10ii—Improve local air quality outdoors through installing and operating a second performance air monitoring station to ensure that the ACT is compliant with NEPM standards.

Progress: The Ambient Air Quality (AAQ) National Environmental Protection Measure (NEPM) Performance Monitoring Station at Florey was fully operational as of 28 February 2014. ACT is now compliant with the AAQ NEPM.

- Recommendation 10iii—Improve local air quality outdoors, through determining the feasibility, (including costs) of mobile monitoring of ambient air quality NEPM standards at locations in and around Canberra.

Progress: ACT Health does not support this recommendation. It would be cost-prohibitive and the quality of the data obtained would be insufficient for any meaningful evaluation or policy making.

SECTION E
HUMAN RESOURCE
MANAGEMENT REPORTING

E.1 HUMAN RESOURCES MANAGEMENT

In 2013–14, the People Strategy and Services (PSS) Branch in ACT Health continued to develop and achieve a wide range of specific initiatives against the major themes of:

- delivering for the future
- strengthening organisational resilience
- sustaining community confidence
- working collaboratively.

Delivering for the future

- The implementation of the ACT Health Workforce Plan 2013–2018 saw the establishment of the tier 1 committee, the Workforce Innovation and Reform Committee (WIRC), to oversee the ongoing development of implementation strategies and measures. A reporting matrix has been developed and transparency within ACT Health has been increased through the development of a specific SharePoint WIRC site.
- The development of compendium documents for workforce planning at division level has progressed.
- Specific workforce plans have been developed or are under development to support the Health Infrastructure Program (HIP). This directly addresses the identified greatest level of workforce risk for HIP as being the organisation's capacity to attract, train and retain sufficient employees with the appropriate capabilities to operate the new facilities as they are developed. This has included establishing and delivering a project to develop workforce design options for the new sub-acute University of Canberra Public Hospital (UCPH). The project used workforce innovation and reform approaches and consultation with ACT Health staff and stakeholders to inform UCPH workforce design and development, supporting the implementation of new models of care and service delivery. The project also positioned the ACT Health Workforce Plan 2013–2018 as the key strategic framework informing workforce planning for HIP projects and across ACT Health more broadly.
- Discussions have commenced on the involvement of ACT Health in the Department of Health Corporate Champions Program, which supports strategies to recruit and retain mature and ageing workers.
- A trial of Linked In, targeting recruitment for 'difficult to fill' positions, is in the planning stages.
- Health Workforce Australia (HWA) initiatives and projects have supported the national health workforce agenda of building capacity, boosting productivity and improving distribution, and are coordinated by an HWA-funded team embedded within People Strategy and Services (PSS). Within this team are the ACT Region Integrated Clinical Training Network (ICTN) lead and secretariat and the simulated learning environment (SLE) lead and project staff. Major achievements in 2013–14 include:
  - redevelopment of the ACT Region ICTN website to meet the needs of the network members
  - two whole-of-network meetings where achievements and simulation learning programs were showcased and planning for future network clinical training events was undertaken
  - enhancement of the web-based SLE lending library and related booking procedures
  - management of the simulation learning equipment and resources
  - onsite support to senior clinicians providing quality simulation learning activities
  - increasing clinical training placements across the region.
- In March 2014, a new enterprise agreement came into effect for nursing and midwifery staff. This established conditions of employment until mid-2017 and set in place a framework for achieving rostering efficiencies during that period. A new enterprise agreement was also concluded for administrative staff in May 2014, with negotiations on agreements covering all other ACT Health staff nearing completion at the end of June.
- A new set of core conditions for visiting medical officers (VMOs) came into force in September 2013. These will bring a new level of consistency to the indexing of VMO payments over the next three years.
- Leadership capability development continues to be a key area of focus in delivering organisational sustainability. The Leadership Network provided opportunities for over 100 leaders at different levels to further develop their leadership practice and form collaborative working relationships and networks with colleagues from across the organisation. The Canberra Hospital and Health Services (CHHS) Leadership Program provided targeted leadership development to executives and senior nursing, medical and allied health leaders from CHHS. Evaluations highlighted the positive value of these programs in enhancing individual and collaborative leadership.
- Procurement and completion of a new contract for the learning management (Capabiliti) and Student Placement Online (SPO) systems ensure these foundations are in place for the future.

Strengthening organisational resilience

- Staff, managers and executives were supported in the management of complex and growing health services by the Employment Services group. During the year, this group made improvements to service delivery in key areas such as recruitment, conditions management and entitlements advice, enhanced the policy framework for a broad range of staffing matters and guided decision making in line with whole-of-government directions and the enterprise agreement frameworks.
- ACT Health has progressed development of an HR reporting process which enables cost centre managers to access HR data and scorecard details specific to their accountability in this area. The program, which is available on SharePoint, will be transitioned to the Performance Innovation Portal (PIP) in the next year. The suite of HR reports has been expanded to ensure user-friendly and organisation-specific reports are available at cost centre level—for example, leave balance reports to enable managers to keep leave balances for employees below the enterprise-agreed two years of accrued leave.
- Reporting profiles include the following key performance indicators:
  - full-time equivalents (FTE), paid FTE, overtime FTE, productive FTE, non-productive FTE
  - commencement and separation rates
  - employment diversity statistics, including retention rates for Aboriginal and Torres Strait Islander employees and people with a disability
  - the use of agency employees in nursing
  - the percentage of employees by employment category (casual, temporary, permanent)
  - traineeship and apprenticeship rates, which are reported twice yearly
  - exit survey data to monitor employees' reasons for leaving the organisation and implement contingency plans as required.
- The first annual equity and diversity audit occurred in March 2014 to strengthen data to inform statistical reporting and provide evidence to support equity and diversity programs in ACT Health. Discussion and investigation are underway regarding identified positions for Aboriginal and Torres Strait Islander people.
- The running of the People Manager Program, which aims to build management capability at frontline supervisor and middle management levels, was a significant achievement, with over 800 attendances and high demand for its five modules. The program includes a focus on management resilience, and its broader objectives in building management capability have contributed to organisational resilience.

Sustaining community confidence

- Workforce planning for the new hospital buildings is underway, with planning based on projected service demand, expected models of care and new technologies. The focus is on ensuring that the right person with the right skills can deliver the right services at the right time to the right person, within budget, to enable a sustainable health workforce for the future.
- Consumer-focused staff education included e-learning on writing consumer publications, and face-to-face training for staff on consumer partnerships has also been implemented.
- ACT Health continued to meet its responsibilities under the working with vulnerable people legislation to ensure that, where services are provided to identified vulnerable groups, ACT Health does this in the safest manner possible.

Working collaboratively

- PSS staff represent ACT Health to work collaboratively with other states and territories and the Commonwealth through the Health Workforce Principal Committee and the Practitioner Regulation Subcommittee. These committees support national workforce policy development and strategy, including regulation, development of new and expanded roles, and national health workforce reform and planning activities.
- ACT Health continued to progress towards the targets in the ACT Public Service Employment Strategies 2012–2015. While ACT Health has not met the targets, it continues to build on the numbers from the previous years and is exploring different avenues to increase employment numbers. The current achievement sits at 1.04 per cent for Indigenous employment against a target of 2 per cent, and at 2.09 per cent for people with a disability against a target of 3.4 per cent. In addition, the Employment Inclusion Officer continued to explore opportunities for specific employment programs to help meet the targets that ACT Health is striving to achieve. This included the development of the Indigenous Youth Careers Pathway (IYCP) program. ACT Health was able to place secondary students in the workplace to achieve competencies under this program.
- The ACTPS Performance Framework was supported by the development and delivery of information sessions and workshops to over 1300 staff and managers. The workshops focused on the practical skills of having performance conversations and providing feedback, including feedback in relation to conduct and behaviour, ensuring performance is values-based and includes an emphasis on collaboration.
- Respect, Equity and Diversity (RED) and improving organisational culture continue to be a focus. The RED contact officer network has expanded to 101 officers, who play an important role in providing support and information to staff members who may be experiencing bullying and harassment.
- Targeted team-based strategies for improving organisational culture continued to support managers and teams to achieve enhanced collaboration and performance.

E.2 LEARNING AND DEVELOPMENT

Learning and development programs

In ACT Health, learning and development programs and activities are provided to ensure staff, volunteers, tertiary students and contractors are educated about legislative and organisational requirements and receive the training recommended in the National Safety and Quality Health Service Standards.

Planned and integrated education and training are based on an annual learning needs analysis and identified organisational requirements. To quality-assure all learning and development, a standard operating procedure guides the design, development and approval of training programs. The Education Activity Register (EAR) monitors all programs registered on the learning management system (Capabiliti) to ensure they are reviewed, evaluated, linked to evidence-based practice, involve consumers, are updated annually, and are approved by the relevant executive director. In 2013–14, there were 158 programs on the EAR.

Learning and development outcomes

In 2013–14, achievements include:

- procurement and completion of a new contract for the learning management (Capabiliti) and Student Placement Online (SPO) systems
- development of the e-learning Workplace Induction Pathway
- implementation of a project to engage consumers in training programs and seek consumer input for applicable clinical programs
- development of e-learning education on writing consumer publications and face-to-face training for staff on partnering with consumers
- development of a report on essential education categories and training completion that is available to all executives
- development of recruitment assessment centres for registered and enrolled nurse graduates commencing in the ACT Health transition to practice programs
- endorsement of program requirements for registered nurses in the transition to practice program to achieve one postgraduate nursing unit with the University of Canberra
- an increase in competency-based training and reporting to comply with the National Safety and Quality Health Service Standards (NSQHSS)
- commencement of face-to-face teaching on aseptic technique for students and clinical staff; development and testing of an e-learning program for aseptic technique; and development of a risk assessment tool and auditing tools for aseptic technique
- development and implementation of an e-learning update program for Neonatal Advanced Life Support
- launch of the Allied Health Assistant Network to support allied health assistants in their roles and promote interprofessional collaboration.

Leadership and culture programs

- The ACT Health Leadership Network is composed of around 100 employees identified by the executive as the leaders and potential leaders who could most benefit from, and contribute to, the network's objectives. In the three workshops held in 2013, participants were encouraged to develop their individual leadership skills and worked in small collaborative groups, which were valuable in allowing participants to form constructive partnerships across the organisation.
- The People Manager Program (PMP) aims to develop knowledge and skills in people management, underpinned by ACT Health's values. The PMP is for clinicians and non-clinicians in front-line supervisor and middle management positions who have people management responsibilities. It consists of five half-day modules. The significant demand for, and delivery of, the PMP in 2013–14 resulted in 1055 staff attending this program. The ACTPS Performance Framework was supported by the development and delivery of information sessions for 887 staff and workshops for 446 supervisors and managers. The workshops focused on the practical skills used in performance conversations and on providing feedback, including feedback on conduct and behaviour.
- Training in managing and preventing bullying, harassment and discrimination was provided to 158 managers and 444 staff. Since the program began in 2011, over 5200 staff and managers have been trained, which represents over 75 per cent of the workforce.
- The number of Respect, Equity and Diversity (RED) contact officers at 30 June 2014 was 101. RED contact officers include nurses, allied health professionals, administrative staff and staff who work outside traditional business hours.

Essential Education

All ACT Health staff are allocated essential education categories based on what the organisation and their manager require them to do in their job role, based on legislative requirements, risk assessment of the need for staff to have training, and training requirements under the NSQHSS.

Orientation Program

All new employees are required to attend the Orientation Program in their first month of employment. Its aim is to ensure new staff are aware of legislative requirements, roles, responsibilities, accountabilities and how ACT Health contributes to the local community. Evaluations from the program have been positive: new employees report gaining a general awareness of their roles and responsibilities and the organisation. In 2013–14, 1083 staff and volunteers attended orientation. A separate program is conducted for contractors according to their role. In 2013–14, 1043 site contractors were inducted into ACT Health.

Workplace Induction Pathway

The Workplace Induction Pathway complements the Orientation Program and is available as a checklist or an e-learning program. All new staff complete this education in their work area. The pathway was developed to ensure staff follow safe practice and to help staff learn about their workplace and the organisation. In 2013–14, 2671 staff completed the pathway.

Managers Orientation Program

All new managers are required to complete the Managers Orientation Program, which is a requirement of the Essential Education policy. The two-day program welcomes new managers and provides information on responsibilities with regard to legislation, policies, procedures and management of staff. In 2013–14, 114 managers attended.

Safety education

Safety training is essential education for all staff, students, contractors and volunteers in ACT Health. It ensures that staff comply with legislative requirements and that ACT Health meets the NSQHS standard requirement that the workforce has access to ongoing safety education.

Program	Outcomes and initiatives	Completion data
Manual tasks E-learning Clinical manual tasks programs Manual tasks—work area-specific programs	Customised programs are provided to meet the needs of specific groups who perform different functions in both clinical and administrative environments. In evaluations, programs receive a 95 per cent positive average rating. Initiatives in 2013–14 include: • improvements in training for wardspersons, as a high-risk group, in wardsperson update days and inclusion of improved competency assessment and basic life support in the program; this has been evaluated positively and participants and managers have achieved 100 per cent competency • improved process for tertiary students to access manual tasks training on clinical placement in consultation with the tertiary sector • implementation of a process to review organisational reported data on body-stressing incidents to inform possible interventions where further training or on-the-job coaching may be required in manual tasks • collaboration with other directorates to engage the expertise of ACT Health educators in specialised areas • consultation with the Health Improvement Program to provide targeted training for staff moving into new buildings or using new equipment.	E-learning completions: 1,118 face-to-face (staff programs): 2,898 attendances Tertiary students and interns: 715 attendances Volunteers: 145 attendances
Predict, Assess and Respond to Challenging/ Aggressive Behaviour (PART)	This externally developed program provides staff with the knowledge and skills to de-escalate and respond to challenging client behaviour. Initiatives in 2013–14 include the following: • A further 11 staff were sponsored to gain accreditation as trainers in collaboration with the Division of Mental Health, Justice Health, Alcohol and Drugs (MHJHAD). • The support of additional trainers has resulted in the scheduling of more programs for all staff and targeted programs for staff of MHJHAD.	Two-day program: 163 attendances One-day additional module (high-risk areas): 76 attendances Refresher: 59 attendances
Personal Safety and Conflict Awareness (Violence and Aggression) e-learning	These externally developed e-learning modules were implemented in 2013–14. Staff can choose which modules to complete. They help staff to respond to violence and aggression in the workplace.	726 staff accessed the modules
Work Safety Act e-learning	The e-learning program was revised in 2013.	469 completions

Human Rights Act training for managers

Human rights training is an essential education requirement for managers. ACT Health trainers who have been trained by the Human Rights Commission provide 41 face-to-face sessions. An e-learning program developed by the Staff Development Unit in consultation with the ACT Human Rights Commission was completed by 246 staff in 2013–14.

Child protection training

Three levels of child protection training are provided to staff. The level of training staff attend depends on their role, their area of work and the likelihood they will have contact with children and young people. Staff may attend more than one level of training—for example, level 1 and level 3. The participant total below reflects the number of attendees at education sessions. These figures include staff from Calvary Bruce and Calvary John James.

Training is provided in flexible delivery formats to meet staff needs. Child protection training is also provided to non-government agencies that receive funding from ACT Health.

Number of ACT Health staff attending child protection training, 2013–14

Level of training	Total number trained
Level 1 (face-to-face)	75
Level 2	716
Level 3	503
Level 3 refresher	169
Total face-to-face	1,463
Level 1 e-learning	612
Level 2 e-learning	349
Total e-learning	961
Total July 2013–June 2014	2,424

ACT Health maintains a partnership with the Community Services Directorate to provide the What About Me series of workshops for government and non-government organisations, with the aim of increasing staff confidence and ability to work with vulnerable children and families. Training has also been provided to external health providers such as Medicare Local staff (50 participants) and Winnunga Nimmityjah Aboriginal Health Centre (19 participants).

Education programs developed in partnership with consumers and consumer groups

In 2013–14, a key initiative was the introduction of staff education programs designed to improve the patient experience. These programs address the requirements of Standard 2, Partnering with Consumers, of the NSQHSS. All education sessions are designed for an interprofessional audience. Partnering with consumers education also commenced in the Orientation Program in August 2013.

The consumers in education working group is developing a process and guidelines for educators to include consumers in the education of clinical staff. An audit of the Education Activity Register (EAR) indicates 14 per cent of programs currently involve consumers in the planning, delivery or evaluation of the education provided to clinical staff.

Program	Number of sessions	Staff attendance	Student attendance	Consumers
Patient Experience Program 10	14 sessions	185 staff attended	24 students attended	2 consumers attended to evaluate
Involving Consumers in Quality Improvement Activities 11	1 session	6 staff attended	N/A	1 consumer as co-presenter
Writing Consumer Publications-E-learning2	N/A	44 staff completed	N/A	HCCA guided and reviewed content

The ACT Health Cultural Competence training program is a new program in 2014 designed to enhance the cultural awareness of nurses and allied health staff working with culturally and linguistically diverse (CALD) consumers and staff. According to 2011 Census, 24.2 per cent of ACT residents were born overseas. Providing culturally competent care has a positive impact on healthcare outcomes and reduces the disparities in healthcare outcomes of CALD patients as compared to non-CALD patients. The content of the program meets the requirements of Standard 2 of the NSQHSS Standards 2012 and item 1.1.6 of the ACT Health Business Plan 2013–14. The two-hour face-to-face program is being delivered as a stand-alone session and as part of the Clinical Supervision Support Essentials program.

In 2013–14, 69 people completed the training. The program is still in its infancy, yet the feedback received has been extremely positive. More than 90 per cent of participants state that the program contributed to their development as a nurse or clinical supervisor/preceptor. Others state that the training should be compulsory.

Recruitment, graduate and transition to practice programs

ACT Health conducts transition to practice programs for enrolled nurses (EN), registered nurses (RN) and allied health graduates. These programs provide a high level of clinical and professional support, care, feedback and guidance during the transition year.

Program	No. of participants	Completions	*Retention rate
RN Graduate Program 2013	97	91	97%
EN Transition Program 2013–14	16	7	87%

Notes:
**Retention means the percentage of graduates who choose to stay and work in ACT Health after successful completion of the 12-month program.*

In 2013–14, the education component of the RN program was accredited with the University of Canberra. The evaluations demonstrated that the programs met participants' expectations and those of the clinical areas. An enrolled nurse program participant was awarded Graduate Nurse of the Year in 2014 at the ACT Health Annual Nursing and Midwifery Awards.

Interprofessional Graduate Program

This program consists of three sessions per year. Under the ethos of 'Learn together—work together', the program brings together graduates from medical, nursing and allied health fields to network and learn about topics that are relevant to all health professionals. Topics covered to date include patient-centred care and team handover, both of which feature prominently in the National Safety and Quality Health Service Standards. Two sessions have been conducted this year, with 97 attendances.

Date	Session topic	Attendances
February	Patient-centred care—'Hear me play'	40 registered nurses 5 allied health staff 57 medical interns
June	Team handover	29 registered nurses 5 allied health staff 11 registered midwives 52 medical interns

Nurse and midwives re-entry programs and overseas-qualified nurse programs

The re-entry programs recruit and provide educational support to ACT residents, nurses and midwives who have not worked in acute health care for up to 10 years. The Overseas-Qualified Nurse Program provides education and support for internationally qualified nurses to obtain registration in Australia and the possibility of obtaining a position in ACT Health. Numbers are limited by the availability of placements and by place of residence. Both programs are accredited with the Nursing and Midwifery Board of Australia but, under new guidelines, ACT Health is seeking to partner with a tertiary institute in the next 12 months.

2013–14	Completed	Currently undertaking	Employed by ACT Health at program completion
Registered nurse re-entry	10	2	2
Midwifery re-entry	4	0	2
Overseas qualified	5	0	2

Clinical programs

ACT Health provides a large number of clinical education programs. Key programs are described below.

Life support programs

These programs are conducted to meet the training and competence requirements of NSQHS Standard 9, (Recognising and responding to clinical deterioration in acute health care). Basic life support is essential education for clinical staff. The table below shows the number of staff trained.

Type of training	No. of participants
Basic Life Support—584 programs	*3,478
Advanced Life Support—19 programs	*210
Advanced Life Support Refresher—18 programs	144
Advanced Life Support two-day course—two programs	32
Neonatal Life Support—nine programs	ACT Health—162 Calvary—58
Update Neonatal Life Support—11 programs	93 Calvary—11
Paediatric Life Support—six programs facilitated by Advanced Paediatric Life Support (Victoria), held in Canberra and coordinated by SDU	ACT Health—109 15 external
Paediatric Life Support Refresher, Canberra Hospital—one program	8

Note:
**The Basic Life Support education and assessment is included as part of the Advanced Life Support program. Therefore, the total Basic Life Support numbers include an additional 210 staff. This means 3688 staff have completed basic life support training.*

COMPASS education

The Early Recognition of the Deteriorating Patient Program (COMPASS) is designed for nurses, physiotherapists, doctors and undergraduates and is delivered by the Early Recognition of the Deteriorating Patient team. This program aims to enable health professionals to recognise the deteriorating patient and initiate appropriate and timely interventions. It consists of self-directed learning, face-to-face education on physiology and use of early warning scores, and interactive case studies.

Training	Length/frequency	No. of sessions	No. of participants
Adult COMPASS Workshop	3 hours	22	255
Paediatric COMPASS Workshop	3 hours	6	14
Maternity COMPASS Workshop	3 hours	5	18
Adult COMPASS Refresher	1 hour	54	1,120
Paediatric COMPASS Refresher	1 hour	24	97
Maternity COMPASS Refresher	1 hour	26	114
Modified Early Warning Scores (MEWS)/Medical Emergency Team (MET) Forum	1 hour bi-monthly	6	237
Neonatal Early Warning Score Pilot	2 hours	20	80
Community Early Warning Score	Part 1—1 hour Part 2—1 hour		Part 1—Physiology and use of the MEWS—54 Part 2—Role plays—34

Call and Respond Early (CARE) family escalation program

This program for patient safety provided 13 90-minute in-services for 29 ward nursing staff. In the previous year, the family escalation program also ran a CARE skills day. This program was revised and renamed 'Skills for potential leaders'. It was presented as a full-day program in collaboration with Organisational Development. Three sessions were held, with 47 participants.

Night Duty Program

This program provides the education required under the NSQHSS and other professional development activities for night staff who may otherwise have limited access to in-service education. In 2013–14, 1141 staff attended 29 sessions.

Intermediated Paediatrics Program (i-PaTCH)

This program is targeted at experienced registered nurses who work with acutely unwell paediatric patients. The program aims to provide participants with an advanced skill set to competently care for the acutely ill child. I-PaTCH is a combination of theoretical and practical training. Participants are required to complete competency assessments during modules and in the ward setting. The program is run over five months, with a study module held every month. Clinical leaders in paediatrics contribute to the course by presenting sessions in each module. This year, there has been a focus on developing and improving the practical-based components and the competency-based assessments. In 2014, eight people attended the course.

Invasive devices education programs

Training in invasive devices is well established in ACT Health: curriculums, evaluations and assessments are in place for the four most commonly used procedures. Participants complete an assessment in the workshop. Aseptic technique is included in all programs in line with the recommendations of NSQHS Standard 3, Preventing and controlling healthcare-associated infections. Further work is in progress for these programs to ensure participants complete all competency assessments in their workplace and in class. RiskMan data is reviewed to check clinical incidents, links to training and the need to change training content.

Program	Outcomes and initiatives	E-learning	Face-to-face workshop
Peripheral Intravenous Cannulation	This program provides clinical staff with training and education in procedures involving peripheral intravenous cannulation, maintenance, safety, disposal and competence. In 2013–14, the delivery of the program was significantly revised, aligned with national standards and Braun Australia, and benchmarked against New South Wales hospitals. Evaluation outcomes from participants were very positive on content, relevance, program delivery and the revised structure. This change in program structure has contributed to an increase in completion rates. The program receives positive evaluations.	Nil	141 participants attended the practical workshops
Venepuncture and Blood Culture Collection	This program provides clinical staff with training and education in procedures involving venepuncture and blood culture collection procedure, maintenance, safety, disposal and competence. In 2013–14, the content of the program was aligned with the NSQHSS and was updated to include aseptic technique. This program receives positive evaluations.	320 participants enrolled in program	87 participants attended the face-to-face workshop
Central Venous Access Devices (CVAD)	This program provides staff with the theory and clinical competencies to safely manage patients who require central venous access devices for the delivery of therapy. The content of the program is aligned with the NSQHS standards, relevant legislation, organisational policies and standard operating procedures.	263 participants enrolled in program. Participants must successfully complete the e-learning before clinical competency assessment.	70 participants attended a CVAD workshop. Workshops are optional and provide information and practical demonstration of procedures. Participants must complete e-learning and clinical assessment to achieve competency.
Indwelling Urinary Catheter	This program is under development as an e-learning course targeted at clinical staff who perform this procedure. It will include a clinical assessment component. The pilot program is undergoing content testing by clinicians, educators and NSQHS Standard 3 members and will be launched in July 2014.		

Education for health staff who support, assess and educate others

ACT Health has a suite of programs to provide professional development to staff from all disciplines who provide workplace learning support and education, competency assessment and student clinical supervision.

This supports compliance with NSQHS Standard 1, which requires that competency-based training is provided to clinical staff and that supervision is provided for individuals to fulfil their designated roles. In 2013–14, the following programs were provided.

Program	Outcomes and initiatives	Attendance 2013–14
Clinical Support and Supervision Essentials	This program targets clinicians providing student clinical supervision and preceptorship. In 2013–14, the content was revised to align with the Health Workforce Australia National Clinical Supervision Competency Framework. Evaluation of the program demonstrates significant improvement in participant satisfaction. There was also an increase in completion rates for assessable requirements, from 57 per cent in the previous year to 73 per cent in 2013–14. An e-learning module is under development to further improve access.	104 participants: 93 per cent from nursing and 7 per cent from allied health
TAE40110, Certificate IV in Training and Assessment	As a registered training organisation, ACT Health provides nationally recognised training to staff engaged in education, competency assessment, and student clinical supervision and support. Content is contextualised to suit the health environment and align with organisational requirements. In 2013–14, the program was significantly revised to provide more flexibility, with e-learning components and shorter modules relevant to different target groups in the organisation. Evaluations from both participants and managers were very positive on the program's content, relevance, delivery and revised structure.	64 new enrolments in 2013–14; 34 qualifications or statements of attainment issued, with more due for completion by the end of 2014

Program	Outcomes and initiatives	Attendance 2013–14
Clinical Development Nurse/Midwife (CDNM) Professional Development Program	This program is designed to provide clinical support and education for CDNMs and as a forum to discuss changes in practice or equipment. In 2013–14, the content of the program was aligned with the National Safety and Quality Health Service Standards, organisational core values, and training identified in a CDNM needs analysis. All professional development activities received positive evaluation.	88 at bi-monthly professional development; 82 at bi-monthly meetings
Teaching on the run	This program is provided to allied health staff who provide clinical teaching and student supervision. It is an external course using a 'train the trainer' model. The modules include planning learning, clinical teaching, supporting learners and assessment. Participants can select which modules they attend.	There were 204 total attendances across the modules in 2013–14. (This is not the number of people trained, as they attend several modules each).
Supervision for allied health	External clinical supervision training at intermediate/advanced level was conducted for allied health staff by the University of Sydney. Of the participants, 89 per cent in Workshop 1 and 81 per cent in Workshop 2 agreed or strongly agreed that the workshop was of high quality.	Two workshops with a total of 32 attendances

Allied Health Clinical Education

In 2013–14, the Allied Health Assistant Network was launched. Regular quarterly meetings support allied health assistants in their roles with clients, promote interprofessional collaboration and information sharing, and provide opportunities for professional development.

The annual Allied Health Symposium was held on 2 April 2014 and attracted 174 participants from the ACT Public Service.

Ongoing allied health education includes:

- professional development days for multiple professions, including social work, speech pathology and psychology
- interprofessional training for occupational therapy and physiotherapy clinicians in line with best practice guidelines for the management of the upper limb following stroke—100 per cent of attendees rated the course useful for their clinical practice
- the Allied Health Clinical Educators' Network to support clinical educators in their roles with staff and students
- monthly training sessions for social workers, quarterly community cross-peer education, fortnightly student practice development sessions and field education training sessions, a monthly journal club, and training or mentoring sessions for junior staff
- occupational therapy ongoing professional development opportunities across all teams, fortnightly student practice development sessions and new graduate monthly mentoring
- speech pathology continuing education program each fortnight.

Scholarships to support further learning for allied health, nursing and midwifery

The Allied Health Office supports ongoing learning and development through the Allied Health Postgraduate Scholarship Scheme, which supports allied health professionals in further learning in clinical practice, education and training, research and/or management and leadership.

From July 2013, the Allied Health Postgraduate Scholarship Scheme supported 22 recipients completing postgraduate study in 2013. A further 32 were approved for the 2014 academic year. Funding support of between 80 per cent and 100 per cent of course costs is provided. Eighty per cent of all recipients supported in 2013–14 were undertaking a master's degree.

The Nursing and Midwifery Office manages a range of scholarships for employed nurses and midwives to support their ongoing learning and education. These include scholarships for Aboriginal and Torres Strait Islander enrolled nurses, post-registration, travel, mental health, and clinical leadership and management. Post-registration scholarships continue to support the greatest number of nurses and midwives, with a total of 136 recipients during the 2013 calendar year. Round 1 of 2014 has supported 137 nurses and midwives to date. Further growth is anticipated once round 2, 2014, applications have been considered.

Funding support of between 50 and 100 per cent of course costs is provided. Recipients range from enrolled nurses undertaking a Bachelor of Nursing qualification (10 per cent) to registered nurses studying at graduate certificate/diploma level (53 per cent) and at master's level (37 per cent).

Student support programs

Student Placement Unit

The Student Placement Unit provides coordination of clinical placements for nursing, midwifery, medical and allied health students and reports to the ACT Chief Nurse.

Collaborative partnerships exist between ACT Health and education providers from 36 tertiary and vocational training facilities throughout Australia. A diverse range of placement options are available in ACT Health facilities that provide opportunities for students to integrate theory into clinical practice. Professional development opportunities are also provided in ACT Health facilities for registered nurses and midwives from regional health services and the Australian Defence Force.

The Student Placement Online (SPO) management system provides a platform for pre-placement preparation, including e-learning programs for legislative compliance prior to the commencement of a clinical placement.

In 2013–14, 22,120 clinical placement days were provided to nursing and midwifery students. Night duty clinical placements were introduced in semester 2 as a new clinical placement initiative, which led to a collaborative evaluation project involving the Research Centre for Nursing and Midwifery Practice and the University of Canberra. In 2013–14, 542 placements were provided to both local and interstate students across 24 allied health disciplines.

The Secondary School Work Experience Program is a four-day placement offered to Year 10, 11 and 12 students attending a high school or college in the ACT. The aim is to provide students with a realistic idea of what it is like to work in health care and encourage them to choose career paths in health. In 2013–14, 329 students were provided with placements.

Postgraduate Certificates for Nurses and Midwives

Two postgraduate certificates are offered to nurses and midwives through the Australian Catholic University (ACU) in partnership with ACT Health. The ACU delivers an online component for two units, and an educator in the Staff Development Unit teaches a revised 2014 curriculum approved by ACU for the remaining two units in each course. This education model combines theory and experiential learning. The advantages for ACT Health of using this model are that staff are well educated for practice, with their study tailored to work area requirements. ACT Health staff who are students are able to work and study at the same time and do not need to pay fees for the ACT Health component. Of the five students completing the Child and Adolescent Health course in June 2014, four students gained a distinction or high distinction course average.

ACU students 2013–14

Course	June–December 2013	January–June 2014
Neonatal	11 students—9 students completed and 2 elected to complete in 2014	2 new students and 2 completing from last year
Child and Adolescent Health (includes either acute paediatrics or a maternal and child health specialty)	12 students—7 students completed and 5 students completed in 2014	13 students
Master's, Neonatal	1 student	1 student
Master's, Child and Adolescent Health	4 students	2 students

E-learning to support Essential Education and clinical care

There are 58 ACT Health e-learning courses that have been implemented in ACT Health to enable 24-hour-a-day, seven-day-a-week access to education and training. Fifteen e-learning courses were implemented in 2013–14 to support clinical and non-clinical staff, with a further 13 under development. Eight courses were reviewed and updated as a result of evaluations and changes to policy.

E-learning courses developed and implemented in 2013–14	
DonateLife—Mandatory Update Day	Certificate IV in Training and Assessment, Module 3
DonateLife Designated Officer Training	Workplace Induction Pathway
Certificate IV in Training and Assessment, Module 1 and 2	Writing Consumer Publications
Neonatal Resuscitation Update	Respecting Patient Choices
5 x Personal Safety and Conflict Awareness Training Modules	Patient ID and Procedure Matching
Certificate IV in Training and Assessment, Module 4	

Courses under development or nearing completion	
Indwelling Catheter	Pressure Injury
Aseptic Technique	Medication Package
Perinatal Depression	Ketamine
Parkinson's Disease	Intrathecal Epidural Morphine
Basic Life Support	Records Management
Radiation Safety	Haemophilia
Clinical Support and Supervision Essentials	

Courses redeveloped in 2013–14 following evaluation or changes to organisation requirements	
Infection Prevention and Control, Occupational Medicine and Waste Management	PCA Competency Test
Australian Charter of Healthcare Rights	Incident Notification
Consent	Risk Management
Human Rights Act	Government Procurement

Demonstrated commitment to whole-of-government learning and development initiatives

Initiative	No. of participants
ACTPS Graduate Program	2 in 2013 and 2 in 2014
Future Leaders Program	4
Executive Development Program	2

Activity	No. of participants	Cost
Studies Assistance	216	$36,126 (financial assistance provided)
Shared Services Calendar of Training	213 attendances	$68,564 (cost of courses)

ACT Health total learning and development activity

Learning and development activity for face-to-face programs and completion of e-learning by division, 2013–14

Health division	No. of attendances	Hours	Salary	E-learning completed
Office of the Director-General	925	2,174	$101,610	537
DDG, Strategy and Corporate	2,205	5,408	$224,182	1,411
DDG, Canberra Hospital and Health Services	57,533	119,808	$4,587,242	18,471
Calvary*	56	N/A	N/A	N/A
Special Purpose Account	57	91	$3,972	14
Service and Capital Planning	97	222	$9,899	36
TOTAL	**60,873**	**127,703**	**$4,926,905**	**20,469**

**Calvary hours and salary costs are not available.*

Note: An additional 1039 participants attended training during the year but were not able to be put on Capabiliti as they do not have profiles.

Future learning and development key priorities

- Continually refining and enhancing leadership, management and supervision programs.
- Developing a process and guidelines for educators to incorporate consumers in the education of clinical staff.
- With the current review of the RED framework, exploring opportunities to improve cultural competence within the renewed framework.
- Engaging medical staff in education.

E.3 WORK HEALTH AND SAFETY

Our priority — a safe and healthy working environment for all employees

Work Health and Safety within ACT Health is primarily the responsibility of the management team. This responsibility is also shared with all staff.

Workplace Safety (WPS) has overarching responsibility for ensuring that ACT Health has an effective Work Health and Safety Management System (WHSMS). The WHSMS assists management and staff to identify, manage, monitor and report safety hazards and their associated risks.

WPS provides occupational medicine services across ACT Health to prevent potential infectious disease transmission to healthcare workers. These services include:

- pre-employment screening
- a vaccination program (including annual influenza vaccinations)
- an immunisation drop-in clinic
- occupational risk exposure and follow-up management, counselling and advice
- cytotoxic screening
- a mobile clinic for seasonal flu vaccinations and
- product monitoring on safety devices, health surveillance and education.

WPS also provides a holistic early intervention physiotherapy service to staff who have sustained a musculoskeletal injury. This assists in early return to work, improved staff morale and decreased workers compensation claims.

ACT Health undertakes health promotion activities, such as encouraging smoking cessation and healthy food choices in the workplace. These add to the achievements already made in keeping staff healthy and safe.

Injury management services were transferred from ACT Health to Chief Minister and Treasury Directorate during 2013–14.

Measures taken during 2013–14

Workplace safety measures undertaken during 2013–14 include:

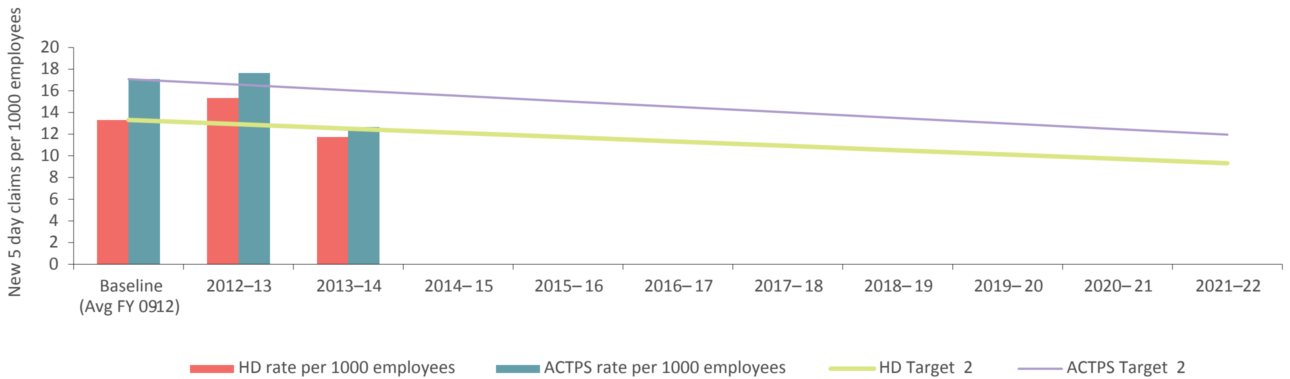
- The WHSMS was enhanced during the year to reflect changes to legislation and changes in operational requirements and processes. A new website has been developed for the WHSMS to provide a simple and centralised updating point, a simpler search function and better user access, and to reduce paper costs. Eleven WHSMS awareness training sessions were run over for four months to familiarise staff with the new web-based system.
- ACT Health Tier 1 Work Health Safety Committee (the peak organisational body for occupational health and safety in ACT Health) met four times during the year. This committee is chaired by the Director-General and includes management and workplace health and safety representatives (HSRs).
- Tier 2 health and safety committees are chaired by executive directors and represent major divisions and branches. Tier 2 committees meet quarterly or monthly and must include more HSRs than management representatives.
- Tier 3 health and safety committees are localised and bring together groups within similar locations or with similar job types. Tier 3 committees usually meet monthly, and must also have greater representation from HSRs than management.
- The fifth year of electronic staff accident and incident reporting has resulted in consistent reporting and enabled ACT Health to quickly identify and implement relevant controls, as well as report incident and trend data to management and workplace HSRs.
- Safety training remained a priority and continued to be provided for HSRs, managers and new staff. An additional face-to-face course was developed and implemented, called Manager's Investigation. This course is run in conjunction with the Work Health Safety for Managers course. It assists managers to put into place relevant preventive and corrective safety controls.

- The ACT Health Infrastructure Program, and the resultant capital construction, has created a need to increase the level of safety advice provided to enable safe work environments for future developments and refurbishment of existing facilities.
- A strong focus has been on dangerous goods and hazardous substances, with improved segregation of flammables and corrosive products in storage areas, training of all staff accessing them and a reduction in the amount of flammable materials stored. Workplace Health and Safety has also developed an Emergency Management Plan for bulk dangerous substances, an asbestos management plan, an online register and supporting materials.
- ACT Health is into its second year of a three-year external auditing program reviewing work health and safety compliance across all ACT Health divisions to our WHSMS, and auditing to the Australian Standard AS/NZS 4801:2001 Occupational Health and Safety Management Systems. Recommendations from the safety audits become safety objectives for each division to action and are reported to the safety committee structure.
- An e-learning course*, Personal Safety and Conflict Awareness*, commenced on 1 October 2013. This new e-learning program is designed to assist in preventing and responding to conflict that can arise between staff and those they provide a service to, or meet, during the course of their work. It is highly recommended for all staff who have any interaction with patients, clients, consumers, visitors or members of the public. The course has proved to be popular with staff, and an additional module is to be added, with special emphasis on the 'lone worker'.
- The RiskMan incident reporting system has had several modules developed or upgraded in response to organisational safety requirements and user feedback, including:
  - the Staff Accident Incident Reporting page is in the process of being upgraded to facilitate easier reporting and a more intuitive interface for users
  - an Occupational Medicine Unit module has been developed to capture data for staff screening and immunisation, including annual influenza vaccinations, and occupational risk exposures, including needlestick injuries
  - a security incident reporting module has been developed to identify, capture and report on staff personal threats and personal safety incidents (Code Black) where security officers are required to attend.

Target 1 — Reduce the number of worker fatalities by at least 20%

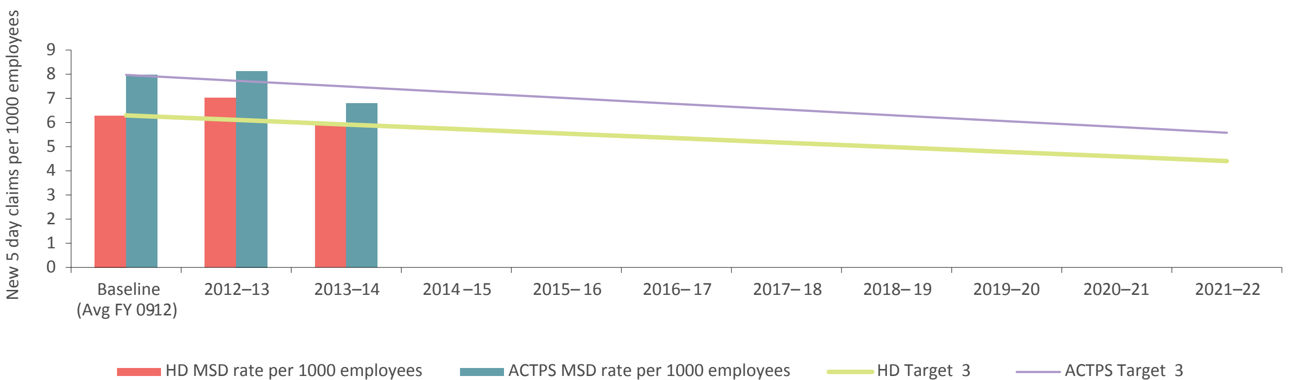
There were no work-related fatalities across ACT Health in 2013–14.

Target 2 — Reduce the incidence rate of claims resulting in one or more weeks off work by at least 30%



Over the last 10 years, ACT Health has consistently reduced the number of new claims that have exceeded five days incapacity per 1000 employees. This improvement varies on a year-to-year basis depending on the nature and complexity of a small number of claims. A small deterioration has occurred in overall performance between the 2009–12 average and 2012–13. However, 2013–14 has matched the baseline. Overall, performance is very good against the ACT Public Service figures.

Target 3 — Reduce the incidence rate of claims for musculoskeletal disorders (MSD) by at least 30%



ACT Health's performance has indicated an improvement compared with the preceding year. The overall trend in performance on these claims is improving with early intervention strategies and proactive case management.

Other key performance indicators

Incidents, accidents, investigations and notices in 2013–14 were as follows (other than notices of non-compliance—see D.6):

- 1367 accident/incident reports were lodged during the 2013–14 financial year (not including non-individual or Redevelopment Unit contractors). This compares with 1355 lodged during the preceding year. Of these reports, 158 resulted in lost time of one day or more, compared with 164 in 2012–13.
- 54 accidents/incidents relating to Health Directorate staff were notified to ACT WorkSafe under section 35 of the Work Health and Safety Act 2011, compared with 74 in 2012–13. In addition, there were a number of instances where contractors working for ACT Health reported incidents directly to WorkSafe ACT.
- Several Provisional Improvement Notices (PINs) were issued by HSRs in 2013–14:
  - a PIN was issued in July 2013 on the medication trolley at Alexander Machonochie Centre. The PIN was lifted. However, there are some longstanding issues with the jail design that are outstanding.
  - a PIN was placed on all doors at the Adult Mental Health Unit (AMHU) by the AMHU's HSR on 28 March 2014, following a series of incidents. The PIN was removed on 17 April 2014 following considerable remedial work on the doors.
- At 30 June 2014 there were 242 elected HSRs within the Health Directorate.
- 304 workstation assessments were completed by WPS Early Intervention Physiotherapy Program during the 2013–14 financial year. Workstation assessments are conducted as part of workers compensation return-to-work plans as well as for non-compensatory purposes.

E.4 WORKPLACE RELATIONS

The reporting year 2013–14 saw a change in direction for the ACT Public Service in the structure of the employment conditions framework. Agency-specific enterprise agreements began to be replaced by service-wide agreements based on employment streams. A new service-wide agreement for nurses and midwives was completed in March 2014, and another for administrative and related classifications in May 2014. Further agreements, covering the rest of the ACT Health workforce, were nearing completion at the end of the financial year.

The year also saw the negotiation of a new core contract for visiting medical officers (VMOs). In addition to setting conditions and rates of payment, the new model contract—which will be introduced as VMO contracts come up for renewal—will clarify how ACT Health policies apply to VMOs, making their obligations and responsibilities in both clinical and non-clinical areas clearer and more transparent.

As part of ACT Health's consultation requirements under all applicable enterprise agreements, quarterly meetings were held with all relevant unions. In addition, the Director-General of ACT Health organised a meeting with all the unions represented within the organisation, allowing access on a bi-monthly basis.

Details of ACT Health's Special Employment Arrangements (SEAs) and Australian Workplace Agreements (AWAs) are set out in the table below. In ACT Health, SEAs are used to attract and retain special skills in high demand, including those of medical and health practitioners and specialised skills in clinical support areas.

Description	No. of Individual SEAs	No. of Group SEAs	Total employees covered by Group SEAs	TOTAL
	A	B	C	(A+C)
SEAs				
Number of SEAs at 30 June 2014	118	22	204	322
Number of SEAs entered into during period	7	1	15	22
Number of SEAs terminated during period	14	2	150	164
Number of SEAs providing for privately plated vehicles as at 30 June 2014	8	0	0	8
Number of SEAs for employees who have transferred from AWAs during period	0	0	0	0
AWAs				
Number of AWAs at 30 June 2014	4	0	0	4
Number of AWAs terminated/lapsed during period (including formal termination and those that have lapsed due to staff departures)	0	0	0	0

	Classification Range	Remuneration as at 30 June 2014
Individual and Group SEAs	DEN1/2, DEN3, DEN4	$52,547 – $162,802
	HPO1-HPO6	$19,971 – $156,296
	MPPSP, MPSPE, MPSSP, MPCHF	$91,251 – $188,911
	PAO2-PAO3	$81,760 – $116,570
	SITB	$129,886
	SOA, SOB, SOC	$125,672 – $162,389
	SPEC-SSPEC	$69,808 – $593,109
	TCMG2–TCMG3	$198,386 – $236,812
AWAs (includes AWAs ceased during reporting period)	SOC	$100,207 – $120,048
	SSPEC	$210,481 – $272,473

E.5 STAFFING PROFILE

Full-time equivalent (FTE) and headcount by gender

	Female	Male	Total
FTE	4,428.6	1,551.3	5,979.9
Headcount	5,139	1,658	6,797
Percentage of workforce (based on headcount)	75.6%	24.4%	100.0%

Headcount by classification and gender

Classification groups	Female	Male	Total
Administrative Officers	775	168	943
Dental	13	5	18
Executive Officers	14	8	22
General Service Officers and equivalent	196	278	474
Health Assistants	74	11	85
Health Professional Officers	810	235	1,045
Information Technology Officers	0	2	2
Legal Officers	0	1	1
Medical Officers	401	456	857
Nursing Staff	2,460	306	2,766
Professional Officers	12	4	16
Senior Officers	247	134	381
Teacher	1	0	1
Technical Officers	134	48	182
Trainees and Apprentices	2	2	4
TOTAL	**5,139**	**1,658**	**6,797**

Headcount by employment category and gender

Employment category	Female	Male	Total
Casual	292	98	390
Permanent full-time	2,431	936	3,367
Permanent part-time	1,564	145	1,709
Temporary full-time	647	444	1,091
Temporary part-time	205	35	240
TOTAL	**5,139**	**1,658**	**6,797**

FTE and headcount by division/branch

Division/branch	FTE	Headcount
Canberra Hospital and Health Services	4,985.4	5,713
Director-General's Reports	102.1	108
Population Health	155.4	172
Health Infrastructure and Planning	60.0	63
Special Purpose Account	13.4	20
Strategy and Corporate	663.6	721
Total	**5,979.9**	**6,797**

Headcount by division/branch and employment type

Division/branch	Permanent	Temporary	Casual
Canberra Hospital and Health Services	4,204	1,185	324
Director General's Reports	233	41	6
Population Health	144	23	5
Health Infrastructure and Planning	43	19	1
Special Purpose Account	4	10	6
Strategy and Corporate	592	76	53
Total	**5,076**	**1331**	**390**

Headcount by age group and gender

Age Group	Female	Male	Total
Under 25	357	100	457
25–34	1,409	507	1,916
35–44	1,238	435	1,673
45–54	1,258	358	1,616
55 and over	877	258	1,135

Headcount by length of service, generation and gender

Length of service (years)	Pre-Baby Boomers		Baby Boomers		Generation X		Generation Y		Total	
	F	M	F	M	F	M	F	M	F	M
0–2	3	0	164	51	383	166	790	341	1,340	558
2–4	4	2	143	44	322	130	413	159	882	335
4–6	1	3	163	37	259	84	244	50	667	174
6–8	3	0	141	49	226	75	137	18	507	142
8–10	5	1	125	40	174	54	63	10	367	105
10–12	3	0	137	37	120	44	32	3	292	84
12–14	2	1	129	34	111	29	14	2	256	66
14 plus	5	4	562	133	256	57	5	0	828	194

Generation	Birth years covered	Generation	Birth years covered
Pre-Baby Boomers	prior to 1946	Generation X	1965 to 1979 inclusive
Baby Boomers	1946 to 1964 inclusive	Generation Y	from 1980

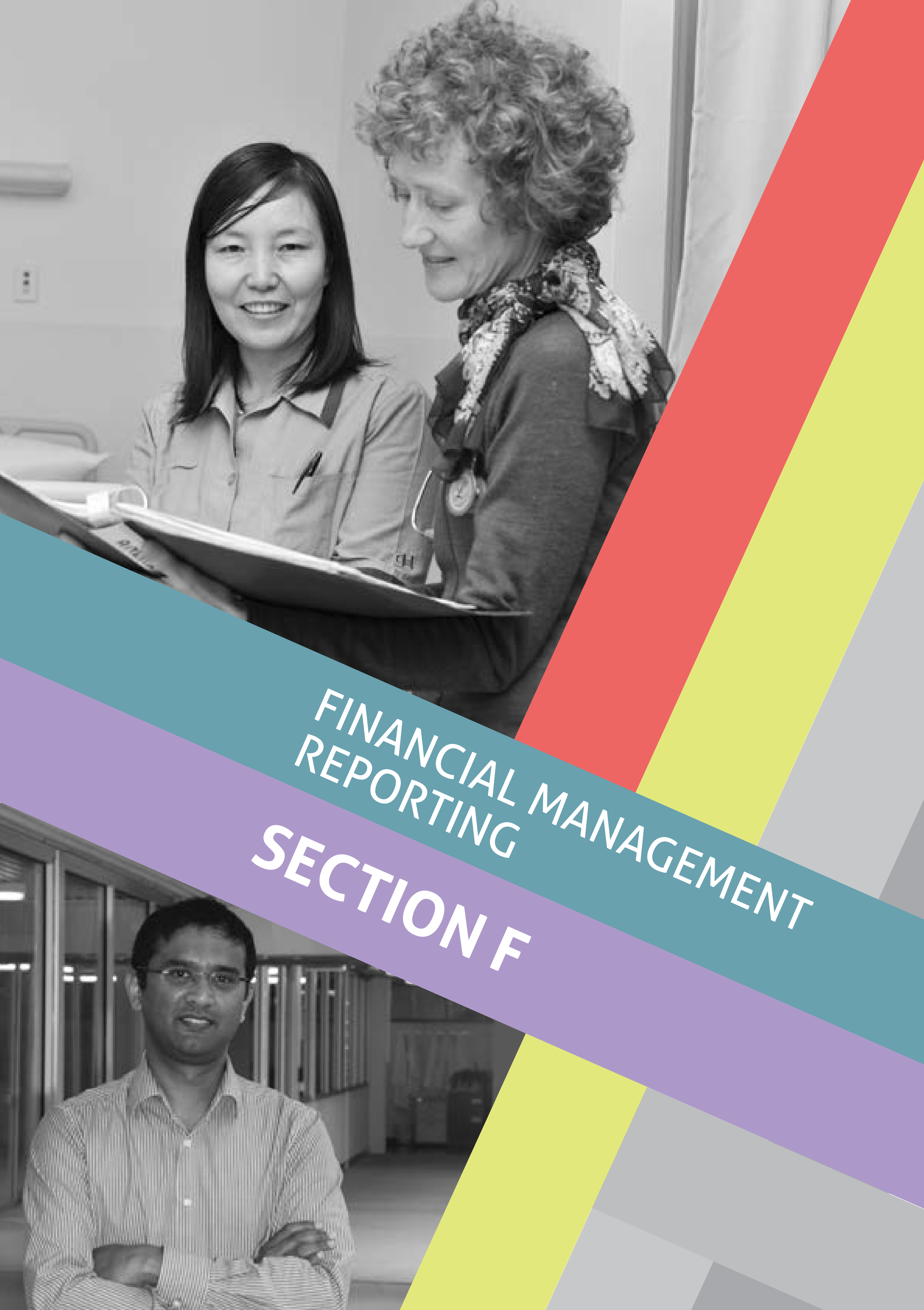
Average length of service by gender (headcount)

	Female	Male	Average (M+F)
Average years of service	7.5	6.2	7.2

Headcount by diversity group

Diversity group	Headcount	Percentage of agency workforce
Aboriginal and Torres Strait Islander	71	1.04%
Culturally and Linguistically Diverse	1,644	24.19%
People with disability	142	2.09%

Note: Employees may identify with more than one of the diversity groups.


FINANCIAL MANAGEMENT
REPORTING
SECTION F

F.1 FINANCIAL MANAGEMENT

Management Discussion and Analysis for the Health Directorate, For the Financial Year Ended 30 June 2014

General Overview

Operations and Principal Activities

The Health Directorate (the Directorate) aims to achieve good health for all residents of the Territory by planning for 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 2013–14 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 2012–13 and 2013–14, and the budget and forward estimates contained in the 2014–15 Health Directorate Budget Statements.

Total Net Cost of Services

	Actual 2012–13 $m	Budget 2013–14 $m	Actual 2013–14 $m	Budget 2014–15 $m	Forward Estimate 2015–16 $m	Forward Estimate 2016–17 $m	Forward Estimate 2017–18 $m
Total Expenses	1,083.8	1,109.7	1,115.9	1,188.7	1,271.6	1,360.3	1,427.5
Total Own Source Revenue	679.8	840.7	849.2	886.8	927.7	970.3	1,007.1
Net Cost of Services	**404.0**	**269.0**	**266.7**	**301.9**	**343.9**	**390.0**	**420.4**

Comparison to Budgeted Net Cost of Services

The Directorate's net cost of services for 2013–14 of $266.7 million was $2.3 million or 0.9 per cent lower than the 2013–14 budget.

A combination of factors resulted in higher than budgeted own source revenue ($8.5 million). The main variations are:

- User Charges Non-ACT Government ($4.9 million) – Largely due to the finalisation of prior year reconciliations resulting in additional Cross Border revenue ($4.7 million) that was not budgeted for and additional high cost drugs reimbursements from the Commonwealth due to indexation and price adjustments for prior years ($1.1 million) which were partially offset by lower than budgeted Inpatient Revenue mainly due to the declining number of Department of Veterans Affairs patients ($1.2 million); and
- Other Revenue ($3.3 million) – mainly due to the receipt of one off grants from the Australian National University and Health Workforce Australia for educational support and new research grants.

This higher than budgeted own source revenue was partially offset by higher than budgeted expenses ($6.2 million). The main variations are:

- Employee Expenses (excluding superannuation) ($30.0 million) – largely due to a reallocation from grants and purchased services ($11.3 million) due to changes in the planned delivery of services from external providers to the Health Directorate, the impact of payrises from the collective agreements being higher than budgeted ($6.3 million), an increase in the rate used to estimate the present value of long service leave from 101.3% to 103.5% ($2.2 million) , the impact of payrises on employee leave provisions ($5.7 million), termination payments ($2.0 million) and an additional charge imposed on worker's compensation policies by Comcare ($3.0 million). An increase in staff numbers, increased overtime costs and penalties account for the balance; and
- Superannuation ($4.3 million) – mainly due to payrise impacts, larger workforce and a slower decline in the number of employees leaving the higher cost CSS, PSS and PSSap schemes than had been anticipated.

The higher than budgeted expenses were partially offset by lower than budgeted expenses for:

- Grants and Purchased Services ($11.3 million) – mainly associated with a reallocation to employee expenses due to changes in the planned delivery of services from external providers to the Health Directorate;
- Supplies and Services ($7.5 million) – cost savings in medical and surgical supplies and pathology supplies ($5.3 million), favourable pharmaceuticals expenses due to more effective purchasing methodologies ($5.4 million), favourable non-contract services due to reduced agency nursing cost ($2.0 million) and lower utility expenses due to the combined impact of lower usage due to a reduction in construction activities and savings on green energy charge ($1.0 million), which were partially offset by blood products which was budgeted for in the Other Expenses category ($8.4 million);
- Other Expenses ($6.0 million) – mainly due to blood products ($8.4 million) which was budgeted against this expense category while the actual expenditure has been included in the supplies and services expense category. This favourability is partially offset by higher than budgeted legal expenses ($1.0 million) and allowances for impairments ($1.0 million); and
- Depreciation and Amortisation ($3.2 million) – mainly due to delays in the completion of some capital works and eHealthy projects including Belconnen Community Health Centre and Integrated Capital Region Cancer Centre.

Comparison to 2012–13 Net Cost of Services

Total net cost of services was $137.3 million or 34.0 per cent lower than the 2012–13 actual cost. This is due to increased own source revenue ($169.4 million), from higher User Charges ACT Government ($174.4 million) mainly due to a review of activity deemed as 'in scope' of public hospitals under the National Health Reform Agreement and indexation and growth in patient activity in acute services, cancer services, rehabilitation, aged and community services and mental health services.

This increased own source revenue was partially offset by increased expenses ($32.1 million). The main increased expenses are:

- Employee Expenses (excluding superannuation) ($49.9 million) – largely due to the impact of collective agreement payrises ($15.1 million), a reallocation from grants and purchased services ($11.3 million) due to changes in the planned delivery of services from external providers to the Health Directorate, an increase in the rate used to estimate the present value of long service leave from 101.3% to 103.5% ($2.2 million), the impact of payrises on employee leave provisions ($9.4 million), termination payments ($2.0 million), an additional charge imposed on worker's compensation policies by Comcare ($3.0 million) and an increase in the overall workforce to cover growth in services in acute services, cancer services, rehabilitation, aged and community services and mental health services;
- Superannuation ($4.2 million) – as a result of a larger workforce, payrises, increase in notional superannuation rates; and
- Supplies and Services ($9.3 million) – from increased costs for visiting medical officers, mainly to cover medical staff on long term leave and fees related to services provided in prior years, increases in floor space for the Health Directorate which results in higher cleaning costs, increased repairs and maintenance, insurance premium, and computer expenses.

These were offset by reduced expenditure against:

- Depreciation and Amortisation ($20.5 million) – the 2012–13 figure included additional depreciation charges for accelerating the depreciation for the old Women's and Children's Hospital building that was partially demolished and rebuilt, Tuggeranong Health centre and Level 5 Building 1 at Canberra Hospital which underwent substantial renovations, and the old Psychiatric ward. This reduction was partially offset by an increase in 2013–14 as a result the commissioning of the Gungahlin Community Health Centre and the new Centenary Hospital for Women and Children; and
- Grants and Purchased Services ($10.2 million) – This is mainly associated with a reallocation to employee expenses due to changes in the planned delivery of services from external providers to the Health Directorate.

Future Trends

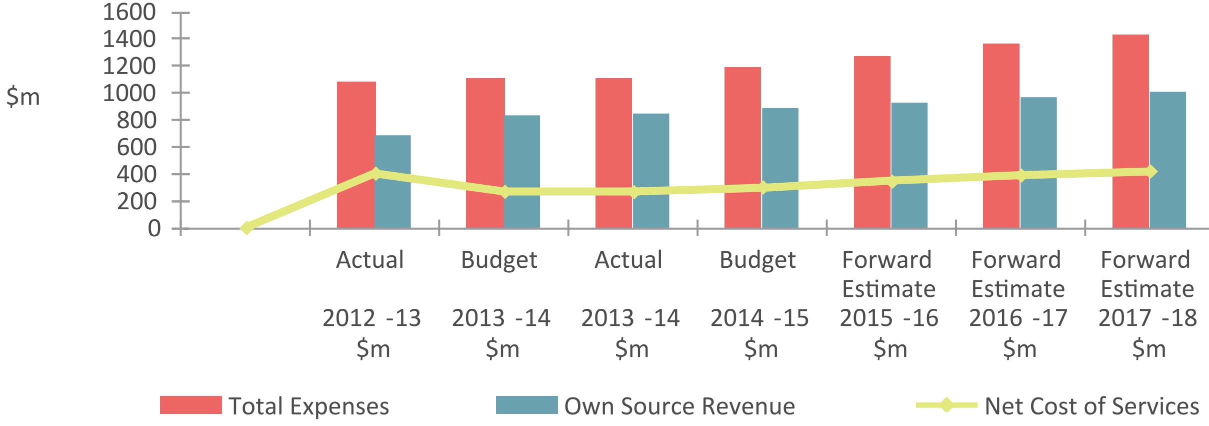


Figure 1: Net Cost of Services

Net cost of services is planned to increase steadily over future years consistent with funding provided in the 2014–15 Budget and the forward estimate years for growth in public health services including acute services, critical care, cancer services, rehabilitation, aged and community services and mental health services. In addition, funding is provided for payrises and general indexation. A significant proportion of these costs are funded from Government Payment for Outputs.

Total Expenditure

Components of Expenditure

Figure 2 below indicates the components of the Directorate's expenses for 2013–14 with the largest components of expense being employee expenses (excluding superannuation) which represents 54.3 per cent or $606.4 million, supplies and services which represents 27.8 per cent or $310.7 million, and superannuation, which represents 6.9 per cent or $76.4 million.

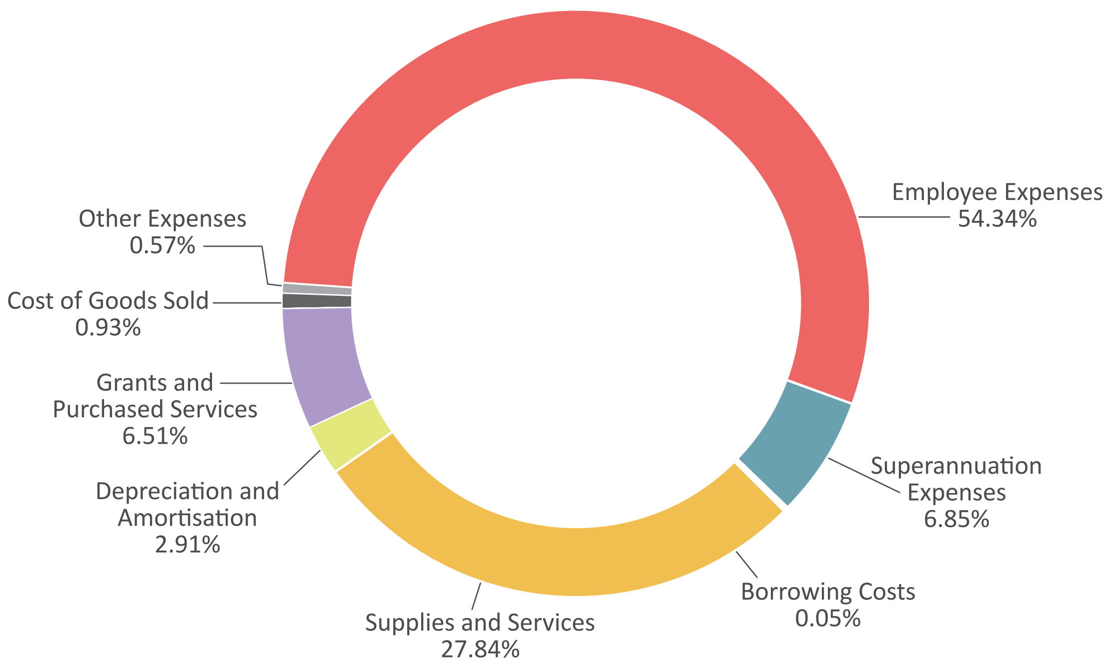


Figure 2 – Components of Expenditure

Comparison to Budget

Total expenses of $1,115.9 million were ($6.2 million), or 0.6 per cent higher than the original 2013–14 budget of $1,109.7 million.

This increase was predominantly due to higher:

- Employee Expenses (excluding superannuation) ($30.0 million) – largely due to a reallocation from grants and purchased services ($11.3 million) due to changes in the planned delivery of services from external providers to the Health Directorate, the impact of collective agreement payrises being higher than budgeted ($6.3 million), an increase in the rate used to estimate the present value of long service leave from 101.3% to 103.5% ($2.2 million) , the impact of payrises on employee leave provisions ($5.7 million), termination payments ($2.0 million) and an additional charge imposed on worker's compensation policies by Comcare ($3.0 million). An increase in staff numbers, increased overtime costs and penalties account for the balance; and
- Superannuation ($4.3 million) – mainly due to payrise impacts, an increasing workforce and a slower decline in the number of employees leaving the higher cost CSS, PSS and PSSap schemes than had been anticipated.

This higher expenditure was partially offset by lower:

- Grants and Purchased Services ($11.3 million) – This is mainly associated with a reallocation to employee expenses due to changes in the planned delivery of services from external providers to the Health Directorate;
- Supplies and Services ($7.5 million) – cost savings in medical and surgical supplies and pathology supplies ($5.3 million), favourable pharmaceuticals expenses due to more effective purchasing methodologies ($5.4 million), favourable non-contract services due to reduced agency nursing cost ($2.0 million) and lower utility expenses due to combined effect of lower usage due to a reduction in construction activities and savings on green energy charge ($1.0 million), which were partially offset by blood products which was budgeted against other expenses ($8.4 million);
- Other Expenses ($6.0 million) – planned expenditure on Blood Products ($8.4 million) was budgeted against this expense category, however the actual expenditure is included in the supplies and services expense category. This favourable position is partially offset by higher than budgeted legal expenses ($1.0 million) and allowances for impairments ($1.0 million); and
- Depreciation and Amortisation ($3.2 million) – mainly due to delays in the completion of some capital works and eHealthy projects including Belconnen Community Health Centre and Integrated Capital Region Cancer Centre.

Comparison to 2012–13 Actual Expenses

Total expenses were ($32.1 million) or 3.0 per cent higher than the 2012–13 actual result. The increase was predominantly due to higher:

- Employee Expenses (excluding superannuation) ($49.9 million) - largely due to the impact of collective agreement pay rises ($15.1 million), a reallocation from grants and purchased services ($11.3 million) due to changes in the planned delivery of services from external providers to the Health Directorate, an increase in the rate used to estimate the present value of long service leave from 101.3% to 103.5% ($2.2 million), the impact of payrises on employee leave provisions ($9.4 million), termination payments ($2.0 million), and an additional charge imposed on worker's compensation policies by Comcare ($3.0 million). Also there has been an increase in the workforce to cover growth in services in acute services, cancer services, rehabilitation, aged and community services and mental health services;
- Superannuation ($4.2 million) – as a result of a larger workforce, payrises, increase in notional superannuation rates; and
- Supplies and Services ($9.3 million) – the main variations are due to increased:
  - visiting medical officers (VMO's) ($3.7 million) – as a result of using additional visiting medical officers due to vacancies and staff specialists on extended leave and $1.1 million that relates to services delivered in 2012–13;
  - insurance ($2.6 million) – mainly due to the Government's self insurance retention limit, which is a component of the premium charged by ACT Insurance Authority increasing from $17.5 million to $20.0 million;
  - repairs and maintenance ($2.6 million) – as a result of preventative and reactive repairs on ageing assets and an increase in maintenance costs for new buildings such as the Belconnen Community Health Centre;
  - clinical expenses/ medical surgical supplies ($2.1 million) – mainly due to price escalation and growth in patient activity, including in acute services, cancer services, rehabilitation, aged and community services and mental health services;
  - computer expenses ($1.7 million) – due to a combination of factors, including price escalation, increase in staff numbers and support costs for projects that became operational during the year. They include the Digital Wireless Network at the Canberra Hospital campus, Digital Intensive Care Unit Clinical Information System, and Clinical Portal Systems, ACT Patient Administration System, Identity and Access Management project, Renal Computerised Information System, Health Services Directory; and
  - contractors and consultants ($1.7 million) – mainly attributable to contractor and IT consultant costs relating to additional operational and maintenance work for a range of IT projects such as ACT Patient Administration System, Clinical Portal Suites, Digital Mammography and Digital Health Infrastructure, and Renal Computerised Information System.

The higher supplies and services were partially offset by lower:

- non-contract services ($2.9 million) – due to reduced usage of agency staff. Agency staff refers to temporary staff sourced at short notice from external labour providers; and
- pharmaceuticals ($1.4 million) – the reduction is mainly attributable to savings achieved from bulk purchasing.

The increased expenses were partially offset by lower:

- Depreciation and Amortisation ($20.5 million) – the 2012–13 figure included additional depreciation charges for accelerating the depreciation for the old Women's and Children's Hospital buildings that was partially demolished and rebuilt, Tuggeranong Health centre and Level 5 Building 1 at Canberra Hospital which underwent substantial renovations, and the old Psychiatric ward. This reduction was partially offset by an increase in 2013–14 as a result the commissioning of the Gungahlin Community Health Centre and the new Centenary Hospital for Women and Children; and
- Grants and Purchased Services ($10.2 million) – as a result of a reallocation to employee expenses due to changes in the planned delivery of services from external providers to the Health Directorate.

Future Trends

Expenses are budgeted to increase steadily across the forward years to account for price escalation and growth in services.

Total Own Source Revenue

Components of Own Source Revenue

Figure 3 below indicates that for the financial year ended 30 June 2014, the Directorate received 84.7 per cent of its total own source revenue ($718.0 million) from ACT Government user charges.

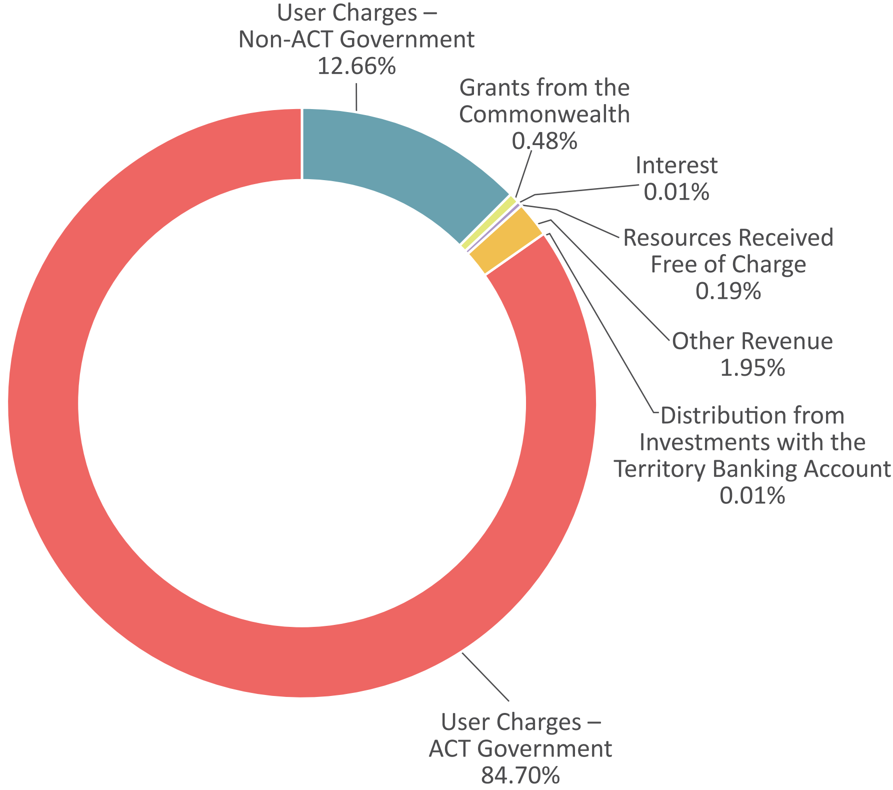


Figure 3 – Components of Own Source Revenue

Comparison to Budget

Own source revenue for the year ending 30 June 2014 was $849.3 million, which was $8.6 million or 1.0 per cent higher than the 2013–14 budget of $840.7 million.

This favourable variance is due to higher:

- User Charges Non-ACT Government ($4.9 million) – due to the receipt of additional cross border revenue following the finalisation of some prior year reconciliations;
- Other Revenue ($3.3 million) – mainly relating to Health Workforce Australia grants and additional prior year expenditure reimbursement for workers' compensation claims; and
- Resources Received Free of Charge ($0.8 million) – mainly related to legal advice from the Government Solicitor's Office and accommodation for patient teaching and training which was received free of charge.

Comparison to 2012–13 Actual Revenue

Own source revenue was $169.5 million or 24.9 per cent higher than the 2012–13 actual result of $679.8 million.

This is mainly due to an increase in ACT Government User Charges ($174.4 million) mainly due to a review of activity deemed as 'in scope' of public hospitals under the National Health Reform Agreement and indexation and growth in patient activity;

This was partially offset by a reduction in Non-ACT Government User Charges ($5.8 million) mainly due to the changed funding arrangements for the treatment of interstate patients in ACT hospitals following the implementation of National Health Reform Agreement (these revenues are now collected through the ACT Local Hospital Network Directorate).

Future Trends

Total own source revenue is expected to increase steadily across the forward years consistent with funding provided to the ACT Local Hospital Network to purchase increased activity from the Canberra Hospital and Health Services in 2014–15 and the forward estimate years.

Financial Position

Total Assets

Components of Total Assets

Figure 4 below indicates that, for the financial year ended 30 June 2014, the Directorate held 74.1 per cent of its assets in property, plant and equipment.

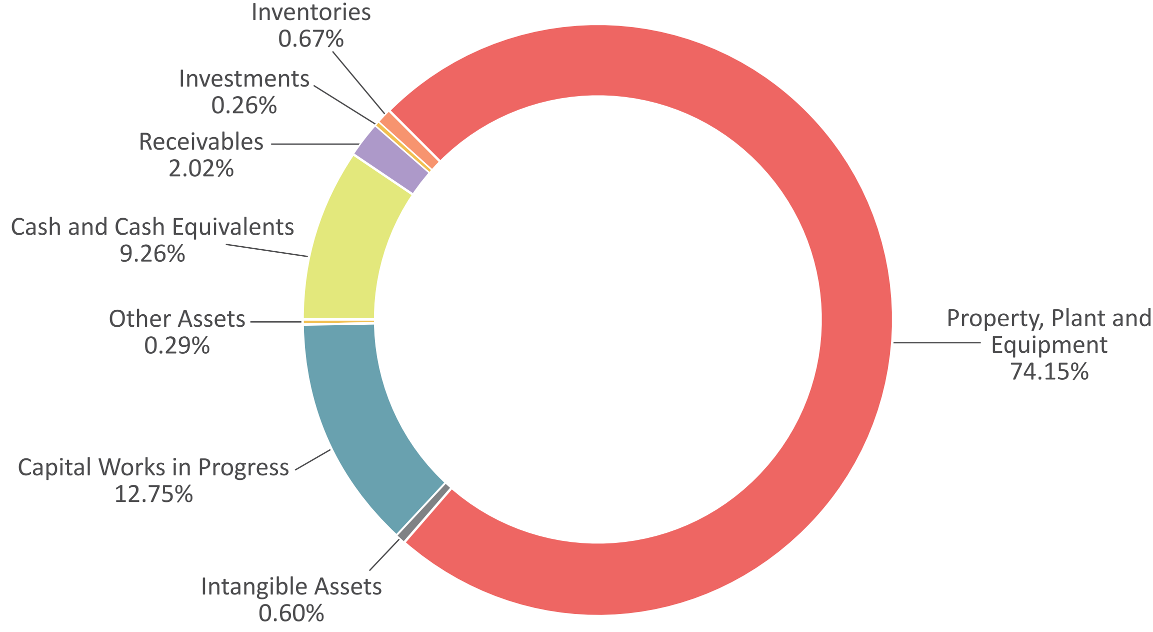


Figure 4 – Total Assets as at 30 June 2014

Comparison to Budget

The total asset position as at 30 June 2014 is $1,158.8 million, $97.6 million lower than the 2013–14 budget of $1,256.4 million.

The variance reflects the timing associated with the acquisition and completion of various assets over the 2013–14 financial year including:

- Property, Plant and Equipment ($143.5 million) – mainly due to delayed commissioning of the Belconnen Community Health Centre and Integrated Capital Region Cancer Service;
- Receivables ($43.7 million) – the budget included a large cross border receivable which has now been settled; and
- Intangibles ($14.1 million) – mainly due to delays with ICT projects such as eHealthy projects, and the Identity Access Management Project.

Partially offset by higher:

- Cash and Cash Equivalents ($83.5 million) – due to earlier than budgeted settlement of cross border receivables; and
- Capital Works in Progress ($19.9 million) – due to the deferral of capital works projects from 2012-13 into future years as a result of procurement delays due to structural and manufacturing issues, and operational commissioning delays.

Comparison to 2012–13 Actual

The Directorate's total asset position is $47.9 million higher than the 2012–13 actual result of $1,110.9 million, largely due to increases in:

- Property, Plant and Equipment including Assets Held for Sale ($151.2 million) – mainly due to completed new building capital works projects including the Centenary Hospital for Women and Children, the Gungahlin Community Health Centre and the Cancer Patient Accommodation property; and
- Cash and Cash Equivalents ($97.7 million) – due to a decrease in receivables associated with the timing of cross border payments by the New South Wales Ministry of Health.

The above increases were partially offset by a reduction in:

- Receivables ($102.8 million) – due to timely settlement of cross border provisional payments and payments from the Local Hospital Network Directorate (LHN) for services provided in 2012–13; and
- Capital Works in Progress ($93.9 million) – as a result of works progressing on the new facilities including the Community Health Centres in Belconnen, Tuggeranong and Gungahlin, the Capital Region Cancer Centre, the Centenary Hospital for Women and Children, for Clinical Services Redevelopment, the Canberra Hospital Emergency Department Intensive Care Unit, Digital Mammography, Identity Access Management and various capital upgrades.

Total Liabilities

Components of Total Liabilities

Figure 5 below indicates that the majority of the Directorate's liabilities relate to employee benefits 81.4 per cent and payables 15.6 per cent.

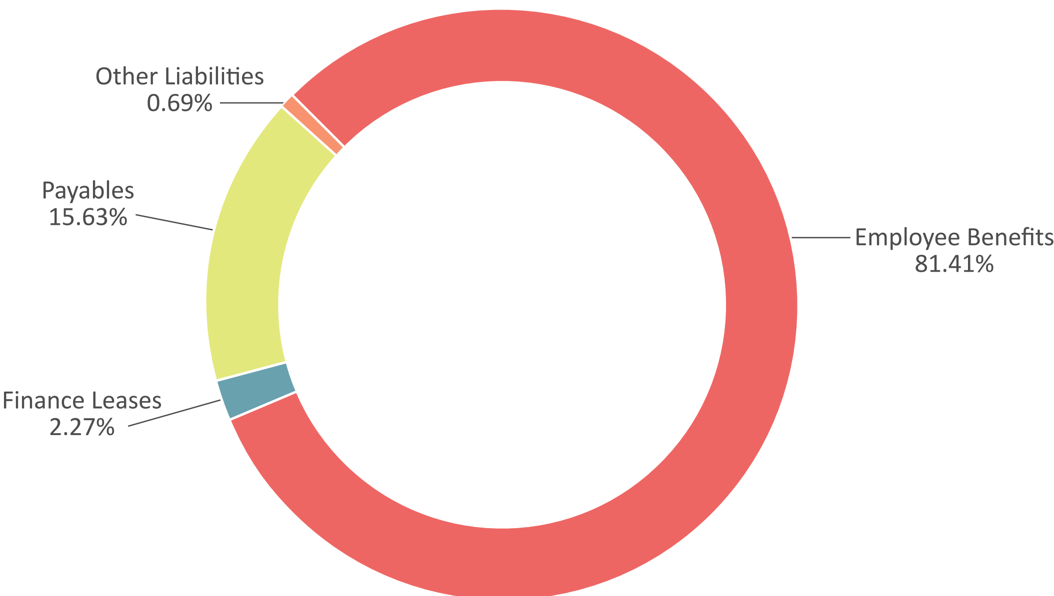


Figure 5 – Total Liabilities as at 30 June 2014

Comparison to Budget

The Directorate's liabilities for the year ended 30 June 2014, of $272.8 million, is $5.2 million higher than the 2013–14 budget of $267.6 million.

This was largely due to higher:

- Employee Benefits ($22.3 million) – mainly due the impact of pay rises on leave provisions, accrued payrise amounts, increases in the rates used to estimate the present value of long service leave from 101.3% to 103.5% and annual leave from 100% to 100.9%.

Offset by lower:

- Payables ($17.2 million) – mainly due to the budget including a large amount for unpaid capital works invoices.

Comparison to 2012–13 Actual

Total liabilities of $272.8m are $18.1 million lower than the actual results as at 30 June 2013 of $290.9 million. This is due to decreases in:

- Payables ($45.0 million) – 2012–13 included a large number of invoices for capital works late in June 2013; and
- Other Liabilities ($1.7 million) – 2012–13 included payment in advance for services provided to the Department of Veterans' Affairs.

The above decreases were partially offset by an increase in:

- Employee Benefits ($29.1 million) – mainly due the impact of pay rises on leave provisions, accrued payrise amounts, increases in the rates used to estimate the present value of long service leave from 101.3% to 103.5% and annual leave from 100% to 100.9%.

Territorial Statement of Revenue 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 19.8 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).

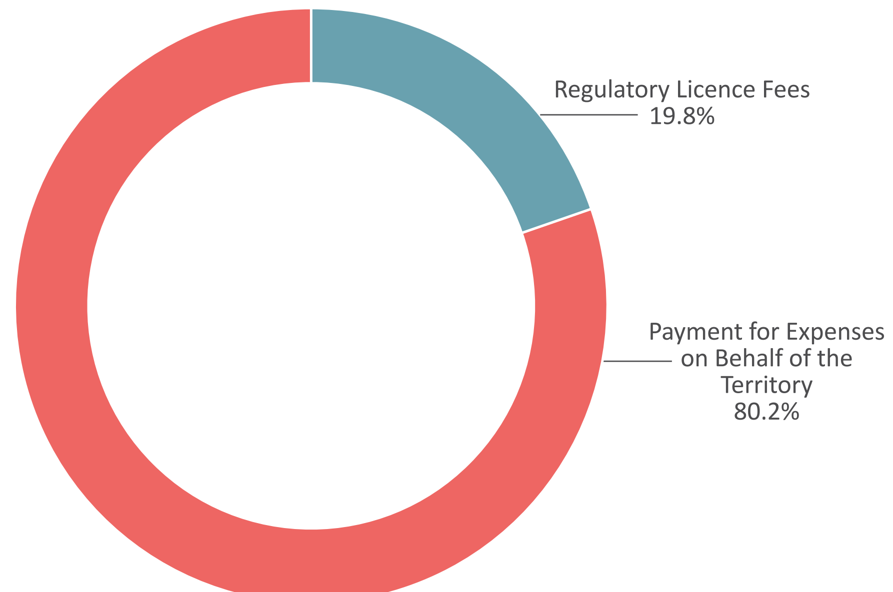


Figure 6 – Sources of Territorial Revenue

Total Territorial income for the year ending 30 June 2014 was $5.8 million, which is consistent with the budget figure of $5.8 million.

Total Territorial income for 2013–14 of $5.8 million is $4.0 million higher than the 2012–13 income of $1.8 million. The main contributor to this increase is:

- Payment for Expenses on Behalf of the Territory ($3.9 million) – This is due to capital works paid to Calvary for the Continuity of Health Services Plan – Essential Infrastructure project which was for the expansion of clinical services including an additional 15 beds, expansion of the Rapid Assessment Unit and a Birthing Centre.

Total Expenses

Figure 7 below indicates that 80.3 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 19.7 per cent being the transfer, to Government, of regulatory licence fees.

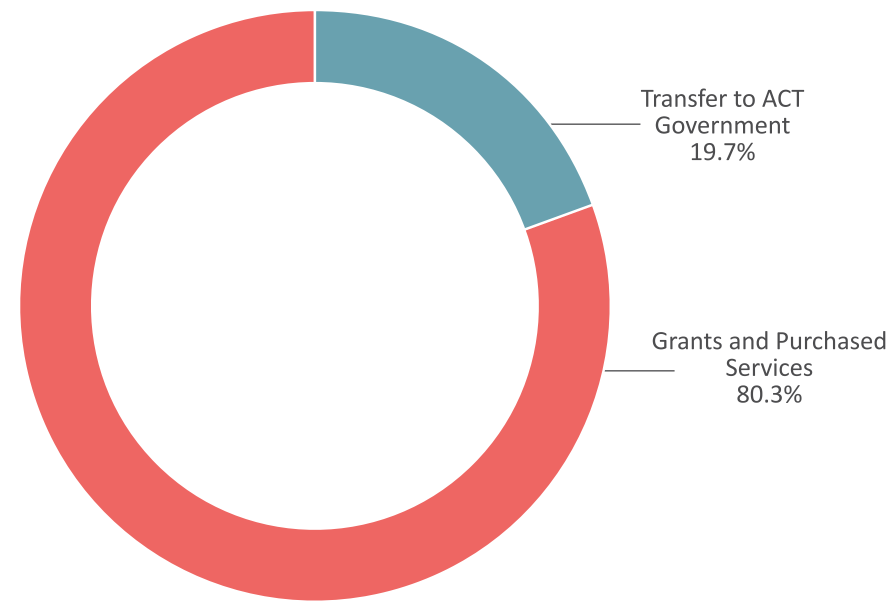


Figure 7 – Sources of Territorial Expenses

Total expenses were $5.7 million, which was $0.1 million lower than the budget of $5.8 million due to lower regulatory licence fees received.

Total expenses were $3.9 million higher than the 2012–13 total of $1.8 million. This is mainly due to payments for new capital works for the Continuity of Health Services Plan – Essential Infrastructure project which was for the expansion of clinical services including an additional 15 beds, expansion of the Rapid Assessment Unit and Birthing Centre.

Attachment A – Comparison of net cost of services to budget 2013–14

					Variance to be Explained	
Description	**Original Budget $'000**	**Plus AAO Transfers $'000**	**Total Funding $'000**	**Less Actual $'000**	**$'000**	**%**
Expenses						
Employee and Superannuation	648,503	–	648,503	682,823	–34,320	–5.29%
Supplies and Services	318,133	–	318,133	310,676	7,457	2.34%
Depreciation and Amortisation	35,673	–	35,673	32,483	3,190	8.94%
Purchased Services	84,023	–	84,023	72,677	11,346	13.50%
Other Expenses	12,826	–	12,826	6,941	5,885	45.88%
Cost of Goods Sold	10,551	–	10,551	10,339	212	2.01%
Total Expenses	**1,109,709**	**–**	**1,109,709**	**1,115,939**	**–6,230**	**–0.56%**
Own Source Revenue						
User Charges	820,738	–	820,738	825,393	–4,655	–0.57%
Interest	278	–	278	195	83	29.86%
Resources Free of Charge	780	–	780	1,618	–838	–107.48%
Gains	1,544	–	1,544	1,394	150	9.71%
Other Revenue	13,230	–	13,230	16,518	–3,288	–24.85%
Grants from the Commonwealth	4,120	–	4,120	4,110	10	0.23%
Total Own Source Revenue	**840,690**	**–**	**840,690**	**849,228**	**–8,538**	**–1.02%**
Total Net Cost of Services	**269,019**	**–**	**269,019**	**266,711**	**2,308**	**0.86%**

F.2 FINANCIAL STATEMENTS

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 2014 have been audited. These comprise the following financial statements and accompanying notes:

- Controlled financial statements – operating statement, balance sheet, statement of changes in equity, cash flow statement 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 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.

The auditor's responsibility

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

The audit was conducted in accordance with Australian Auditing Standards to obtain 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 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 these 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 these financial statements. If users of these 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 2014:

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

(ii) present fairly the financial position of the Directorate as at 30 June 2014 and results of its operations and cash flows for the year then ended.

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

M. Cooper

Dr Maxine Cooper
Auditor-General
17 September 2014

Health Directorate
Financial Statements
For the Year Ended 30 June 2014

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 2014 and the financial position of the Directorate on that date.

Dr Peggy Brown

Director-General

Health Directorate

16 September 2014

Health Directorate
Financial Statements
For the Year Ended 30 June 2014

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 2014 and the financial position of the Directorate on that date.

Mr Ron Foster

Chief Finance Officer

Health Directorate

16 September 2014

Health Directorate
Controlled Financial Statements
For The Year Ended 30 June 2014

Health Directorate
Operating Statement
For the year Ended 30 June 2014

	Note No.	Actual 2014 $'000	Original Budget 2014 $'000	Actual 2013 $'000
Income				
Revenue				
Government Payment for Outputs	4	229,062	231,100	364,256
User Charges – ACT Government	5	718,016	718,290	543,569
User Charges – Non-ACT Government	5	107,377	102,448	113,214
Interest	6	97	100	106
Distribution from Investments with the Territory Banking Account	7	98	178	144
Resources Received Free of Charge	8	1,618	780	1,010
Other Revenue	9	20,628	17,350	19,425
Total Revenue		**1,076,896**	**1,070,246**	**1,041,724**
Gains				
Gains on Investments	10	4	-	21
Other Gains	11	1,394	1,544	2,356
Total Gains		**1,398**	**1,544**	**2,377**
Total Income		**1,078,294**	**1,071,790**	**1,044,101**
Expenses				
Employee Expenses	12	606,380	576,404	556,505
Superannuation Expenses	13	76,443	72,099	72,276
Supplies and Services	14	310,676	318,133	301,333
Depreciation and Amortisation	15	32,483	35,673	53,014
Grants and Purchased Services	16	72,677	84,023	82,888
Borrowing Costs	17	551	401	375
Cost of Goods Sold	18	10,339	10,551	10,475
Other Expenses	19	6,390	12,425	6,924
Total Expenses		**1,115,939**	**1,109,709**	**1,083,790**
Operating (Deficit)		**(37,645)**	**(37,919)**	**(39,689)**
Other Comprehensive Income				
Items that will not be reclassified subsequently to profit or loss				
(Decrease) in the Asset Revaluation Surplus	37	(14,489)	-	-
Total Comprehensive (Deficit)		**(52,134)**	**(37,919)**	**(39,689)**

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 2014

	Note No.	Actual 2014 $'000	Original Budget 2014 $'000	Actual 2013 $'000
Current Assets				
Cash and Cash Equivalents	23	107,256	23,803	9,562
Investments		-	2,990	-
Receivables	24	23,458	67,010	126,339
Inventories	25	7,806	7,953	8,113
Assets Held for Sale	26	29	168	34
Other Assets	31	3,391	2,715	2,675
Total Current Assets		**141,940**	**104,639**	**146,723**
Non-Current Assets				
Receivables	24	-	200	-
Investments	27	3,015	-	3,011
Property, Plant and Equipment	28	859,100	1,002,588	707,919
Intangible Assets	29	6,933	21,023	11,636
Capital Works in Progress	30	147,783	127,925	241,636
Total Non-Current Assets		**1,016,831**	**1,151,736**	**964,202**
Total Assets		**1,158,771**	**1,256,375**	**1,110,925**
Current Liabilities				
Payables	32	42,647	59,851	87,773
Finance Leases	33	2,156	3,488	2,315
Employee Benefits	34	208,007	181,438	180,522
Other Liabilities	36	523	1,056	2,224
Total Current Liabilities		**253,333**	**245,833**	**272,834**
Non-Current Liabilities				
Finance Leases	33	4,042	2,002	4,162
Employee Benefits	34	14,044	18,282	12,457
Other Provisions	35	1,375	1,503	1,503
Total Non-Current Liabilities		**19,461**	**21,787**	**18,122**
Total Liabilities		**272,794**	**267,620**	**290,956**
Net Assets		**885,977**	**988,755**	**819,969**
Equity				
Accumulated Funds		756,459	844,748	675,962
Asset Revaluation Surplus	37	129,518	144,007	144,007
Total Equity		**885,977**	**988,755**	**819,969**

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 2014

	Note No.	Accumulated Funds Actual 2014 $'000	Asset Revaluation Surplus Actual 2014 $'000	Total Equity Actual 2014 $'000	Original Budget 2014
Balance at 1 July 2013		**675,962**	**144,007**	**819,969**	**836,266**
Comprehensive Income					
Operating (Deficit)		(37,645)	-	(37,645)	(37,919)
(Decrease) in the Asset Revaluation Surplus	37	-	(14,489)	(14,489)	-
Total Comprehensive (Deficit)		**(37,645)**	**(14,489)**	**(52,134)**	**(37,919)**
Transactions Involving Owners Affecting Accumulated Funds					
Capital Injections		118,142	-	118,142	190,408
Total Transactions Involving Owners Affecting Accumulated Funds		**118,142**	**-**	**118,142**	**190,408**
Balance at 30 June 2014		**756,459**	**129,518**	**885,977**	**988,755**

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

	Accumulated Funds Actual 2013 $'000	Asset Revaluation Surplus Actual 2013 $'000	Total Equity Actual 2013 $'000
Balance at 1 July 2012	**585,683**	**144,007**	**729,690**
Comprehensive Income			
Operating (Deficit)	(39,689)	-	(39,689)
Total Comprehensive (Deficit)	**(39,689)**	**-**	**(39,689)**
Transactions Involving Owners Affecting Accumulated Funds			
Capital Injections	129,968	-	129,968
Total Transactions Involving Owners Affecting Accumulated Funds	**129,968**	**-**	**129,968**
Balance at 30 June 2013	**675,962**	**144,007**	**819,969**

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 2014

	Note No.	Actual 2014 $'000	Original Budget 2014 $'000	Actual 2013 $'000
Cash Flows from Operating Activities				
Receipts				
Government Payment for Outputs		229,062	231,100	364,256
User Charges – ACT Government		778,083	820,496	483,564
User Charges – Non-ACT Government		148,228	-	112,659
Grants Received from the Commonwealth		4,110	4,120	-
Interest Received		97	100	106
Distribution from Investments with the Territory Banking Account		106	178	145
Goods and Services Tax Input Tax Credits from the Australian Taxation Office		44,129	-	48,063
Goods and Services Tax Collected from Customers		6,164	-	5,952
Other		16,002	82,174	19,183
Total Receipts from Operating Activities		**1,225,982**	**1,138,168**	**1,033,928**
Payments				
Employee		575,760	563,462	542,570
Superannuation		75,847	72,099	72,068
Supplies and Services		321,786	318,937	296,813
Grants and Purchased Services		73,679	84,023	80,159
Goods and Services Tax Paid to Suppliers		50,321	-	53,131
Borrowing Costs		351	401	375
Other		20,082	90,545	30,344
Total Payments from Operating Activities		**1,117,825**	**1,129,467**	**1,075,460**
Net Cash Inflows/(Outflows) from Operating Activities	**41**	**108,157**	**8,701**	**(41,532)**
Cash Flows from Investing Activities				
Receipts				
Proceeds from Sale of Property, Plant and Equipment		1,566	-	2,438
Total Receipts from Investing Activities		**1,566**	**-**	**2,438**
Payments				
Payments for Property, Plant and Equipment		38,948	198,686	128,584
Payments for Capital Works		88,893	-	18,200
Total Payments from Investing Activities		**127,841**	**198,686**	**146,784**
Net Cash (Outflows) from Investing Activities		**(126,275)**	**(198,686)**	**(144,346)**
Cash Flows from Financing Activities				
Receipts				
Capital Injections		118,142	190,408	129,968
Total Receipts from Financing Activities		**118,142**	**190,408**	**129,968**
Payments				
Repayment of Finance Leases		2,330	1,452	3,907
Total Payments from Financing Activities		**2,330**	**1,452**	**3,907**
Net Cash Inflows from Financing Activities		**115,812**	**188,956**	**126,061**
Net Increase/(Decrease) in Cash and Cash Equivalents		**97,694**	**(1,029)**	**(59,817)**
Cash and Cash Equivalents at the Beginning of the Reporting Period		9,562	24,832	69,379
Cash and Cash Equivalents at the End of the Reporting Period	**41**	**107,256**	**23,803**	**9,562**

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 2014

	Original Budget 2014 $'000	Total Appropriated 2014 $'000	Appropriation Drawn 2014 $'000	Appropriation Drawn 2013 $'000
Controlled				
Government Payment for Outputs	231,100	240,769	229,062	364,256
Capital Injections	190,408	203,806	118,142	129,968
Total Controlled Appropriation	**421,508**	**444,575**	**347,204**	**494,224**

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 Total Appropriated is mainly due to enterprise bargaining agreement funding for pay rises provided through the *Appropriation Act 2013–14 (No. 2)* ($6.356m) and revised Commonwealth funding for the Long Stay Older Patients National Partnership Agreement ($3.207m).

Capital Injections

The difference between the Original Budget and Total Appropriated in 2013–14 is due to the Section 16b capital injection reconciliation instrument of $13.164m from 2012–13 and $0.234m from the unplanned Commonwealth capital grant for the Telehealth project. The Section 16b instrument is used to move the balance of capital injection from the end of one year into the following financial year to continue to provide the balance of the appropriation for each capital project.

Variances between 'Total Appropriated' and 'Appropriation Drawn'

Government Payment for Outputs

The difference between the Total Appropriated and Appropriation Drawn is mainly due to the deferral of Commonwealth funding ($7.383m including Improving Public Hospital Services, Preventative Health, Essential Vaccines and Treating more Public Dental Patients) to 2014–15. The main reason for the deferral of Commonwealth funding is to align revenue with the latest planned timing of delivery of services. There was also a reduction in Commonwealth funding ($1.4m) largely related to reward funding for the Improving Public Hospitals Services National Partnership Agreement (NPA) and Health Services NPA, and undrawn enterprise bargaining agreement funding due to delayed finalisation of agreements ($2.924m).

Capital Injections

The difference between the Total Appropriated and Appropriation Drawn in 2013–14 is due to the deferral of capital works projects from 2013–14 to 2014–15 and 2015–16. The main reason for the deferral of capital works projects from 2013–14 into future years was due to delays from a change in the way construction contracts are let combining various works packages under the new contract form, Government Contract 21 (CG21) which required longer negotiations and delays related to decisions on procurement models. The new contract provides improved protection for the Government by providing incentives to the contractor for finishing under budget and no additional charges to Government for contractor errors. Also the Central Sterilising Service project has been put on hold to allow further assessment of site options and therefore the funds weren't drawn down.

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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 for 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.

The balance sheet shows that current liabilities ($253.3 million) exceed current assets ($141.9 million) by $111.4 million. This is not considered to be a liquidity risk as its operations are funded through appropriation from the ACT Government on a cash-needs basis. This is consistant with the Whole-of-Government cash management regime which requires excess cash balances to be held centrally rather than within individual Directorate bank accounts.

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 such as those included in property, plant and equipment and financial instruments which were valued at fair value in accordance with the (re)valuation policies applicable to the Directorate during the reporting period.

Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. Fair value is measured using the market approach, the cost approach or the income approach valuation techniques as appropriate. In estimating the fair value of an asset or liability, the Directorate takes into account the characteristics of the asset or liability if market participants would take those characteristics into account when pricing the asset or liability at measurement date.

The above approach to fair value measurement does not apply to leasing transactions within the scope of AASB 117 *Leases* or measurements that have some similarities to fair value but are not fair value, such as net realisable value in AASB 102 *Inventories* or value in use in AASB 136 *Impairment of Assets*.

For disclosure purposes fair value measurements are categorised into Level 1, 2 or 3 based on the extent to which the inputs to the valuation techniques are observable and the significance of the inputs to the fair value measurement in its entirety. 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 that the Directorate can access at the measurement date;
- Level 2–inputs other than quoted prices included within Level 1 that are observable for the asset or liability, either directly or indirectly; and
- Level 3–inputs for the asset or liability that are not based on observable market data (unobservable inputs) that are unobservable for particular assets or liabilities.

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

The Directorate is an individual reporting entity.

Note 2. Summary of Significant Accounting Policies (continued)

(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 2014 together with the financial position of the Directorate as at 30 June 2014.

(d) Comparative Figures

Budget Figures

To facilitate a comparison with Budget Papers, as required by the *Financial Management Act 1996*, budget information for 2013–14 has been presented in the financial statements. Budget numbers in the financial statements are the original budget numbers that appear in the Budget Papers.

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:

Government Payment for Outputs and Payment for Expense on Behalf of the Territory

Government Payment for Outputs and payment for expense on behalf of the Territory are recognised as revenues when the Directorate gains control over the funding. Control over appropriated funds is obtained upon the receipt of cash.

Note 2. Summary of Significant Accounting Policies (continued)

(f) Revenue Recognition (continued)

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 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.

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

For the hospital treatment of chargeable patients, inpatient fees are recognised as revenue when the services have been provided.

Revenue related to hospital services provided to the Department of Veterans Affairs patients 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 Department of Veterans Affairs. 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 Department of Veterans Affairs.

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.

Grants

Grants are non-reciprocal in nature and 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.

Revenue Received in Advance

Revenue received in advance is recognised as a liability if there is a present obligation to return the funds received, otherwise all are recorded as revenue.

Note 2. Summary of Significant Accounting Policies (continued)

(g) 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, whereas 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.

(h) 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.

(i) Borrowing Costs

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

(j) 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 20: Waivers, Impairment Losses and Write-offs.

(k) 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.

(l) 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 (or a cash-generating unit) exceeds its recoverable amount. The recoverable amount is the higher of the asset's 'fair value less costs of disposal' 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.

Note 2. Summary of Significant Accounting Policies (continued)

(m) 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. Directorate money held in the Territory Banking Account Cash Fund is classified as a Cash Equivalent.

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.

(n) 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.

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.

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 as 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 off against the allowance 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.

(o) Investments

The Directorate holds one long-term investment. It is held with the Territory Banking Account in a unit trust called the Cash Enhanced Fund. 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.

(p) 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)

(q) 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.

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

Property, plant and equipment are 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 are 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 are capitalised.

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

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

Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date.

Fair value for land and non-specialised buildings is measured using the market approach valuation technique. This approach uses prices and other relevant information generated by market transactions involving identical or similar assets.

Fair value for specialised buildings and leasehold improvements is measured by reference to the cost of replacing the remaining future economic benefits embodied in the asset (i.e depreciated replacement cost). This is the cost approach valuation technique. Depreciated replacement cost is the current replacement cost of an asset less accumulated depreciation calculated on the basis of such cost to reflect the already consumed economic benefits, expired economic benefits or obsolescence of the asset. Current replacement cost is determined by reference to the cost of a substitute asset of comparable utility, the gross project size specifications or the historical cost, adjusted by relevant indices.

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 cost of plant and equipment comprises the purchase price, any directly attributable costs, and the initial estimate of the cost of dismantling and removing the plant and equipment and restoring the site on which it is located.

Note 2. Summary of Significant Accounting Policies (continued)

(t) 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.

(u) 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

Land improvements are included with buildings.

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

(v) Payables

Payables are a financial liability and are initially recognised at fair value based on the transaction cost and subsequent to initial recognition at amortised cost, 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.

Note 2. Summary of Significant Accounting Policies (continued)

(w) 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 (AASB 13 *Fair Value Measurement* definition of fair value does not apply – see AASB 117.6A) 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.

(x) Employee Benefits

Employee benefits include:

- short-term employee benefits that are, if expected to be settled wholly before twelve months after the end of the annual reporting period in which the employees render the related services, such as wages and salaries, annual leave loading, and applicable on-costs.
- other long-term benefits such as long service leave and annual leave; and
- termination benefits.

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.

Wages and Salaries

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

Annual and Long Service Leave

Annual and long service leave including applicable on-costs that are not expected to be wholly settled before twelve months after the end of the reporting period when the employees render the related service are measured at the present value of estimated future payments to be made in respect of services provided by employees up to the end of the reporting period. Consideration is given to the future wage and salary levels, experience of employee departures and periods of service. At the end of each reporting period, the present value of future annual leave and long service leave payments is estimated using market yields on Commonwealth Government bonds with terms to maturity that match, as closely as possible, the estimated future cash flows.

Annual leave liabilities have been estimated on the assumption that they will be wholly settled within three years. In 2013–14 the rate used to estimate the present value of future payments for annual leave is 100.9%.

In 2013–14, the rate used to estimate the present value of future payments for long service leave is 103.5% (101.3% in 2012–13).

Note 2. Summary of Significant Accounting Policies (continued)

(x) Employee Benefits (continued)

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 of 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 on-costs.

The significant judgements and assumptions included in the estimation of annual and long service leave liabilities are determined by an actuary. The Australian Government Actuary performed this assessment in May 2014. The assessment by an actuary is performed every 5 years. However it may be performed more frequently if there is a significant contextual change in the parameters underlying the 2014 report. The next actuarial review is expected to be undertaken by May 2019. Further information about this estimate is provided in Note 2(ac) *Significant Accounting Judgements and Estimates*.

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. Conditional long service leave liabilities are classified as non-current because the directorate has an unconditional right to defer the settlement of the liability until the employee has completed the requisite years of service.

(y) 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.

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.

The Superannuation Provision Account recognises the total Territory superannuation liability for the CSS and PSS. 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.

Note 2. Summary of Significant Accounting Policies (continued)

(z) 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.

(aa) Insurance

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

(ab) 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.

Third party transactions are excluded from the Directorate's financial statements. Details of third party monies are shown at Note 43: Third Party Monies.

(ac) 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 estimate 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 have 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 annual and long service leave requires a consideration of the future wages and salary levels, experience of employee departures, probability that leave will be taken in service 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 (x): Employee Benefits.

c. *Cross Border (Interstate) Health Revenue:* the cross border revenue in the Health Directorate relates to activity prior to 2012-13 and it is based on cost weighted separations and an agreed price. 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.

d. *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.

e. *Contingent Liabilities*: contingent liabilities are an estimate provided by the ACT Government Solicitor of the likely liability for legal claim against the Directorate.

f. *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 (n): Receivables.

g. *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.

Note 2. Summary of Significant Accounting Policies (continued)

(ad) 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 2017);
- AASB 127 Separate Financial Statements (application date 1 January 2014 for not-for-profit entities);
- AASB 1031 Materiality (application date 1 January 2014);
- AASB 1055 Budgetary Reporting (application date 1 July 2014);
- AASB 2010-7 Amendments to Australian Accounting Standards arising from AASB 9 (December 2010) [AASB 1, 3, 4, 5, 7, 101, 102, 108, 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 2017);
- AASB 2011-7 Amendments to Australian Accounting Standards arising from the Consolidation and Joint Arrangements Standards [AASB 1, 2, 3, 5, 7, 9, 2009–11, 101, 107, 112, 118, 121, 124, 132, 133, 136, 138, 139, 1023 & 1038 and Interpretations 5, 9, 16 & 17] (application date 1 January 2014 for not-for-profit entities);
- AASB 2012-3 Amendments to Australian Accounting Standards – Offsetting Financial Assets and Financial Liabilities [AASB 132] (application date 1 January 2014)
- AASB 2013-3 Amendments to AASB 136 Recoverable Amount Disclosures for Non-Financial Assets (application date 1 January 2014);
- AASB 2013-8 Amendments to Australian Accounting Standards – Australian Implementation Guidance for Not-for-Profit Entities – Control and Structured Entities [AASB 10, AASB 12 & AASB 1049] (application date 1 January 2014);
- AASB 2013-9 Amendments to Australian Accounting Standards – Conceptual Framework, Materiality and Financial Instruments Part B Materiality [AASB 1, 3, 4, 5, 7, 9 (December 2009), 9 (December 2010), 101, 102, 108, 112, 118, 120, 121, 132, 134, 136, 137, 139, 1023, 1038, 1049, 1050, 1051, 1052, 1055, AAS 25, Interpretation 1, 2, 4, 5, 6, 7, 9, 10, 12, 14, 15, 16, 17, 18, 19, 20, 21, 107, 110, 115, 125, 127, 129, 131, 132, 1003, 1019, 1030, 1031, 1038 & 1042] (application date 1 January 2014) Part C Financial Instruments [AASB 9 December (2009); 2009–11 AASB 9 (December 2010) & 2010-7] (application date 1 January 2015), and
- AASB 2014-1 Amendments to Australian Accounting Standards Part A: Annual Improvements 2010–2012 and 2011–2013 Cycles [AASB 2, 3, 8, 9 (December 2009), 9 (December 2010), 13, 116, 119, 124, 137, 138, 139, 140; 1052 & Interpretation 129] (application date 1 July 2014); Part C Materiality (application date 1 July 2014); and Part E Financial Instruments [AASB 1,3, 4, 5, 7, 9 (December 2009) 9 (December 2010), 101, 102, 108, 112, 118, 120, 121, 132, 136, 137, 139, Interpretation 2, 5, 10, 12, 16, 19 and 107] (application date 1 January 2015 except paragraphs 64-72 (applicable 1 January 2017) and paragraphs 73-107 (applicable 1 January 2018).

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

Change in Accounting Policy and Accounting Estimates

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

Correction of Prior Period Errors

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

Note 4. Government Payment for Outputs

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

	2014 $'000	2013 $'000
Revenue from the ACT Government		
Government Payment for Outputs[a]	229,062	364,256
Total Government Payment for Outputs	**229,062**	**364,256**

a. The decrease was due to the commencement of a new funding agreement under the National Health Reform Agreement. This new funding arrangement commenced from March 2013.

Note 5. User Charges

User charge revenue is derived by providing goods and services to other ACT Government agencies and to the public. User charge revenue is not part of ACT Government appropriation and is paid by the user of the goods or services. This revenue is driven by consumer demand and is commercial in nature.

	2014 $'000	2013 $'000
User Charges – ACT Government		
Local Hospital Network Funding[a]	717,273	542,759
Service Revenue	743	810
Total User Charges – ACT Government	**718,016**	**543,569**
User Charges – Non-ACT Government		
Service Revenue[b]	11,032	9,709
Amounts Received for Highly Specialised Drugs[c]	17,602	15,639
Cross Border (Interstate) Health Revenue[d]	4,726	13,445
Inpatient Fees[e]	31,677	33,253
Facilities Fees	24,382	23,846
Non-inpatient Fees	866	780
Inventory Sales	13,279	12,864
Accommodation and Meals	3,813	3,678
Total User Charges–Non-ACT Government	**107,377**	**113,214**
Total User Charges	**825,393**	**656,783**

Implanted Prostheses Revenue $2,541,706 ($2,224,353 in 2013), Day Patients Fees $1,070,507 ($820,858 in 2013) and Hostel Fees $324,218 ($314,982 in 2013) have been reclassified as Inpatient Fees. This had the effect of increasing Inpatient Fees by $3,936,431 ($3,360,193 in 2013) and decreasing the Service Revenue by the same amount.

a. The increase in revenue relates to a review of activity deemed as 'in scope' of public hospitals under the National Health Reform, indexation and growth in patient activity in acute services, cancer services, rehabilitation, aged and community services and mental health services.

b. The increase mainly relates to revenues related to new programs including the Child Benefit Dental Scheme and the Dental Health Graduate Program and indexation.

c. The increase is mainly attributable to price adjustments for high cost drugs supplied in prior years, and indexation. Previously the revenue was recognised in line with cost and any price adjustments were brought to account in the subsequent years following a reconciliation process. From 2013–14, Medicare implemented an online claim process, and this has resulted in recognition of revenue at the latest list price which has resulted in additional revenue being recognised this year for drugs supplied in prior years.

d. The decrease is due to the changed funding arrangements for the treatment of interstate patients in ACT hospitals following the implementation of the National Health Reform Agreement. This revenue is now collected through the ACT Local Health Network Directorate. The amounts for 2013–14 and 2012–13 relate to prior year activity confirmed through an annual acquittal process with the New South Wales Ministry of Health.

e. The decrease is largely attributable to a lower number of Department of Veterans Affairs patients treated at Canberra Hospital and Health Services.

Note 6. Interest

	2014 $'000	2013 $'000
Revenue from Non-ACT Government Entities		
Interest Revenue	97	106
Total Interest Revenue from Non-ACT Government Entities	**97**	**106**
Total Interest Revenue	**97**	**106**
Total interest revenue from financial assets not at fair value through profit and loss	97	106

Note 7. Distribution from Investments with the Territory Banking Account

	2014 $'000	2013 $'000
Revenue from ACT Government Entities		
Distribution from Investments with the Territory Banking Account	98	144
Total Distribution from Investments with the Territory Banking Account	**98**	**144**

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 11: Other Gains.

	2014 $'000	2013 $'000
Revenue from ACT Government Entities		
Legal Services[a]	1,479	1,010
Other Resources Received Free of Charge[b]	139	-
Total Resources Received Free of Charge	**1,618**	**1,010**

a. The increase is due to requests for legal advice rising from 87 in 2012–13 to 115 in 2013–14.
b. This is for room hire for patient education and training.

Note 9. Other Revenue

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

	2014 $'000	2013 $'000
Revenue from Non-ACT Government Entities		
Grants[a]	20,628	19,425
Total Revenue from Non-ACT Government Entities	**20,628**	**19,425**
Total Other Revenue	**20,628**	**19,425**

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

a. The increase is mainly due to a one off Australian National University educational support grant and new research grants.

	2014 $'000	2013 $'000
Contribution Analysis – Grants		
Contributions which have conditions of expenditure still required to be met:		
Contributions recognised as revenue during current year for which expenditure in manner specified had not occurred as at balance date	1,610	583
Contributions recognised in previous years which were not expended in the current financial year	8,167	9,154
Total amount of unexpected contributions as balance date	**9,777**	**9,737**

Note 10. Gains on Investments

	2014 $'000	2013 $'000
Revenue from ACT Government Entities		
Unrealised Gains on Investments	4	21
Total Gains on Investments	**4**	**21**

a. The rate of investment return for 2012–13 was higher than that for the current year.

Note 11. Other Gains

Other gains are 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.

	2014 $'000	2013 $'000
Gains from the Sale of Assets[a]	85	331
Donations[b]	1,309	2,025
Total Other Gains	**1,394**	**2,356**

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

a. These gains from the sale of assets relate to the disposal of motor vehicles that were on a finance lease which matured during the year. The decrease is due to a lower number of leases maturing in 2013–14 and achieving lower profit when sold.
b. The decrease is mainly attributable to a reduction in special purpose donations as well as donations from the public.

	2014 $'000	2013 $'000
Contribution Analysis – Donations		
Contributions which have conditions of expenditure still required to be met:		
Contributions recognised as revenue during current year for which expenditure in manner specified had not occurred as at balance date	918	594
Contributions recognised in previous years which were not expended in the current financial year	2,975	2,851
Total amount of unexpected contributions as balance date	**3,893**	**3,445**

Note 12. Employee Expenses

	2014 $'000	2013 $'000
Wages and Salaries [a]	549,176	507,914
Annual Leave Expenses	14,905	14,253
Long Service Leave Expenses[b]	11,876	8,253
Worker Compensation Insurance Premium [c]	20,355	18,361
Termination Payments	2,066	778
Other Employee Benefits and On-Costs[d]	8,002	6,946
Total Employee Expenses	**606,380**	**556,505**
	No.	**No.**
Average full-time equivalent staff levels during the year were:	5,873	5,535

a. The increase in Wages and Salaries mainly relates to payrises under collective agreements and staff increases related to growth in services in acute services, cancer services, rehabilitation, aged and community services and mental health services.
b. The increase in Long Service Leave is mainly due to an increase in the rate used to estimate the present value of Long Service Leave payments from 101.3% to 103.5% and the effect of payrises under the collective agreements.
c. The increase largely relates to a debt servicing levy, which is an additional charge imposed by Comcare on all worker's compensation policies.
d. The increase is mainly due to an increase in the number of staff on maternity leave.

Note 13. Superannuation Expenses

	2014 $'000	2013 $'000
Superannuation Contributions to the Territory Banking Account	38,526	39,024
Productivity Benefit	5,066	5,011
Superannuation Payment to ComSuper (for the PSSAP)	3,467	3,525
Superannuation to External Providers[a]	29,384	24,716
Total Superannuation Expenses	**76,443**	**72,276**

a. The increase is due to payrises under collective agreements and that most new employees are members of superannuation schemes managed by external providers.

Note 14. Supplies and Services

	2014 $'000	2013 $'000
Audit Expenses[a]	459	504
Blood Products[b]	8,494	9,344
Clinical Expenses/Medical Surgical Supplies[c]	59,487	57,436
Communications[d]	4,171	3,690
Computer Expenses[e]	33,742	32,007
Contractors and Consultants[f]	7,229	5,535
Domestic Services, Food and Utilities	32,025	31,762
General Administration	17,516	17,959
Hire and Rental Charges	4,279	4,065
Insurance[g]	31,181	28,550
Minor Capital[h]	3,341	4,303
Non-Contract Services[i]	5,130	8,074
Operating Lease Rental Payments	6,415	6,459
Pharmaceuticals	35,476	36,863
Printing and Stationery[j]	2,566	2,253
Property and Rental Expenses[k]	2,717	3,009
Public Relations[l]	898	667
Publications[m]	1,299	1,191
Repairs and Maintenance[n]	15,851	13,227
Staff Development and Recruitment[o]	6,682	6,277
Travel and Accommodation	1,152	1,178
Vehicle Expenses	1,490	1,554
Visiting Medical Officers[p]	29,076	25,426
Total Supplies and Services	**310,676**	**301,333**

a. The decrease is mainly due to a one off review of outpatient billing that was conducted in 2012–13.
b. Blood products are paid as a provisional payment with financial reconciliation undertaken by the National Blood Authority at the end of the year. There was a refund in 2013–14 for lower consumption of red blood cell blood products in 2012–13 and a reduction in the cost of immunoglobulin.
c. The increase of 3.6% compared to 2012–13 is mainly due to price escalation and growth in patient activity in acute care services, cancer services, rehabilitation, aged and community services and mental health services .
d. The increase is due to higher postage costs as a result of increased services and postage price rises with the basic postage stamp increasing from $0.60 to $0.70.
e. The increase is due to a combination of factors, including indexation, and an increase in staff numbers and support costs for projects that became operational in 2013–14. They include a Digital Wireless Network, Digital Intensive Care Unit Clinical Information System, Clinical Portal Systems, ACT Patient Administration System, Identity and Access Management System, Renal Clinical Information System and a Health Services Directory.
f. The increase is attributable to contractor costs relating to additional operational and maintenance work for a range of information technology projects such as ACT Patient Administration System, Clinical Portal Suites, Digital Mammography, Digital Health Infrastructure and Renal Clinical Information System.
g. The increase is mainly due to the Government's self insurance retention limit rising from $17.5m to $20m.
h. The decrease mainly relates to a reduction in the quantity of medical equipment purchases that fell below the capitalisation threshold of $5,000 compared to 2012–13.
i. The decrease is due to reduced usage of agency staff. Agency staff refers to temporary staff sourced at short notice from external labour providers.
j. The increase is largely due to indexation and an increase in staff numbers.
k. The decrease mainly relates to the cessation of rental at Swanson Plaza in Belconnen for Mental Health Services and a decrease in temporary rental accommodation for new medical staff.
l. The increase mainly relates to payments to the Health Education and Training Institute for Medical training accreditation.
m. The increase is due to purchasing additional research and informative publications.
n. This is mainly attributable to increased expenditure on preventative and reactive repairs of ageing assets and an increase in maintenance costs for new buildings.
o. The increase mainly relates to conference and course fees.
p. The increase relates to using additional Visiting Medical Officer's due to vacancies and staff specialists on extended leave in 2013–14 and $1.1m recognised in 2013–14 for services relating to 2012–13.

Note 15. Depreciation and Amortisation

	2014 $'000	2013 $'000
Depreciation		
Buildings[a]	15,096	35,854
Plant and Equipment	10,763	10,952
Leasehold Improvements	1,783	1,754
Total Depreciation	**27,642**	**48,560**
Amortisation		
Intangible Assets	4,841	4,454
Total Amortisation	**4,841**	**4,454**
Total Depreciation and Amortisation	**32,483**	**53,014**

a. The decrease mainly relates to accelerating the depreciation in 2012–13 for the original Women and Children's Hospital ($16.1 million) and Tuggeranong Health Centre ($1.4 million) which were partially demolished for reconstruction and for the Canberra Hospital Psychiatric Unit building ($1.9 million) and Canberra Hospital Tower Block level 5 ($2.7 million) which are planned to undergo significant refurbishment work.

Note 16. Grants and Purchased Services

Grants are sums of money provided 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 in the ACT.

Cross Border Health Costs relates to costs incurred by ACT residents in interstate hospitals.

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

	2014 $'000	2013 $'000
Grants		
Grants	2,509	2,637
Total Grants	**2,509**	**2,637**
Purchased Services		
Calvary Hospital[a]	3,121	14,708
Non-Government Organisations[b]	63,544	59,436
Cross Border Health Costs[c]	32	2,788
Other	3,471	3,319
Total Purchased Services	**70,168**	**80,251**
Total Grants and Purchased Services	**72,677**	**82,888**

a. The decrease is due to a review of the scope of public hospital activity resulting in additional activity being considered in scope for activity based funding and is being purchased through the ACT Local Hospital Network Directorate rather than the Health Directorate.

b. The increase mainly relates to indexation, new programs including Multicultural Health and growth in current programs for aged care accommodation and sub acute services.

c. The decrease is due to cross border hospital services being purchased from 2012–13 by the ACT Local Hospital Network Directorate rather than the Health Directorate. These amounts relate to prior year activity.

Note 17. Borrowing Costs

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

	2014 $'000	2013 $'000
Finance Charges	351	375
Finance Cost on Make Good[a]	200	-
Total Borrowing Costs	**551**	**375**

a. This relates to unwinding of discount on make good provision.

Note 18. Cost of Goods Sold

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

	2014 $'000	2013 $'000
Cost of Goods Sold	10,339	10,475
Total Cost of Goods Sold	**10,339**	**10,475**

Note 19. Other Expenses

	2014 $'000	2013 $'000
Miscellaneous Expenses[a]	1,004	2,219
Legal Settlements[b]	2,999	2,374
Waivers, Impairment Losses and Write-offs (see Note 20)	2,338	2,292
Loss on Sale of Assets	49	38
Total Other Expenses	**6,390**	**6,923**

a. The decrease mainly relates to the feasibility and design costs for the Skills Development Centre Project incurred in 2013.

b. The increase is predominantly in relation to more medical negligence legal claims being settled due to the civil blitz arrangements introduced by the ACT Courts resulting in better case management of older claims and court ordered mediations.

Note 20. 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 waivers, impairment losses and write-offs listed below have occurred during the reporting period for the Directorate.

	No.	2014 $'000	No.	2013 $'000
Waivers				
Waivers[a]	-	-	1	14
Total Waivers	-	-	1	14
Impairment Losses				
Impairment Loss from Receivables				
Trade Receivables[b]	178	653	92	395
Total Impairment Loss from Receivables	**178**	**653**	**92**	**395**
Impairment Loss from Property, Plant and Equipment				
Plant and Equipment[c]	61	530	156	1,121
Total Impairment Loss from Property, Plant and Equipment	61	530	156	1,121
Total Impairment Losses	**239**	**1,183**	**248**	**1,516**
Write-offs				
Irrecoverable Debts[d]	2,469	1,155	1,949	762
Total Write-offs	**2,469**	**1,155**	**1,949**	**762**
Total Waivers, Impairment Losses and Write-offs	**2,708**	**2,338**	**2,198**	**2,292**

a. The decrease is due to the Treasurer's decision, in 2013, to grant a debtor a 50 per cent waiver of debt owed for hospital treatment on compassionate grounds.

b. This increase is largely attributable to Medicare ineligible patient debts that are impaired.

c. The decrease is mainly attributable to less medical and surgical equipment that has been assessed as not operating efficiently, is under repair or cannot be located within the Directorate than the previous year.

d. The increase mainly relates to an increase in Medicare ineligible patient debts.

Note 21. Auditor's Remuneration

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

	2014 $'000	2013 $'000
Audit Services		
Audit Fees Paid or Payable to the ACT Auditor-General's Office[a]	208	225
Total Audit Fees	**208**	**225**

a. The decrease mainly relates to a reduction in the resources required to conduct the 2013–14 audit as assessed by the ACT Auditor-General.

All amounts shown in the Auditor's Remuneration note are inclusive of GST. No other services were provided by the ACT Auditor-General's Office.

Note 22. 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 Directorate made no Act of Grace Payments during the reporting period or the prior period.

Note 23. Cash and Cash Equivalents

The Directorate holds a number of bank accounts, as part of the whole-of-government banking arrangements, with Westpac Banking Corporation and previously with the Commonwealth Bank. The Directorate received interest at the rate of 3.45% (3.44% in 2013). These funds are able to be withdrawn upon request.

	2014 $'000	2013 $'000
Cash on Hand	44	46
Cash at Bank[a]	107,212	9,516
Total Cash and Cash Equivalents	**107,256**	**9,562**

a. The increase in cash at bank is mainly due to the receipt from New South Wales Ministry of Health of outstanding prior year Cross Border health revenue for the treatment of New South Wales patients in ACT public hospitals, cash for a 27th pay in 2014–15 and funding for pay rises under collective agreements not finalised in 2013–14.

Note 24. Receivables

	2014 $'000	2013 $'000
Current Receivables		
Trade Receivables[a]	1,203	1,984
Trade Receivables – Patient Fees[b]	8,447	7,535
	9,650	**9,519**
Less: Allowance for Impairment Losses[c]	(2,591)	(1,668)
	7,059	**7,851**
Other Trade Receivables[d]	8,863	74,767
Less: Allowance for Impairment Losses	(209)	(478)
	8,654	**74,289**
Net GST Receivable	3,718	4,035
Accrued Revenue	4,027	4,254
Accrued Revenue – Cross Border[e]	-	35,910
Total Current Receivables	**23,458**	**126,339**
Total Receivables	**23,458**	**126,339**

a. The decrease mainly relates to lower level of debt for consumables sold to private hospitals.
b. The increase mainly reflects growth in revenue from chargeable patients. Chargeable patients are those that are not public patients, includes privately insured, compensable and Medicare ineligibles.
c. The increase is mainly attributable to Medicare ineligible and compensable patients.
d. In 2012–13 there was a large receivable from the ACT Local Hospital Network Directorate for the provision of hospital services under the new funding arrangement and funds were delayed until a cross border agreement with the New South Wales Ministry of Health had been finalised.
e. Since 2012–13 Cross Border revenue has been received by the ACT Local Hospital Network Directorate. All outstanding revenue prior to this period has now been received.

Ageing of Receivables	Not Overdue $'000	Overdue Less Than 30 days $'000	Overdue 30 to 60 days $'000	Overdue Greater Than 60 days $'000	Total $'000
2014					
Not Impaired					
Receivables[a]	18,442	2,087	553	2,376	23,458
Cross Border	-	-	-	-	-
Impaired					
Receivables	-	-	-	2,800	2,800
2013					
Not Impaired					
Receivables	77,647	3,503	1,486	7,793	90,429
Cross Border	35,910	-	-	-	35,910
Impaired					
Receivables	-	-	-	2,146	2,146

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

a. 'Not Overdue' component of Receivables largely consist of Goods and Services Input Tax receivable from the Australian Taxation Office and private patient fees accrued in June.
'Overdue – Greater Than 60 Days' are mostly third party, workers' 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. This also includes amounts receivable from Calvary Health Care for medical officers seconded from Canberra Hospital and Health Services.

Note 24. Receivables (continued)

	2014 $'000	2013 $'000
Reconciliation of the Allowance for Impairment Losses		
Allowance for Impairment Losses at the Beginning of the Reporting Period	2,146	2,235
Additional Allowance and Impairment Losses Recognised	654	395
Reduction in Allowance	–	(484)
Allowance for Impairment Losses at the End of the Reporting Period	**2,800**	**2,146**

	2014 $'000	2013 $'000
Classification of ACT Government/Non-ACT Government Receivables		
Receivables with ACT Government Agencies		
Net Trade Receivables	59	67
Net Other Trade Receivables	112	60,349
Accrued Revenue	7	16
Net Goods and Services Tax Receivable	52	52
Total Receivables with ACT Government Agencies	**230**	**60,484**
Receivables with Non-ACT Government Entities		
Net Trade Receivables	7,000	7,784
Net Other Trade Receivables	8,542	49,850
Net Goods and Services Tax Receivable	3,666	3,983
Accrued Revenue	4,020	4,238
Total Receivables with Non-ACT Government Entities	**23,228**	**65,855**
Total Receivables	**23,458**	**126,339**

Note 25. Inventories

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

	2014 $'000	2013 $'000
Current Inventory		
Purchased Items – Cost	7,806	8,113
Total Current Inventory	**7,806**	**8,113**
Total Inventory	**7,806**	**8,113**

Note 26. Assets Held for Sale

The Directorate has 2 motor vehicles which have been returned to the Fleet Manager and are expected to be sold in July 2014. The residual and all lease payments have been paid. As such these vehicles have been classified as plant and equipment held for sale.

	2014 $'000	2013 $'000
Plant and Equipment Held for Sale	29	34
Total Assets Held for Sale	**29**	**34**

Fair Value Hierarchy

Details of the Directorate's assets held for sale at fair value and information about the Fair Value Hierarchy as at 30 June 2014 are as follows:

	Classification According to Fair Value Hierarchy			
	Level 1 $'000	Level 2 $'000	Level 3 $'000	Total $'000
2014				
Assets Held for Sale at Fair Value				
Plant and Equipment		29	-	29
	-	29	-	29

The Fair Value Hierarchy is discussed in Note 28: Property, Plant and Equipment.

Transfers Between Categories

There were no transfers between Levels 1, 2 and 3 during the period.

Valuation Techniques, Inputs and Processes

Level 2 fair values of assets held for sale are derived using the market approach. These assets have been written down to fair value less costs to sell. Fair value has been determined by reference to market evidence of sales prices of comparable assets. Assets held for sale represent a non-recurring fair value measurement.

Note 27. Investments

	2014 $'000	2013 $'000
Non-Current Investments		
Investments with the Territory Banking Account – Cash Enhanced Fund at Fair Value	3,015	3,011
Total Non-Current Investments	**3,015**	**3,011**
Total Investments	**3,015**	**3,011**

Note 28. 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.

	2014 $'000	2013 $'000
Land and Buildings		
Land at Fair Value	40,250	36,827
Total Land Assets	**40,250**	**36,827**
Buildings at Fair Value[a]	803,413	669,366
Less: Accumulated Depreciation	(32,123)	(48,881)
Total Written Down Value of Buildings	**771,290**	**620,485**
Total Land and Written Down Value of Buildings	**811,540**	**657,312**
Leasehold Improvements		
Leasehold Improvements at Fair Value	8,549	9,761
Less: Accumulated Depreciation	(3,738)	(3,132)
Total Written Down Value of Leasehold Improvements	**4,811**	**6,629**
Plant and Equipment		
Plant and Equipment at Cost	107,993	104,271
Less: Accumulated Depreciation	(64,714)	(59,172)
Less: Accumulated Impairment Losses	(530)	(1,121)
Total Written Down Value of Plant and Equipment	**42,749**	**43,978**
Total Written Down Value of Property, Plant and Equipment	**859,100**	**707,919**

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 separately disclosed as outlined below.

Carrying Amount of Assets Under a Finance Lease	2014 $'000	2013 $'000
Plant and Equipment Under a Finance Lease	8,271	8,775
Accumulated Depreciation of Plant and Equipment under a Finance Lease	(2,307)	(2,130)
Total Written Down Value of Assets Under a Finance Lease	**5,964**	**6,645**

a. The increase relates to completed capital works projects including the Centenary Hospital for Women and Children, Belconnen Community Health Centre, Tuggeranong Community Health Centre, Canberra Region Cancer Centre, Canberra Hospital Emergency Department and Intensive Care Unit expansion.

Note 28. Property, Plant and Equipment (continued)

Reconciliation of Property, Plant and Equipment

The following table shows the movement of Property, Plant and Equipment during 2013–14.

	Land $'000	Buildings $'000	Leasehold Improvements $'000	Plant and Equipment $'000	Total $'000
Carrying Amount at 1 July 2013	36,827	620,486	6,629	43,978	707,919
Additions	360	183,394	275	11,182	195,212
Revaluation Increments/(Decrement)	3,063	(17,494)	(310)	-	(14,741)
Assets Classified as Held for Sale	-	-	-	(29)	(29)
Disposals	-	-	-	(7,431)	(7,431)
Depreciation	-	(15,096)	(1,783)	(10,763)	(27,642)
Depreciation Write Back for Asset Disposals	-	-	-	5,221	5,221
Impairment Losses Recognised in the Operating (Deficit)	-	-	-	(530)	(530)
Reversal of Impairment Losses Recognised in the Operating (Deficit)	-	-	-	1,121	1,121
Carrying Amount at 30 June 2014	**40,250**	**771,290**	**4,811**	**42,749**	**859,100**

The following table shows the movement of Property, Plant and Equipment during 2012–13.

	Land $'000	Buildings $'000	Leasehold Improvements $'000	Plant and Equipment $'000	Total $'000
Carrying Amount at 1 July 2012	36,820	538,127	7,866	44,936	627,749
Additions	7	118,213	517	13,162	131,899
Assets Classified as Held for Sale	-	-	-	(34)	(34)
Disposals	-	-	-	(4,561)	(4,561)
Depreciation	-	(35,854)	(1,754)	(10,952)	(48,560)
Depreciation Write Back for Asset Disposals	-	-	-	1,934	1,934
Impairment Losses Recognised in the Operating (Deficit)	-	-	-	(1,121)	(1,121)
Reversal of Impairment Losses Recognised in the Operating (Deficit)	-	-	-	613	613
Carrying Amount at 30 June 2013	**36,827**	**620,486**	**6,629**	**43,978**	**707,919**

Valuation of Non-Current Assets

Certified practicing registered valuers AON Risks Solutions performed an independent valuation of the Directorate's Land, Buildings and Leasehold Improvements as at 30 June 2014. Names and qualifications of the valuers are:

1. Mr Geoff Pyman FAPI, MRICS – Certified Practising Valuer
2. Mr Michael Farley – Certified Practising Valuer

The next valuation will be undertaken during 2016–17.

Fair Value Hierarchy

The Directorate is required to classify property, plant and equipment 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 that the Directorate can access at the measurement date;
- Level 2–inputs other than quoted prices included within Level 1 that are observable for the asset or liability, either directly or indirectly; and
- Level 3–inputs that are unobservable for particular assets or liabilities.

Details of the Directorate's property, plant and equipment at fair value and information about the Fair Value Hierarchy as at 30 June 2014 are as follows:

	Classification According to Fair Value Hierarchy			
	Level 1 $'000	Level 2 $'000	Level 3 $'000	Total $'000
Property, Plant and Equipment at Fair Value				
Land	-	-	40,250	**40,250**
Buildings	-	2,845	768,445	**771,290**
Leasehold Improvements	-	-	4,811	**4,811**
		2,845	**813,506**	**816,351**

The Directorate has used the exemption under AASB 13.C3 *Fair Value Measurement* that comparative infomation for periods before initial application of the standards need not be applied.

Note 28. Property, Plant and Equipment (continued)

Transfers between Categories

There have been no transfers between Levels 1, 2 and 3 during the reporting period.

Valuation Techniques, Inputs and processes

Level 2 Valuation Techniques and Inputs

Valuation Technique: the technique used to value land and buildings is the market approach that reflects recent transaction prices for similar properties and buildings (comparable in location and size).

Inputs: Prices and other relevant information generated by market transactions involving comparable land and buildings were considered. Regard was taken of the Crown Lease terms and tenure, the Australian Capital Territory Plan and the National Capital Plan, where applicable, as well as current zoning.

Level 3 Valuation Techniques and Inputs

Valuation Technique: Land where there is no active market or significant restrictions is valued through the market approach which values a selection of land with similar approximate utility.

Inputs: In determining the value of land with similar approximate utility significant adjustments to market based data was required.

Valuation Technique: Buildings and Leasehold Improvements were considered specialised assets by the valuers and measured using the cost approach that reflects the cost to a market participant to construct assets of comparable utility adjusted for obsolescence. For buildings historical cost per square metre of floor area was also used in measuring fair value.

Inputs: In determining the value of buildings and leasehold improvements regard was given to the age and condition of the assets, their estimated replacement cost and current use. This required the use of data internal to the Directorate.

There has been no change to the above valuation techniques during the year.

Fair value measurement using significant unobservable inputs (Level 3)	Land $'000	Buildings $'000	Leasehold Improvements $'000
Fair Value at 1 July 2013	36,827	620,486	6,629
Additions	360	180,549	275
Revaluation increments/(decrements) recognised in Profit or Loss	-	-	-
Revaluation increments/(decrements) recognised in Other Comprehensive Income	3,063	(17,494)	(310)
Transfer (from/(to) Level 2)	-	-	-
Impairment Losses Recognised in Other Comprehensive Income	-	-	-
Depreciation	-	(15,096)	(1,783)
Acquisition/Disposal through Administrative Restructuring			
Acquisition/(Disposal) from transfers	-	-	-
Impairment Losses Recognised in the Operating Surplus/Deficit	-	-	-
Reversal of Impairment Losses Recognised in the Operating Surplus/Deficit	-	-	-
Other Movements	-	-	-
Fair Value at 30 June 2014	**40,250**	**768,445**	**4,811**
Total gains or losses for the period included in Profit or Loss, under 'Other Gains'	-	-	-
Change in unrealised gains or losses for the period included in Profit or Loss for assets held at 30 June 2014	-	-	-

Information about significant unobservable inputs (Level 3) in fair value measurements				
Description and fair value as at 30 June 2014 $'000	**Valuation technique(s)**	**Significant unobservable inputs**	**Range of unobservable inputs (weighted average)**	**Relationship of unobservable inputs to fair value**
Land 40,250	Market approach	Selection of land with similar approximate utility and permissible usage	\$0.40 – \$1,200 per m^2	Higher value of comparable land increases values
Buildings 768,445	Depreciated replacement cost	Consumed physical, functional and economic obsolescence	0% – 92%	Greater consumption of obsolescence reduces values
Leasehold Improvements 4,811	Depreciated replacement cost	Consumed physical, functional and economic obsolescence	29% – 88%	Greater consumption of obsolescence reduces values

Note 29. Intangible Assets

The Directorate has only internally generated software. This software consists mainly of 'the patient administration system software'.

	2014 $'000	2013 $'000
Computer Software		
Internally Generated Software		
Computer Software at Cost	39,957	39,819
Less: Accumulated Amortisation	(33,024)	(28,183)
Total Internally Generated Software	***6,933***	***11,636***
Total Computer Software	**6,933**	**11,636**
Total Intangible Assets	**6,933**	**11,636**

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 2013–14.

	Internally Generated Software $'000	Total $'000
Carrying Amount at 1 July 2013	11,636	11,636
Additions	138	138
Amortisation	(4,841)	(4,841)
Carrying Amount at 30 June 2014	**6,933**	**6,933**

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 2012–13.

	Internally Generated Software $'000	Total $'000
Carrying Amount at 1 July 2012	**9,870**	**9,870**
Additions	6,220	6,220
Amortisation	(4,454)	(4,454)
Carrying Amount at 30 June 2013	**11,636**	**11,636**

Note 30. 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 in 2013–14, include hospital buildings, community health centres and computer software.

	2014 $'000	2013 $'000
Building Works in Progress[a]	79,626	186,265
Plant and Equipment Works in Progress[b]	2,186	915
Computer Software Works in Progress[c]	65,914	54,398
Other Works in Progress	57	58
Total Capital Works in Progress	**147,783**	**241,636**

a. The decrease in building works in progress is a result of the completion of several projects. These completed works include a new Community Health Centre in Belconnen and refurbished Tuggeranong Health Centre, a new Canberra Region Cancer Centre, Centenary Hospital for Women and Children, expansion of the Canberra Hospital Emergency Department and Intensive Care Unit, and various capital upgrade projects.

b. The increase in plant and equipment works in progress is mainly due to Improving Critical Care Outreach and Training in the ACT and Southern NSW Project. This project is to provide access to a range of visual and audio communication tools to assist in the decision making and provision of medical care for patients.

c. The increase in computer software works in progress is mainly for the e-Healthy project which is providing the information technology and communication systems needed to support the Health Infrastructure Program and National E-Health Program, the Identity Access Management project which is providing a system that automates and manages identity and access to information, and the Digital Mammography project which is changing the breast screening system from analogue (hard copy) to digital (soft copy).

Reconciliation of Capital Works in Progress

The following table shows the movement of Capital Works in Progress during 2013–2014.

	Building Works in Progress $'000	Plant and Equipment Works in Progress $'000	Computer Software Works in Progres $'000	Other Works in Progress $'000	Total $'000
Carrying Amount at 1 July 2013	**186,265**	**915**	**54,398**	**58**	**241,636**
Additions	77,742	1,271	12,472	-	91,485
Capital Works Expensed	(711)	-	(957)	-	(1,668)
Capital Works in Progress Completed and Transferred to Property, Plant and Equipment	(183,670)	-	-	-	(183,670)
Carrying Amount at 30 June 2014	**79,626**	**2,186**	**65,913**	**58**	**147,783**

Reconciliation of Capital Works in Progress

The following table shows the movement of Capital Works in Progress during 2012–2013.

	Building Works in Progress $'000	Plant and Equipment Works in Progress $'000	Computer Software Works in Progres $'000	Other Works in Progress $'000	Total $'000
Carrying Amount at 1 July 2012	**177,252**	**154**	**40,641**	**188**	**218,235**
Additions	128,826	887	19,911	28	149,651
Capital Works in Progress Completed and Transferred to Property, Plant and Equipment and Intangible Assets	(118,715)	(121)	(6,154)	(28)	(125,018)
Capital Works Expensed	(1,098)	(5)	-	(130)	(1,232)
Carrying Amount at 30 June 2013	**186,265**	**915**	**54,398**	**58**	**241,636**

Note 31. Other Assets

	2014 $'000	2013 $'000
Current Other Assets		
Prepayments[a]	3,391	2,675
Total Current Other Assets	**3,391**	**2,675**
Total Other Assets	**3,391**	**2,675**

a. The increase mainly relates to Information and Communication Technology Service Level Agreement charges paid to Shared Services Information and Communication Technology.

Note 32. Payables

	2014 $'000	2013 $'000
Current Payables		
Trade Payables[a]	4,099	17,351
Other Payables	19	19
Accrued Expenses[b]	38,529	70,403
Total Current Payables	**42,647**	**87,773**
Total Payables	**42,647**	**87,773**

a. 2012–13 included a large number of invoices payable for capital works paid in 2013–14.
b. The reduction is due to less accruals for capital works projects as a number of the works were progressed to physical completion.

	2014 $'000	2013 $'000
Payables are aged as follows:		
Not Overdue	41,371	78,388
Overdue for Less than 30 Days	767	8,926
Overdue for 30 to 60 Days	337	435
Overdue for More than 60 Days	172	24
Total Payables	**42,647**	**87,773**
Classification of ACT Government/Non-ACT Government Payables		
Payables with ACT Government Entities		
Trade Payables	-	9,449
Accrued Expenses	8,563	34,760
Total Payables with ACT Government Entities	**8,563**	**44,209**
Payables with Non-ACT Government Entities		
Trade Payables	4,099	7,902
Other Payables	19	19
Accrued Expenses	29,966	35,643
Total Payables with Non-ACT Government Entities	**34,084**	**43,564**
Total Payables	**42,647**	**87,773**

Note 33. Finance Leases

The Directorate has 70 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 4.85% to 7.99% and the terms vary from 6 months to 5 years. These leases allow for extensions, but have no terms of renewal or purchase options nor escalation clauses.

	2014 $'000	2013 $'000
Current Finance Leases		
Secured		
Finance Leases	2,156	2,315
Total Current Finance Leases	**2,156**	**2,315**
Non-Current Finance Leases		
Secured		
Finance Leases	4,042	4,162
Total Non-Current Finance Leases	**4,042**	**4,162**
Total Finance Leases	**6,198**	**6,477**

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.

	2014 $'000	2013 $'000
Finance lease commitments are payable as follows:		
Within one year	2,437	2,613
Later than one year but not later than five years	4,199	4,412
Minimum Lease Payments	**6,636**	**7,025**
Less: Future Finance Lease Charges	(438)	(548)
Amount Recognised as a Liability	**6,198**	**6,477**
Add: Lease incentive involved with non-cancellable operating lease	-	-
Total Present Value of Minimum Lease Payments	**6,198**	**6,477**
The present value of the minimum lease payments are as follows:		
Within one year	2,437	2,613
Later than one year but not later than five years	3,761	3,864
Total Present Value of Minimum Lease Payments	**6,198**	**6,477**
Classification on the Balance Sheet		
Finance Leases		
Current Finance Leases	2,156	2,315
Non-Current Finance Leases	4,042	4,162
Total Finance Leases	**6,198**	**6,477**

Note 34. Employee Benefits

	2014 $'000	2013 $'000
Current Employee Benefits		
Annual Leave[a]	90,413	83,716
Long Service Leave[b]	86,752	79,538
Accrued Salaries[c]	30,599	17,025
Other Benefits	243	243
Total Current Employee Benefits	**208,007**	**180,522**
Non-Current Employee Benefits		
Long Service Leave[d]	14,044	12,457
Total Non-Current Employee Benefits	**14,044**	**12,457**
Total Employee Benefits	**222,051**	**192,979**

a. The increase is mainly due to the impact of collective agreement pay rises, an increase in staff numbers for growth in services provided to patients and the growth in liability due to leave earned exceeding leave taken.
b. The increase is mainly due to the impact of collective agreement pay rises, an increase in staff numbers for growth in services provided to patients and the growth in liability due to leave earned exceeding leave taken. An increase in the rate used to estimate the present value of future long service leave payments increasing from 101.3% to 103.5% also contributed to this variance.
c. The increase is due to back pay for administration and clerical staff who had their collective agreement settled in late June 2014 ($2.5 million), a pay rise for staff whose collective agreements have not been finalised ($7.5 million) and an additional days pay accrued in 2014 compared to 2013.
d. The increase is mainly due to an increase in the rate used to estimate the present value of future long service leave payments increasing from 101.3% to 103.5%.

	2014 $'000	2013 $'000
Estimate of when Leave is Payable		
Estimated Amount Payable within 12 months		
Annual Leave	50,646	46,895
Long Service Leave	7,420	6,107
Accrued Salaries	28,001	17,026
Other Benefits	2,841	243
Total Employee Benefits Payable within 12 months	**88,908**	**70,271**
Estimated Amount Payable after 12 months		
Annual Leave	39,767	36,820
Long Service Leave	93,376	85,888
Total Employee Benefits Payable after 12 months	**113,143**	**122,708**
Total Employee Benefits	**222,051**	**192,979**

Note 35. 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.

	2014 $'000	2013 $'000
Non-Current Other Provisions		
Provision for Make Good at the beginning of the Reporting Period	1,503	1,503
Increase in Provision due to unwinding of discount	200	-
Make good charges incurred	(76)	-
Decrease due to revaluation	(252)	-
Total Other Provisions[a]	**1,375**	**1,503**

a. The reduction relates to a terminated lease at Swanson Plaza Belconnen and Level 5, 1 Moore Street Civic.

Note 36. Other Liabilities

	2014 $'000	2013 $'000
Current Other Liabilities		
Revenue Received in Advance[a]	523	2,224
Total Current Other Liabilities	**523**	**2,224**
Total Other Liabilities	**523**	**2,224**

a. The 2012–13 amount included payment in advance by the Department of Veterans' Affairs for services provided to eligible patients.

Note 37. Equity

Asset Revaluation Surplus

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

	2014 $'000	2013 $'000
Balance at the Beginning of the Reporting Period	**144,007**	**144,007**
Increment in Land due to Revaluation	3,063	-
Decrement in Buildings due to Revaluation	(17,494)	-
Decrement in Leasehold Improvements due to Revaluation	(58)	-
Total (Decrease) in the Asset Revaluation Surplus	**(14,489)**	**-**
Balance at the End of the Reporting Period	**129,518**	**144,007**

Note 38. 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 risk since 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 the financial results.

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 it holds net of any allowance for impairment. The Directorate expects to collect all financial assets that are not past due or impaired.

Credit risk is managed by the Directorate for cash at bank by holding bank balances with the ACT Government's banker, Westpac Banking Corporation (Westpac). Westpac holds a AA- issuer credit rating with Standard and Poors. An AA- credit rating is defined as 'very strong capacity to meet financial commitments'.

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 the Commonwealth Governments. As the Commonwealth Government has a AAA credit rating it is considered that there is a very low risk of default for those receivables.

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

Liquidity Risk

Liquidity risk is the risk that the Directorate will encounter difficulties in meeting obligations associated with financial liabilities that are settled by delivering cash or other financial assets. 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 sources of cash to pay these obligations are user charges revenue from Local Health Network Directorate and 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.

Note 38. Financial Instruments (continued)

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 by 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 Cash Enhanced Fund. The Directorate has units in the Cash Enhanced Fund 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.

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 2014 $'000	Fair Value 2014 $'000	Carrying Amount 2013 $'000	Fair Value 2013 $'000
Financial Assets				
Cash and Cash Equivalents	107,256	107,256	9,562	9,562
Receivables	19,740	19,740	122,304	122,304
Investment with the Territory Banking Account	3,015	3,015	3,011	3,011
Total Financial Assets	**130,011**	**130,011**	**134,877**	**134,877**
Financial Liabilities				
Payables	42,647	42,647	87,773	87,773
Finance Leases	6,198	6,198	6,477	6,477
Total Financial Liabilities	**48,845**	**48,845**	**94,250**	**94,250**

Fair Value Hierarchy

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.

2014	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 – Cash Enhanced Fund	-	3,015	-	3,015
Total Financial Assets	**-**	**3,015**	**-**	**3,015**

Transfer Between Categories

There have been no transfers of financial assets or liabilities between Level 1 and Level 2 during the reporting period. The Fair Value Hierarchy for financial instruments measured at fair value is shown for the year ended 30 June 2013 in accordance with AASB 7.27(a) Financial Instruments: Disclosures [for not-for-profit entities].

2013	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 – Cash Enhanced Fund	-	3,011	-	3,011
Total Financial Assets	**-**	**3,011**	**-**	**3,011**

Transfer Between Categories

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

Note 38. 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 weighted average interest rates by maturity period as at 30 June 2014. Except for non-current payables, 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:				
	Note No.	Weighted Average Interest Rate	Floating Interest Rate $'000	1 Year or Less $'000	Over 1 to 5 Years $'000	Over 5 Years $'000	Non-Interest Bearing $'000	Total $'000
Financial Instruments								
Financial Assets								
Cash and Cash Equivalents	23		-	-	-	-	107,256	107,256
Receivables	24		-	-	-	-	19,740	19,740
Investments with the Territory Banking Account	27	3.45%	3,015	-	-	-	-	3,015
Total Financial Assets			**3,015**	**-**	**-**	**-**	**126,996**	**130,011**
Financial Liabilities								
Payables	32		-	-	-	-	42,647	42,647
Finance Leases	33	5.62%	-	2,437	4,199	-	-	6,636
Total Financial Liabilities			**-**	**2,437**	**4,199**	**-**	**42,647**	**49,283**
Net Financial Assets/(Liabilities)			**3,015**	**(2,437)**	**(4,199)**	**-**	**84,349**	**80,728**

The following table sets out the Directorate's maturity analysis for financial assets and liabilities as well as the exposure to interest rates, including weighted average interest rates by maturity period as at 30 June 2013. Except for non-current payables, 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:				
	Note No.	Weighted Average Interest Rate	Floating Interest Rate $'000	1 Year or Less $'000	Over 1 to 5 Years $'000	Over 5 Years $'000	Non-Interest Bearing $'000	Total $'000
Financial Instruments								
Financial Assets								
Cash and Cash Equivalents	23		-	-	-	-	9,562	9,562
Receivables	24		-	-	-	-	122,304	122,304
Investments with the Territory Banking Account	27	3.44%	3,011	-	-	-	-	3,011
Total Financial Assets			**3,011**	**-**	**-**	**-**	**131,866**	**134,877**
Financial Liabilities								
Payables	32		-	-	-	-	87,773	87,773
Finance Leases	33	5.57%	-	2,613	4,412	-	-	7,025
Total Financial Liabilities			**-**	**2,613**	**4,412**	**-**	**87,773**	**94,798**
Net Financial Assets/(Liabilities)			**3,011**	**(2,613)**	**(4,412)**	**-**	**44,093**	**40,079**

Carrying Amount of Each Specified Category of Financial Asset and Financial Liability	2014 $'000	2013 $'000
Financial Assets		
Loans and Receivables Measured at Amortised Cost	19,740	122,304
Financial Assets at Fair Value through the Profit and Loss Designated upon Initial Recognition	3,015	3,011
Financial Liabilities		
Financial Liabilities Measured at Amortised Cost	48,845	94,250
Gains/(Losses) on Each Category of Financial Asset and Financial Liability		
Gains/(Losses) on Financial Assets		
Financial Assets at Fair Value through the Profit and Loss Designated upon Initial Recognition	98	144

Note 39. Commitments

Capital Commitments

Capital commitments contracted at reporting date include the Canberra Hospital Redevelopment, Health Centres in Belconnen and Tuggeranong, Centenary Hospital for Women and Children, University of Canberra Public Hospital, Adult Secure Mental Health Unit, Clinical Services and Inpatient Unit Design and Infrastructure Expansion, Calvary Hospital Car Park, Aboriginal and Torres Strait Islander Residential Alcohol and Other Drug Rehabilitation Facility, Mental Health Young Persons Unit, An e-Healthy Future, the Canberra Hospital Essential Infrastructure and Engineering Works and other minor new works construction projects. These have not been recognised as liabilities.

Capital Commitments–Property, Plant and Equipment	2014 $'000	2013 $'000
Payable:		
Within one year[a]	102,335	167,629
Later than one year but not later than five years	77,637	80,497
Total Capital Commitments – Property, Plant and Equipment	**179,972**	**248,126**
Total Capital Commitments	**179,972**	**248,126**

a. The decrease is a due to the completion of major building projects in 2013–14 including the Centenary Hospital for Women and Children, Belconnen Community Health Centre and Tuggeranong Community Health Centre.

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.

Non-cancellable operating lease commitments are payable as follows:	2014 $'000	2013 $'000
Within one year	8,343	7,830
Later than one year but not later than five years[a]	22,911	16,974
Later than five years	422	-
Total Operating Lease Commitments	**31,676**	**24,804**

Other Commitments

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

Non-cancellable other commitments are payable as follows:	2014 $'000	2013 $'000
Within one year	55,615	49,497
Later than one year but not later than five years[b]	38,829	53,060
Total Other Commitments	**94,444**	**102,557**

a. The increase is mainly due to a new rental contract for office space at 12 Moore Street, Civic through to 2021.

b. The decrease in other commitments later than one year but not greater than five years is due to the timing of contracting with Non-Government Organisations for mental health services, health and community care (HACC) services under 65 years, aged care services, alcohol and other drug services, primary and chronic health services, women, youth and children health services, population health services and Aboriginal and Torres Strait Islander health services with most contracts running for three years. There are currently no contracts extending further than 2015–16.

Finance Lease Commitments

Finance lease commitments are disclosed in Note 33: Finance Leases.

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

Note 40. Contingent Liabilities

Contingent Liabilities

The Directorate is subject to 115 legal actions (2013 – 123 actions). These actions have an estimated net liability of $5,490,000 (2013 – $5,190,000), which has not been provided for in the accounts. The estimated liability has been calculated net of amounts covered under the Directorate's insurance policy.

There were no contingent assets as at 30 June 2014 other than those relating to the Directorates' insurance policy.

Note 41. 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	2014 $'000	2013 $'000
Cash and Cash Equivalents Recorded in the Balance Sheet	107,256	9,562
Total Cash and Cash Equivalents at the end of the reporting period as recorded in the Cash Flow Statement	**107,256**	**9,562**

b. Reconciliation of Net Cash Inflows/(Outflows) from Operating Activities to the Operating (Deficit)	2014 $'000	2013 $'000
Operating (Deficit)	(37,645)	(39,688)
Add/(Less) Non-Cash Items		
Depreciation of Property, Plant and Equipment	27,642	48,560
Amortisation of Intangibles	4,841	4,454
Bad and Doubtful Debts	1,808	1,171
Asset Book Value Written Down	16	509
Impairment Loss of Non-Current Assets	530	1,121
Unrealised Gain on Investments	(4)	(21)
Cash Before Changes in Operating Assets and Liabilities	**(2,812)**	**16,106**
Changes in Operating Assets and Liabilities		
Increase/(Decrease) in Receivables	102,415	(68,609)
Decrease/(Increase) in Inventories	306	(559)
(Increase) in Other Assets	(716)	(160)
(Decrease) in Payables	(18,407)	(3,565)
Increase in Provisions	29,071	13,686
(Decrease)/Increase in Other Liabilities	(1,701)	1,569
Net Changes in Operating Assets and Liabilities	**110,969**	**(57,638)**
Net Cash Inflows/(Outflows) from Operating Activities	**108,157**	**(41,532)**

c. Non-Cash Financing and Investing Activities	2014 $'000	2013 $'000
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.		
Acquisition of Motor Vehicles by Means of Finance Lease[a]	2,322	3,908

a. The decrease in the value of finance leases is due to the timing of the motor vehicle leases which are mostly on a three year lease. In 2014, 70 new vehicles were acquired compared to 185 in 2013.

Note 42. Events Occurring After Balance Date

There were no events occurring after the balance date, which would affect the financial statements as at 30 June 2014, or in the future reporting periods.

Note 43. 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.

Registration Boards and Ethics Committee Trust Account	2014 $'000	2013 $'000
Balance at the Beginning of the Reporting Period	563	529
Cash Receipts	1,077	900
Cash Payments	(1,123)	(866)
Balance at the End of the Reporting Period	**517**	**563**

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

Mental Health Trust Account	2014 $'000	2013 $'000
Balance at the Beginning of the Reporting Period	36	27
Cash Receipts	322	108
Cash Payments	(325)	(99)
Balance at the End of the Reporting Period	**33**	**36**

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

Private Practice Hospital Account	2014 $'000	2013 $'000
Balance at the Beginning of the Reporting Period	24,836	23,267
Cash Receipts	23,835	24,973
Cash Payments	(22,174)	(23,404)
Balance at the End of the Reporting Period	**26,497**	**24,836**

Health Directorate Territorial Financial Statements For the Year Ended 30 June 2014

Health Directorate
Statement of Income and Expenses on Behalf of the Territory For the Year Ended 30 June 2014

	Note No.	Actual 2014 $'000	Original Budget 2014 $'000	Actual 2013 $'000
Income				
Revenue				
Payments for Expenses on Behalf of the Territory	45	4,615	4,615	746
Fees	46	1,136	1,230	1,094
Total Revenue		**5,751**	**5,845**	**1,840**
Total Income		**5,751**	**5,845**	**1,840**
Expenses				
Grants and Purchased Services	47	4,615	4,615	746
Transfer to Government	48	1,133	1,230	1,094
Total Expenses		**5,748**	**5,845**	**1,840**
Total Comprehensive Surplus		**3**	**-**	**-**

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 2014

	Note No.	Actual 2014 $'000	Original Budget 2014 $'000	Actual 2013 $'000
Current Assets				
Cash and Cash Equivalents	49	268	300	295
Receivables	50	35	-	5
Total Current Assets		**303**	**300**	**300**
Total Assets		**303**	**300**	**300**
Non-Current Liabilities				
Advance from the Territory Banking Account	51	300	300	300
Total Liabilities		**300**	**300**	**300**
Net Assets		**3**	**-**	**-**
Equity				
Accumulated Funds		3	-	-
Total Equity		**3**	**-**	**-**

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

Health Directorate
Statemet of Changes in Equity on Behalf of the Territory
For the Year Ended 30 June 2014

	Accumulated Funds 2014 $'000	Total Equity 2014 $'000	Original Budget 2014 $'000
Balance at 1 July 2013	-	-	-
Comprehensive Income			
Operating Surplus	3	3	-
Total Comprehensive Income	3	3	-
Balance at 30 June 2014	**3**	**3**	**-**

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

	Accumulated Funds 2013 $'000	Total Equity 2013 $'000
Balance at 1 July 2012	-	-
Comprehensive Income		
Operating Surplus/(Deficit)	-	-
Total Comprehensive Income	-	-
Balance at 30 June 2013	**-**	**-**

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 2014

	Note No.	Actual 2014 $'000	Original Budget 2014 $'000	Actual 2013 $'000
Cash Flows from Operating Activities				
Receipts				
Cash from the ACT Government for Expenses on Behalf of the Territory		4,615	4,615	746
Fees		1,136	1,230	1,094
Other Receipts		467	462	69
Total Receipts from Operating Activities		**6,218**	**6,307**	**1,909**
Payments				
Grants and Purchased Services		4,615	4,615	746
Transfer of Territory Receipts to the ACT Government		1,133	1,230	1,094
Other		497	462	74
Total Payments from Operating Activities		**6,245**	**6,307**	**1,914**
Net Cash (Outflows) From Operating Activities	**52**	**(27)**	**-**	**(5)**
Net (Decrease) in Cash		(27)	-	(5)
Cash and Cash Equivalents at the Beginning of the Reporting Period		295	300	300
Cash and Cash Equivalents at the End of the Reporting Period	**52**	**268**	**300**	**295**

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 2014

	Original Budget 2014 $'000	Total Appropriated 2014 $'000	Appropriation Drawn 2014 $'000	Appropriation Drawn 2013 $'000
Territorial				
Expenses on Behalf of the Territory	4,615	4,615	4,615	746
Total Territorial Appropriation	**4,615**	**4,615**	**4,615**	**746**

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

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Note 44. 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 45. 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 on-passing of appropriated funds for capital funding for Calvary Public Hospital.

(See Note 47: Grants and Purchased Services – Territorial)

	2014 $'000	2013 $'000
Payment for Expenses on Behalf of the Territory[a]	4,615	746
Total Payment for Expenses on Behalf of the Territory	**4,615**	**746**

a. This revenue relates to capital works at Calvary Hospital. The increase reflects funding for additional beds in acute services, a rapid assessment unit and two birthing suites in 2013–14.

Note 46. Fees – Territorial

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

	2014 $'000	2013 $'000
Fees		
Fees for Regulatory Services	1,136	1,094
Total Fees	**1,136**	**1,094**

Note 47. 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 re-current 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.

	2014 $'000	2013 $'000
Capital Grants to External Parties – Calvary Hospital[a]	4,615	746
Total Grants and Purchased Services	**4,615**	**746**

a. This relates to payments for capital works at Calvary Hospital. The increase is due to payments for additional beds in acute services, a rapid assessment unit and two birthing suites.

Note 48. 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.

	2014 $'000	2013 $'000
Transfer to the Territory Banking Account	1,133	1,094
Total Transfer to Government	**1,133**	**1,094**

Note 49. Cash and Cash Equivalents – Territorial

The Directorate holds one Territorial bank account. Interest is not earned on cash at bank held in the Territorial Bank Account.

	2014 $'000	2013 $'000
Cash at Bank	268	295
Total Cash and Cash Equivalents	**268**	**295**

Note 50. Receivables – Territorial

	2014 $'000	2013 $'000
Current Receivables		
Goods and Services Tax Receivable	35	5
Less: Allowance for Impairment Losses	-	-
Total Current Receivables	**35**	**5**
Total Non-Current Receivables	-	-
Total Receivables	**35**	**5**

Ageing of Receivables	Not Overdue $'000	Overdue Less than 30 days $'000	Overdue 30 to 60 days $'000	Overdue Greater than 60 days $'000	Total $'000
2014					
Not Impaired Receivables	35	-	-	-	35
Impaired Receivables	-	-	-	-	-
2013					
Not Impaired Receivables	5	-	-	-	5
Impaired Receivables	-	-	-	-	-

Classification of ACT Government/Non-ACT Government Receivables	2014 $'000	2013 $'000
Receivables with Non-ACT Government Entities		
Net Goods and Services Tax Receivable	35	5
Total Receivables with Non-ACT Government Entities	35	5
Total Receivables	**35**	**5**

Note 51. Advance from the Territory Banking Account – Territorial

	2014 $'000	2013 $'000
Advance from the Territory Banking Account	300	300
Total Advance from the Territory Banking Account	**300**	**300**

This cash advance is for the purpose of funding the Goods and Services Tax (GST) 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 52. 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

	2014 $'000	2013 $'000
Total Cash Disclosed on the Statement of Assets and Liabilities on Behalf of the Territory	268	295
Cash at the End of the Reporting Period as Recorded in the Cash Flow Statement on Behalf of the Territory	**268**	**295**

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

	2014 $'000	2013 $'000
Operating Surplus	3	-
Cash Before Changes in Operating Assets and Liabilities	**3**	**-**
Changes in Operating Assets and Liabilities		
(Increase) in Receivables	(30)	(5)
Net Changes in Operating Assets and Liabilities	**(30)**	**(5)**
Net Cash (Outflows) from Operating Activities	**(27)**	**(5)**

Note 53. 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 44: 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 its Territorial financial assets and financial liabilities held in non-interest bearing arrangements. This means that 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 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 less an allowance for impairment losses.

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, Westpac Banking Corporation (Westpac). Westpac holds a AA-issuer credit rating with Standard and Poors.

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 by 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 53. 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 2014 $'000	Fair Value 2014 $'000	Carrying Amount 2013 $'000	Fair Value 2013 $'000
Financial Assets				
Cash and Cash Equivalents	268	268	295	295
Receivables	35	35	5	5
Total Financial Assets	**303**	**303**	**300**	**300**
Financial Liabilities				
Advance from the Territory Banking Account	300	300	300	300
Total Financial Liabilities	**300**	**300**	**300**	**300**
Net Financial Assets	**3**	**3**	**–**	**–**

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 2014. 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 No.	Weighted Average Interest Rate	Floating Interest Rate $'000	1 Year or Less $'000	Over 1 to 5 Years $'000	Over 5 Years $'000	Non-Interest Bearing $'000	Total $'000
Financial Instruments								
Financial Assets								
Cash and Cash Equivalents	49		-	-	-	-	268	268
Total Financial Assets			-	-	-	-	268	268
Financial Liabilities								
Advance from the Territory Banking Account	51		-	-	-	-	300	300
Total Financial Liabilities			-	-	-	-	300	300
Net Financial (Liabilities)			**-**	**-**	**-**	**-**	**(32)**	**(32)**

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 2013. All financial assets and liabilities, excluding Advance from 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 No.	Floating Interest Rate $'000	1 Year or Less $'000	Over 1 to 5 Years $'000	Over 5 Years $'000	Non-Interest Bearing $'000	Total $'000
Financial Instruments							
Financial Assets							
Cash and Cash Equivalents	49	-	-	-	-	295	295
Total Financial Assets		-	-	-	-	295	295
Financial Liabilities							
Advance from the Territory Banking Account	51	-	-	-	-	300	300
Total Financial Liabilities		-	-	-	-	300	300
Net Financial Assets / (Liabilities)		**-**	**-**	**-**	**-**	**(5)**	**(5)**

Note 53. Financial Instruments – Territorial (continued)

Carrying Amount of Each Class of Financial Asset and Financial Liability	2014 $'000	2013 $'000
Financial Assets		
Loans and Receivables Measured at Amortised Cost	-	-
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 54. Commitments – Territorial

Capital Commitments

Capital commitments at reporting date that have not been recognised as liabilities are as follows:

	2014 $'000	2013 $'000
Capital Grant Commitments		
Within one year	784	765
Later than one year but not later than five years	-	-
Total Capital Commitments	**784**	**765**

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

Note 55. Contingent Liabilities and Contingent Assets – Territorial

There were no contingent liabilities or contingent assets as at 30 June 2014, (Nil at 30 June 2013).

There were no indemnities as at 30 June 2014, (Nil at 30 June 2013).

Note 56. Events Occurring After Balance Date – Territorial

There were no events occurring after the balance date, which would affect the financial statements as at 30 June 2014, or in the future reporting periods.

F.3 CAPITAL WORKS

Capital works in ACT Health occur under the leadership of the Health Infrastructure and Planning Branch.

Health Infrastructure and Planning is responsible for the delivery of the Health Infrastructure Program (HIP), a significant investment in future health services for the ACT community and surrounding region, as well as Strategic Accommodation and the Capital Upgrades Program.

The HIP, a major capital infrastructure program, responds to a complex mix of population growth and ageing, and changing technology and provider and consumer expectations—all of which contribute to a significant increase in demand for health services in the ACT and to changes in the way services are delivered. Demand for health services is projected to increase rapidly over the next 10 years and beyond, and the HIP is a planned, comprehensive and structured response to these pressures. Underpinned by future health services demand projections, the HIP encompasses review of future requirements for models of care and service delivery, technology and workforce in conjunction with a significant capital works program. This reporting year marks the sixth year of the HIP.

The Capital Upgrades Program is funded annually. Prioritisation of work is determined under the following categories:

- building upgrades
- electrical, fire and safety upgrades
- mechanical system upgrades
- patient and medical facility upgrades
- workplace improvement upgrades
- medical and administration office upgrades.

Projects completed in 2013–14 under the HIP were as follows:

- Belconnen Community Health Centre (BCHC): physical works commenced in January 2012 and construction was completed in September 2013. The BCHC provides an increased capacity in traditional community health services such as dental, community nursing and community mental health services. It provides for an expanded range of clinical services previously provided on hospital grounds, such as renal dialysis, some specialist outpatient services and chronic disease management.
- A new Walk-in Centre was designed and installed in the new Belconnen Community Health Centre. Works commenced on the fit-out in September 2013 and were completed in June 2014. Clinical operations will commence at the Walk-in Centre in July 2014.
- Centenary Hospital for Women and Children, Stage 2, at the Canberra Hospital: this work involved a major refurbishment of the existing maternity building and was completed in December 2013. The completed hospital brings together the Centre for Newborn Care, Gynaecology and Women's Health, Maternity Services and Paediatric Services in one complex. The George Gregan Foundation Playground is located in the new building.
- Canberra Hospital Emergency Department (ED) and Intensive Care Unit (ICU) Extension (part of Staging and Decanting—Continuity of Services and partly funded by the Commonwealth): this was an amalgam of two projects, both located in Building 12. The extension included an additional eight treatment spaces in ED and seven beds in the ICU. Construction was completed in September 2013.
- Tuggeranong Community Health Centre (refurbishment and Stage 2): this project involved the refurbishment and extension of the physical infrastructure of the Tuggeranong Community Health Centre and the expansion and enhancement of the health services provided at the centre. The extension and refurbishment were designed to meet the future health needs of the local population. Physical works commenced in October 2012 and were completed in March 2014.
- Construction of a Walk-in Centre located at the Tuggeranong Community Health Centre was included as part of the overall construction works of the project. The construction works were completed concurrently with the community health centre works. The Walk-in Centre was completed in March 2014 and commenced clinical activity in June 2014.

Works in progress under the HIP at 30 June 2014 are:

- Refurbishment of Building 1, Level 5, at the Canberra Hospital (part of Staging and Decanting): refurbishment has been undertaken to a complete floor within the main tower block to provide 60 hospital beds, which will permit the decanting of existing wards in Building 3. Construction is nearing completion and the ward is expected to open in September 2014.

- Canberra Region Cancer Centre (CRCC): the new facility will provide an integrated treatment centre for cancer services for the Canberra region. A significant water leak occurred in the CRCC building in September 2013, resulting in extensive damage to three levels and causing a lengthy delay in the project program. Construction is now due for completion in July 2014, and the facility will commence clinical activity in August 2014.
- Emergency Department paediatric streaming is a component of the Clinical Services Inpatient Unit Design and Infrastructure Expansion (CSIUDIE) project at the Canberra Hospital. This project will deliver an independent triage and treatment area for Emergency Department patients up to the age of 16. Planning commenced in May 2013 and preliminary sketch plans are complete. A head contractor has been appointed to undertake construction, which is programmed to commence in November 2014. Building completion is due in September 2015.
- Another component of the CSIUDIE project is essential infrastructure works, including forward design for new clinical infrastructure at the Canberra Hospital. The development of the functional brief for the project to plan development of new Clinical Buildings 3 and 2 is ongoing and is expected to be completed in August 2014. In May 2014, a principal consultant was engaged to undertake both a proof of concept phase and preliminary sketch plan (PSP) design for the project. The proof of concept phase aims to prove the existing Concept Master Development Plan forming part of the future facility profile prepared by Aurora Projects in 2012. Once the proof of concept phase has been completed and has received approval from ACT Health, the principal consultant will develop the PSP. It is expected that PSP work will be completed by mid-2015. In addition to the forward design work, an audit of existing buildings 1, 10 and 12 is underway. The output of this audit process will inform the proof of concept and long term master planning for the campus.
- Calvary car park: The new Calvary car park will provide 704 parking spaces in a structured car park over five levels, resulting in a net increase of approximately 515 spaces on the Calvary Hospital campus. The tender evaluation process for the construction contractor was completed in May 2014 and at the time of writing negotiations were underway with the preferred tenderer. The sublease for the site is almost complete following Calvary Health Care's approval and it is expected that the territory's leasing, land titles registration and ACT Health's execution of the sublease will be completed in August 2014, before the award of contract. The design planning and procurement of enabling works are progressing. The new car park will be commissioned in the second half of 2015.
- Staging and Decanting Bundle Package at the Canberra Hospital: scope development has been undertaken for this project to relocate services from the existing Building 3. A head contractor was selected in May 2014 to undertake the planning, design, construction, commissioning and relocation of all functions to enable the complete decanting of Building 3 by 30 June 2016.
- Adult Secure Mental Health Unit—Forward Design and Finalising Design: a principal consultant was appointed in late 2013 to develop a preliminary sketch plan (PSP) design. The PSP design was completed in June 2014. At the time of writing negotiations were underway with a preferred tenderer to be appointed as head contractor to complete the final sketch plan (FSP) design and construction of the 25-bed facility. An amendment to legislation will facilitate the fast-track approval of this project. Construction is expected to commence in early 2015, with project completion scheduled for late 2016.
- University of Canberra Public Hospital: this will comprise 140 overnight beds, made up of 20 mental health rehabilitation and 120 general rehabilitation beds. The project has achieved a number of milestones, with a site on the University of Canberra campus identified as the preferred location for the facility. The service delivery plan to inform a concept design of the facility was developed based on user group and stakeholder consultation, and was released for community consultation in May 2014. The contract to appoint the principal consultant to undertake design was awarded in May 2014. Construction is expected to commence in mid-2015.
- Ngunnawal Bush Healing Farm: the project experienced delays relating to the development application (DA) process. During the reporting year, the model of care (phase 2) and both the preliminary sketch plans and final sketch plans for the facility were endorsed by ACT Health. Construction documentation in readiness for construction tender has been completed. In June 2013, ACT Health was advised that applications for a review of the May 2013 decision to approve the lease variation development application decision had been received by the ACT Civil and Administrative Tribunal. In April 2014, the ACT Civil and Administrative Tribunal upheld the lease variation decision under review, with two further amendments related to the need to submit a survey of the area proposed as a group or organised camp, and the need for ACT Health, as leaseholder, to accept full responsibility for maintenance and repair of the access track to the property. At 30 June 2014, the design and siting DA was pending. Land management activities on the Miowera property have been ongoing, and planning for construction has progressed.
- The Canberra Hospital—Continuity of Services Essential Infrastructure (COSEI): the procurement process for a contractor for this package of infrastructure works on the Canberra Hospital campus was completed in March 2014. The project has two stages. Stage 1 includes design of the main works package and the lump-sum delivery of a fire booster works package. It also includes a separate signage and wayfinding works package. Stage 2 includes the construction, upgrade and/or enhancement of a multiple discipline in-ground engineering services works package, including the completion of ring main infrastructure works undertaken in recent years to enable development on the southern and northern ends of the Canberra Hospital campus. The fire booster works were being completed in July 2014. Fabrication of the main external hospital signage will be prioritised and a phased construction process will commence, with the main signs starting in September 2014.

The following tables contain Health Directorate capital works project information and the reconciliation schedule required.

Capital works table—Health Directorate

Project	Proposed or actual completion date	Original project value $'000	Revised project value $'000	Prior years expenditure $'000	2013–14 expenditure $'000	Total expenditure to date $'000
New Works						
Calvary Hospital Car Park (Design)	July 2014	1,300	1,300	n/a	431	431
University of Canberra Public Hospital (Design)	July 2015	8,252	8,252	n/a	13	13
Continuity of Health Services Plan – Essential Infrastructure	August 2015	16,517	16,517	n/a	234	234
Clinical Services and Inpatient Unit Design and Infrastructure Expansion	June 2016	40,780	40,780	n/a	752	752
Capital Upgrade Program Services						
Building Upgrades	January 2015	705	705	n/a	183	183
Electrical/Fire/Safety Upgrades	January 2015	570	570	n/a	435	435
Heating, Ventilation and Air Conditioning Systems Upgrades	January 2015	375	375	n/a	86	86
Medical Facilities Upgrades	January 2015	660	660	n/a	298	298
Facilities Improvements to Laboratory and Outpatients Area	January 2015	890	890	n/a	10	10
Upgrade of Medical and Administrative Offices	January 2015	646	646	n/a	163	163
Building Upgrades to address Condition Report findings including Works to Bathrooms, Plumbing and Other Works	November 2014	580	580	379	45	424
Ambulatory Care Improvements at the Canberra Hospital including the Respiratory Medicine and Gastroenterology Areas	December 2014	680	680	41	500	541
Augmentation of Medical and Administrative Offices to meet Organisational Change and Growth	November 2014	420	420	262	29	291
Works in Progress						
Integrated Cancer Centre – Phase 2	July 2014	15,102	20,412	12,378	7,278	19,656
Adult Secure Mental Health Unit (Finalising Design)	April 2015	2,000	2,000	0	512	512
Staging and Decanting – Moving To Our Future	June 2016	22,300	22,300	247	4,506	4,753
Staging, Decanting and Continuity of Services	June 2016	19,430	19,430	5,580	4,944	10,524
Clinical Services Redevelopment – Phase 3	June 2016	25,700	18,690	2,040	5,685	7,725
Northside Hospital Specification and Documentation	July 2015	4,000	4,000	882	986	1,868
Aboriginal Torres Strait Islander Residential Alcohol and Other Drug Rehabilitation Facility	June 2016	6,883	8,933	2,166	77	2,243
Linear Accelerator Procurement and Replacement	August 2014	18,700	17,250	16,517	6	16,523
Health Infrastructure Program – Project Management	October 2014	19,319	19,319	4,225	11,265	15,490
Clinical Services Redevelopment – Phase 2	October 2014	15,000	8,850	7,781	212	7,993
HIP Change Management and Communication Support	December 2014	4,117	4,117	3,022	732	3,754
Mental Health Young Persons Unit	On Hold	775	775	121	0	121
Provision for Project Definition Planning	June 2015	63,800	58,040	55,490	1,082	56,572
Major Building Plant Replacement and Upgrade	December 2014	5,292	5,292	1,230	1,992	3,222
An E-Healthy Future	March 2016	90,185	90,185	46,814	7,501	54,315
Digital Mammography	November 2014	5,715	5,715	5,368	–288	5,080
Neonatal Intensive Care Unit – Video Streaming Services	September 2014	200	200	108	18	126

Project	Proposed or actual completion date	Original project value $'000	Revised project value $'000	Prior years expenditure $'000	2013–14 expenditure $'000	Total expenditure to date $'000
Projects – Physically complete but financially incomplete						
Belconnen and Tuggeranong Walk-in Centres	June 2014	951	951	n/a	951	951
Fire/Safety/Security Upgrades to address outcomes of Fire reports, Improve Access Control to Plant Rooms, Upgrade Flooring and Other Works	June 2014	352	352	313	24	337
Mechanical Systems Upgrades to Building Plant and Equipment at the Canberra Hospital and other Health Facilities	December 2013	580	580	563	0	563
New Multistorey Car Park TCH	June 2011	29,000	42,720	41,978	218	42,196
Enhanced Community Centre Back Up Power	March 2014	3,540	2,340	250	1,092	1,342
Tuggeranong Health Centre – Stage 2	March 2014	14,000	14,000	1,424	12,249	13,673
National Health Reform	September 2013	15,098	10,088	8,732	1,329	10,061
Enhanced Community Health Centre – Belconnen	September 2013	51,344	51,344	39,025	11,544	50,569
Women and Children's Hospital*	November 2013	90,000	111,997*	103,235	8,762	111,997
New Gungahlin Health Centre	August 2012	18,000	18,000	17,426	114	17,540
Adult Acute Mental Health Inpatient Unit	March 2012	23,630	28,480	28,272	208	28,480
Identity and Access Management	June 2014	3,100	3,100	2,544	486	3,030
Completed Projects – physically and financially complete						
Facilities Improvements to Patient Accommodation at the Canberra Hospital	December 2013	620	620	268	352	620
Central Sterilising Services	June 2014	17,270	275	255	16	271
Adult Secure Mental Health Unit (Forward Design)	June 2014	1,200	1,200	755	445	1,200
Integrated Capital Region Cancer Centre – Phase 1	June 2014	27,900	29,652	29,230	422	29,652
Refurbishment of Health Centre – Tuggeranong	March 2014	5,000	5,000	5,000	0	5,000

** Revised project value includes $937 thousand in donation revenue from external sources.*

Capital works table—Territorial

Project	Proposed completion date	Original project value $'000	Revised project value $ '000	Prior years expenditure $'000	2013–14 expenditure $'000	Total expenditure to date $'000
Capital Upgrade Program Services						
Building Management System Upgrade	July 2014	100	100	n/a	90	90
Fire Safety System Upgrade	December 2014	200	200	n/a	80	80
Installation of a Primary-Secondary Loop for the Environmental Cooling System to meet the needs of a Growing Hospital and Reduce Energy Costs	September 2014	200	200	0	48	48
Residential Accommodation Refurbishment – Calvary	December 2014	310	310	79	69	148
Completed Projects – physically and financially complete						
Continuity of Health Services Plan – Essential Infrastructure	June 2014	3,850	3,850	n/a	3,850	3,850
Liquid Oxygen Vessel Upgrade	November 2013	15	15	n/a	15	15
Environmental Improvements to Cooling System	June 2014	300	300	n/a	300	300
Xavier Building Floor Replacement	May 2014	150	150	n/a	150	150
Improvements to Patient Safety – Expansion of Reticulated Suction System	February 2014	50	50	0	50	50
Improvements to Keaney Environmental Cooling System which will provide redundancy	February 2014	296	296	0	296	296
Installation of a Service Column in the Intensive Care Unit to Provide Reticulated Gas, Power and Data to a Cardiac Procedure Room	June 2013	80	80	39	41	80
Fire Safety Upgrades – Calvary	September 2012	300	300	224	76	300

Reconciliation schedule—capital works and capital injection

Approved Capital Works Program financing to capital injection as per cash flow statement						
	Original $'000	Section 16B $'000	Variation $'000	Deferred $'000	Not drawn $'000	Total $'000
Capital Works	164,004	7,126	0	–58,864	–10,248	102,018
ICT Capital Injections	18,338	–1,592	0	–5,926	–3,306	7,514
Other Capital Injections	8,066	7,630	234	–5,026	–2,294	8,610
Total Departmental	**190,408**	**13,164**	**234**	**–69,816**	**–15,848**	**118,142**
Total Territorial	**4,615**	**0**	**0**	**0**	**0**	**4,615**

F.4 ASSET MANAGEMENT

Assets managed

ACT Health managed assets with a total written down value of $859.1 million at 30 June 2014, including:

- built property assets $771.290 million
- land $40.250 million
- plant and equipment $36.785 million
- leased plant and equipment $5.964 million
- leasehold improvements $4.811 million.

The estimated replacement value of these assets was $1,419 million, of which property assets were $1,293 million. The following table lists ACT Health's property assets.

The Canberra Hospital (CH) campus	Area m²
CH Building 1—Tower Block	37,560
CH Building 2—Reception/Administration	5950
CH Building 3—Oncology/Aged Care/Rehabilitation	17,390
CH Building 3—Radiation Oncology	1,650
CH Building 4—ANU Medical School	4,115
CH Building 5—Staff Training/Accommodation	8,230
CH Building 6—/Offices	4,710
CH Building 7—Alcohol and Drug	1,260
CH Building 8—Pain Management	660
CH Building 9—Accommodation	740
CH Building 10—Pathology	10,250
CH Building 11—Centenary Hospital for Women and Children	19,200
CH Building 12—Diagnostic and Treatment (including Emergency Department/Intensive Care Unit	19,510
CH Building 13—Helipad Northern Car park	7,980
CH Building 14—Child Care	627
CH Building 15—To be refurbished	2,020
CH Building 19—Canberra Region Cancer Centre	7,980
CH Building 22—Information Management	243
CH Building 23—Redevelopment Unit Offices	1,810
CH Building 24— Health Administration Offices	1,332
CH Building 25— Adult Mental Health Unit	5,436
CH Building 26— Southern Car park	53,000
Gaunt Place Building 1—Dialysis Unit	871
Gaunt Place Building 2—RILU	688
Gaunt Place Buildings 3, 4, 5, 6 (Health Offices)	668
Yamba Drive car park (Phillip Block 7, Section 1)	N/A

Health facilities	Area m²
Belconnen Health Centre	3,800
Belconnen Community Health Centre	11,160
Dickson Health Centre	490
Gungahlin Health Centre	2,608
Phillip Health Centre	3,676
Tuggeranong Community Health Centre	6,760
Bruce—Arcadia House	467
Bruce—Brian Hennessy House	3,719
Health Protection Services—Holder	1,600
Monash—Health Protection Service Air Monitoring Station	18
Lanyon Family Care Centre	194
Ngunnawal Family Care Centre	215
Weston—Independent Living Centre	1,143
Barton—Clare Holland House	1,600
Curtin—QEII Family Centre	1,120
Kambah—Step Up Step Down Unit	279
Fadden—Karralika	534
Florey – Health Protection Service Air Monitoring Station	18
Isabella Plains—Karralika	1,400
O'Connor—Mental Illness Fellowship	200
Rivett—Burrangiri Respite Care Centre	1,054
Watson Hostel	2,431
Paddy's River—Miowera	206
Duffy—Cancer Patient Accommodation	319
Student Accommodation—Phillip (3 units)	276
Student Accommodation—Belconnen (2 units)	220
Student Accommodation—Garran (1 unit)	117

During 2013–14, no assets were removed from the asset register. The following assets were added to the register:

- Canberra Hospital Building 19, Canberra Region Cancer Centre
- Health Protection Service Air Monitoring Station—Florey
- Belconnen Community Health Centre
- additions to Tuggeranong Community Health Centre
- Canberra Hospital Building 12, Diagnostic and Treatment Emergency Department/Intensive Care Unit extension.

At 30 June 2014, ACT Health did not have any surplus properties.

Assets maintenance and upgrade

Works were undertaken at properties throughout ACT Health's portfolio in 2013–14. Works completed in the reporting year were:

- Canberra Hospital—provision of an eight-bed medi-hotel facility in Building 5
- Canberra Hospital—refurbishment of the Gastroenterology and Hepatology Unit
- Canberra Hospital—kitchen upgrades to Building 5
- Canberra Hospital—replacement of boiler systems to Buildings 10 and 12
- Canberra Hospital—fire safety system upgrade to Building 1
- Canberra Hospital—Cardiac Catheter Laboratory UPS and air-conditioning upgrades
- Brian Hennessy Rehabilitation Centre—fire safety system upgrades and installation of sprinkler system
- Clare Holland House—clean utility and medication room upgrades
- Arcadia House—fire safety system upgrades and installation of sprinkler system
- Arcadia House—security fence upgrade.

Details of the capital works program are included in section F.3, Capital works.

Property, plant and equipment are maintained to a high standard to meet health requirements. Expenditure on repairs and maintenance, excluding salaries, was $15.851 million, which represents 1.23 per cent of the replacement value.

Building audits

Sixty-four building condition assessments, hazardous materials audits and fire reports were undertaken as part of a rolling three-year program to assess all buildings managed by ACT Health. These audits are used to inform the directorate's ongoing asset management program. The condition audits assessed these properties as being in normal or average condition.

Office accommodation

The agency employs 6797 staff, of whom 1259 occupy office-style accommodation in the sites listed in the table below, at an average utilisation rate of 13.0 square metres (m^2) per employee.

Location	Property	Owned/ leased	Work points/staff on 30 June 2014	Office area (m^2)	Utilisation rate m^2 per employee
Civic	1 Moore Street, Level 3	Leased	158	1,954	12.4
Civic	11 Moore Street, Level 2 and 3	Leased	153	2,290	15.0
Civic	12 Moore Street, Level 1	Leased	43	447	10.4
Curtin	Carruthers Street	Leased	217	3,187	9.9
Garran	Canberra Hospital, Building 2	Owned	54	808	15.0
Garran	Canberra Hospital, Building 6	Owned	202	3,051	15.1
Garran	Canberra Hospital, Building 12, Medical Records	Owned	62	613	9.9
Garran	Canberra Hospital, Building 22	Leased	23	243	10.6
Garran	Canberra Hospital, Building 23	Owned	158	1,810	11.5
Garran	Canberra Hospital, Building 24	Owned	62	1,332	19.7
Holder	Health Protection Services	Owned	75	1,163	15.5
Phillip	1 Bowes Place	Leased	52	583	11.2

The remaining 5538 staff work in non-office environments in ACT Health's acute and non-acute facilities. Due to the clinical nature of these workplaces, the average area per employee is not applicable.

F.5 GOVERNMENT CONTRACTING

Procurement principles and processes

In 2013–14, ACT Health performed all procurement activities in accordance with the government tender thresholds and complied with procurement policies and procedures as stated in the *Government Procurement Act 2001* (the Act), Government Procurement Regulation 2007 (the Regulations), and Government Procurement Amendment Regulation 2009 (No. 1).

To ensure compliance with ACT Government procurement legislation, ACT Health:

- sought advice on government procurement policies and procedures from Shared Services Procurement
- notified Shared Services Procurement of all procurements over $25,000 undertaken by ACT Health
- appropriately referred procurements requiring single, restrictive or open tender procurement processes to Shared Services Procurement
- referred to Shared Services Procurement, where necessary, all procurements requiring Government Procurement Board consideration and/or approval.

To ensure contractors meet their industrial relations obligations, all tenders and contracts drafted by Shared Services Procurement on behalf of ACT Health include conditions provided by the ACT Government Solicitor's office to reflect the Act and the Regulations. These include the Ethical Suppliers Guideline and compliance with the government procurement circular on ethical suppliers.

In accordance with procurement legislation, ACT Health afforded the highest standard of probity and ethical behaviour towards prospective tenderers. This behaviour included: equality, impartiality, transparency and fair dealing.

A competitive procurement process is conducted wherever possible; however, due to the specialised nature of the industry, ACT Health frequently accesses single select and restricted select procurement methodologies. Below is the justification for these procurement methodologies:

- There is a need for both hardware and software procurements to be compatible with existing medical equipment within the clinical setting.
- Clinical units look to standardise medical equipment with existing equipment. This mitigation strategy reduces the risk of human error in the delivery of clinical practice, through familiarity of equipment via established equipment operating procedures.
- There may be a limited number of providers that possess the specialised medical knowledge and/or expertise that can fulfil the agency's requirements.
- Timing may preclude public tenders being called in situations where medical equipment is temporarily or permanently disabled, causing disruption to medical services.

Single select and/or restricted select procurement processes are completed in accordance with the provisions of the *Government Procurement Regulations 2007* and are approved by the Director-General with a statement of justification as required by the Act.

Frequently, ACT Health relies on the New South Wales Department of Commerce Standing Offer Agreements for restricted select procurement. Through open tender, NSW has a selected panel of preferred suppliers and providers.

In order to utilise the buying power of the NSW Government, ACT Health frequently asks panel suppliers to offer NSW Department of Commerce pricing on tenders. This strategy not only increases the chance of better value for money to the Territory in comparison to a stand-alone open tender, but also creates a more efficient procurement process. It meets the threshold requirements of the Act and Regulations as those panel suppliers have previously tendered through an open tender process through the NSW Department of Commerce.

An ACT Health Procurement Package was introduced in September 2010 as a tool to educate ACT Health staff about their responsibilities for the proper expenditure of public monies in accordance with the Act. ACT Health encourages its staff, where possible, to seek quotations in accordance with the tender thresholds as stated in the Regulations.

To further support the procurement processes, in 2013–14 an e-learning package was developed and provided to ACT Health staff by the Staff Development Unit, which provides procedural guidance on procurement activities.

Health Infrastructure and Planning (HI&P) has entered into contracts with the following non-prequalified contractors due to specific requirements of the contracts, as listed:

Contractor name	Price (GST inclusive)	Reason for use of non-prequalified contractor
A Dec Trading Company Inc. t/a ADEC Australia	$650,857.52	Requirement to buy equipment that is compatible with existing equipment and standardisation of a product.
Aurora Projects Pty Ltd	$194,214.00	The consultant was engaged in accordance with the approved Technical Advisory Panel process.
Aurora Projects Pty Ltd	$340,379.22	The consultant was engaged in accordance with the approved Health Planning Services Panel Deed.
Solid Support Delay Analysis Pty Ltd	$326,264.00	The Government Prequalification Codes do not include master programmer specialist consultants.
Solid Support Delay Analysis Pty Ltd	$900,000.00	The Government Prequalification Codes do not include master programmer specialist consultants.
Southern Generators and Electrical Pty Ltd	$651,919.00	A limited number of electrical suppliers were available because of the requirement for them to have knowledge of and experience with electrical generators.
Thinc Health Australia Pty Ltd	$200,000.00	The consultant was engaged in accordance with the approved Health Planning Services Panel Deed.

ACT Government uses 'Social Procurement' as a mechanism to achieve broader social inclusion by engaging mainstream suppliers that include social benefits as part of delivering goods and services. 'Social Enterprises' use sound business principles to return financial and societal benefits to the community.

External sources of labour and services

In 2013–14, ACT Health engaged a range of external consultants and contractors to undertake services in the following areas:

- frontline clinical health services
- structural and procedural reviews of current business models
- dispute resolution services, including complaint investigation and mediation services
- capital works projects.

The following tables catalogue all procurements over $25,000 undertaken by ACT Health for contractors, consultants and visiting medical officers (VMOs) for the reporting period.

Contractors

Name of Contractor	Description of Contract	Cost (Exclusive of GST)	Date Contract Let	End Date	Select Tender Yes/No	Reason for Select Tender
Individual contracts which exceed $25,000; and smaller contracts awarded to the same contractor which, in total, exceed $25,000.						
Contractor – A person who performs a Job, Task, Project on behalf of the organisation, I.e. a job that can be done by a staff member, but there are no resources to do in house.						
Acute Services (Output 1.1)						
ACT Nursing Service Pty Ltd	Day to day on call Agency nurses.	$748,032.00	16-Feb-11	Ongoing	No	
Ausstat Health and Medical Recruitment	Medical locum contract labour.	$53,897.00		Month to month	Yes	Backfilling of clinical staff.
Australian National University	Contracted Research Manager, Dr Rachel Li, Trauma and Orthopaedic Research.	$205,225.00		Month to month	Yes	Expertise in the field of trauma and orthopaedics.
Baptist Community Services	Provision of chaplaincy services.	$117,079.80		Month to month	No	
Calvary Private Health Care Canberra Limited T/A Calvary John James Hospital	Panel for Private Contracting of Elective Surgery in the ACT.	$81,460.00	16-May-13	25-Dec-15	No	
Dr Bob Goodarzi Kambah Village Dental	Provision of dental services.	$32,616.15	01-Jul-13	30-Jun-14	Yes	Specialised dental services.
Dr Duc Pham	Provision of dental services.	$43,958.80	01-Jul-13	30-Jun-14	Yes	Specialised dental services.
Dr Joseph Jho	Provision of dental services.	$51,262.35	01-Jul-13	30-Jun-14	Yes	Specialised dental services.
Dr Oncall Pty Ltd	Medical locum contract labour.	$59,142.00		Month to month	Yes	Backfilling of clinical staff.

Name of Contractor	Description of Contract	Cost (Exclusive of GST)	Date Contract Let	End Date	Select Tender Yes/No	Reason for Select Tender
Dr Sabin Dutta Signature Smiles	Provision of dental services.	$35,502.30	01-Jul-13	30-Jun-14	Yes	Specialised dental services.
Hays Specialist Recruitment (Australia) Pty Limited	Provision of clinical contract staff; and trade labour staff.	$148,243.96	21-Mar-13	03-Mar-16	No	
Lin and Lan Nguyen Kambah Professional Centre	Provision of dental services.	$27,600.95	01-Jul-13	30-Jun-14	Yes	Specialised dental services.
Medic Oncall Recruitment	Medical locum contract labour.	$123,033.00	Month to month		Yes	Backfilling of clinical staff.
Mediserve Pty. Ltd.	Day-to-day on call Agency nurses.	$415,252.00	16-Feb-11	Ongoing	No	
National Health Call Centre Network t/a Health Direct	Participation in the National Call Centre Network	$886,753.71	01-Jul-12	Ongoing	No	
National Healthcare Services	Provision of Agency nurses.	$605,781.00	16-Feb-10	Ongoing	No	
Professional Nursing Agency	Provision of specialised Agency nurses.	$282,187.00	Month to month		Yes	Specialised nursing services.
Recruitment Solutions Group Australia Pty Ltd	Provision of specialised Agency nurses.	$32,245.00	Month to month		Yes	Specialised nursing services.
The Smile Lounge – Civic and Airport	Provision of dental services.	$34,359.80	01-Jul-13	30-Jun-14	Yes	Specialised dental services.
Translating and Interpreting Services (TIS)	Translation and interpreter services.	$470,331.54	Month to month		No	
Wanniassa Dental Surgery	Provision of dental services.	$44,197.70	01-Jul-13	30-Jun-14	Yes	Specialised dental services.
Weston Dentistry	Provision of dental services.	$25,540.10	01-Jul-13	30-Jun-14	Yes	Specialised dental services.
Public Health Services (Output 1.3)						
AMR Pty Ltd	Ways to Wellbeing research.	$25,454.55	19-Jun-14	30-Jun-15	No	
Building and Environmental Services Today	Food safety and Environment inspections.	$124,346.79	01-Jul-13	30-Jun-14	No	
Central Dental Services Pty Ltd	Provision of dental prosthetic services.	$53,409.50	01-Jul-13	30-Jun-14	Yes	Dental prosthetic services.
Chris McCarthy Denture Clinic	Provision of dental prosthetic services.	$39,435.65	01-Jul-13	30-Jun-14	Yes	Dental prosthetic services.
Gammasonics Institute for Medical Research Pty Ltd	Compliance Testing of Radiation Sources in the ACT.	$32,797.00	01-Jul-13	30-Jun-14	No	
Grey Canberra	Health Brands Integration Strategy; and 'Healthy Food and Drink Choices Policy'.	$52,474.54	19-Jun-14	30-Jun-15	Yes	Greater knowledge and understanding of requirements.
JCBD Consulting	Food Safety Inspections and Food Safety Plan Audits.	$30,035.25	01-Jul-13	30-Jun-14	No	
Miller Group Social Policy & Management Consultants	Evaluation of the delivery and impact of 'Healthier Work'	$37,461.81	17-Jul-12	31-Mar-15	No	
Nutrition Australia ACT	Food and Drink Policy implementation.	$53,000.00	01-Mar-13	30-Jun-15	Yes	Only provider of targeted services.
Race Dental Laboratory	Provision of dental prosthetic services.	$39,845.63	01-Jul-13	30-Jun-14	Yes	Dental prosthetic services.
Sapere Research Group Limited	Provision of specialist Health Planning Services to ACT Health.	$47,650.00	21-Jun-12	31-May-15	No	
TelemedCare	Telephone Coaching Services for people in the ACT with specific chronic diseases.	$25,499.70	01-Jul-13	30-Jun-14	Yes	Expertise in the management and services of Chronic Disease.
The Denture Clinic (Australia) Pty Ltd	Provision of dental prosthetic services.	$34,727.65	01-Jul-13	30-Jun-14	Yes	Dental prosthetic services.
Veritec Pty Ltd	Provision of the Training Management System.	$43,995.00	16-Jan-14	30-Jun-14	No	

Name of Contractor	Description of Contract	Cost (Exclusive of GST)	Date Contract Let	End Date	Select Tender Yes/No	Reason for Select Tender
Cancer Services (Output 1.4)						
NSW Cancer Institute	Cancer Registry.	$130,000.00	01-Jul-11	30-Jun-14	No	
Orima Research	Review of Communication Strategies by ACT Cervical Screening Program and Research on Awareness, Attitudes and Behaviours for Cervical Screening.	$45,029.99	01-Oct-13	31-May-14	No	
Early Intervention and Prevention (Output 1.6)						
Medibank Health Solutions	Telephone Coaching Services for people in the ACT with specific chronic diseases.	$310,404.00	08-Jul-10	30-Sep-14	Yes	Expertise in the management and services of Chronic Disease.
Contractors distributed as Overheads of Outputs						
Allstaff Australia Pty Ltd	Provision of contract trade labour staff.	$123,227.55	01-Apr-11	Ongoing	No	
Barry Funnell	Specialised electrical contractor.	$71,285.00	11-Jun-09	Ongoing	No	
Christopher Bruce	Plumbing contractor.	$28,262.90	Month to month		Yes	Technical services rendered.
Construct ACT Project Management	Carpentry contractor.	$37,587.00	Month to month		Yes	Technical services rendered.
Cordelta Pty Ltd	Provision of the Training Management System.	$41,207.00	26-Jul-12	15-Jan-14	No	
Diversiti Pty Ltd	Supply Services Inventory E-Rostering.	$38,098.02	01-May-11	Ongoing	Yes	Specialist knowledge of software being utilised.
Griffith Massage Centre	Remedial massage for work-related strains.	$46,738.30	01-Jul-08	Ongoing	No	
Mogues Enterprises Pty Ltd	Drafting of the ACT Health Annual Report.	$39,600.00	03-Jun-13	19-Aug-13	Yes	Expertise in healthcare editing.
Optum Health & Technologies Pty Ltd and PPC Worldwide	Counselling services for staff.	$125,287.50	01-Jul-13	30-Jun-14	Yes	Preferred provider for ACT Government.
Oracle Corporation Australia Pty Ltd	eRecruitment System upgrade.	$65,090.91	30-Jun-13	30-Jun-14	Yes	Sole provider for systems upgrade.
Peoplebank Australia Pty Ltd	Medical Grade Network Scope of Works – Peter Hewitt.	$162,330.00	28-Jun-12	11-Feb-14	Yes	Experience and specialist knowledge of health sector
Spevans Enterprises Pty Ltd	Carpentry contractor.	$60,568.19	05-Dec-12	05-Dec-13	No	
Wizard Corporate Training	Microsoft Office Suite training to ACT Health Staff.	$37,372.00	01-Jul-13	30-Jun-14	No	

Consultants

Name of Consultant	Description of Contract	Cost (Exclusive of GST)	Date Contract Let	End Date	Select Tender Yes/No	Reason for Select Tender
Individual contracts which exceed $25,000; and smaller contracts awarded to the same consultant which, in total, exceed $25,000.						
Consultant – A person who has the knowledge and expertise to perform a task, project, or other which is not available within the Health Directorate and Produces a report, audit, investigation, or other to Health Directorate or third parties.						
Acute Services (Output 1.1)						
Rosalie Boyce Consulting	Allied Health Review.	$64,318.18	03-Feb-14	01-Sep-14	Yes	Limited consultants with Allied Health experience available.
Public Health Services (Output 1.3)						
Canberra Property Management Pty Ltd	Expert advice on various public health matters in research, development and implementation of policies in relation to drinking water; recreational water; waste water; and land/air contamination and emerging public health issues.	$63,884.69	01-Jul-13	30-Jun-14	No	

Name of Consultant	Description of Contract	Cost (Exclusive of GST)	Date Contract Let	End Date	Select Tender Yes/No	Reason for Select Tender
Taylor Nelson Sofres	Consultancy for Wellbeing Campaign and Testing.	$30,000.00	20-Nov-13	31-Mar-14	Yes	Greater expertise in the field with relevant experience.
Cancer Services (Output 1.4)						
Orion Health	Electronic Health Record – Breast Screen Migration from ACTPAS Project.	$341,000.00	08-Aug-12	07-Aug-17	No	
Rehabilitation, Aged and Community Care (Output 1.5)						
Rob Allaburton and Associates	Community Consultation – Aged Day Care Program.	$29,871.00	25-Aug-13	26-Nov-13	Yes	Expertise in aged care.
Consultants distributed as Overheads of Outputs						
Cogent Business Solutions Pty Ltd	Evaluation and Review of contract change proposals to Domestic & Environmental Services.	$75,431.64	Month to Month		Yes	Expertise and knowledge of Environmental Services and contract proposals.
Frank Palmer & Associates Pty Ltd	Appointed to undertake arbitration following negotiations of Visiting Medical Officers contracts in 2013 in accordance with s. 106 of the Health Act 1993.	$26,121.36	14-Aug-13	14-Aug-13	No	Conducted the previous round of VMO contract arbitration and approved by all parties: AMA, VMOA and ACT Health.
Kaizen Management Systems	Work Health and Safety (OHS) internal auditing of ACT Health's safety management system to the workplace (qualified RABQSA Lead Auditor).	$56,627.00	22-Dec-10	21-Dec-16	No	
Noetic Solutions Pty Ltd	Provision of consultancy services for organisational Emergency Management review.	$28,000.00	16-May-14	27-Jun-14	Yes	Specialised consultancy with necessary technical capabilities to fulfill requirements.
Price Waterhouse Coopers	Internal Audit consultancy services; and Investigation Services.	$218,824.57	22-May-12	31-May-15	No	Preferred ACT Government provider.
Protiviti Pty Ltd	Healthcare Facility Audits; and Internal Audit consultancy services.	$92,402.26	01-Jul-13	30-Jun-14	No	

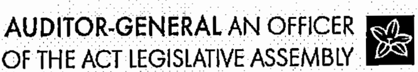
Visiting medical officers

Title	Surname	First Name	Speciality	Description Of Contract	Date Contract Commences	Date Contract Expires	Total Amount (Exclusive of GST)
1.1 Acute Services							
Dr	Adendorff	Bruce	Anaesthesia	VMO	01-Apr-13	31-Mar-16	$66,571.25
Dr	Adham	Omar	O&G	VMO	12-Feb-13	27-May-14	$336,801.87
Dr	Albekaa	Safi	ENT Surgery	VMO	01-Nov-07	01-Nov-14	$62,752.21
Dr	Al-Sameraaii	Ahmad	Urology	VMO	01-Jun-13	31-May-16	$301,910.73
Dr	Ashman	Bryan	Orthopaedic Surgery	VMO	01-Sep-12	31-Aug-15	$386,065.34
Dr	Aubin	Phil	Orthopaedic Surgery	VMO	11-Feb-14	10-Feb-17	$87,811.41
Dr	Auzins	Edwin	General Dentistry (OMFS)	VMO	02-Jul-11	01-Jul-14	$49,348.15
Dr	Bassett	Mark	Gastroenterology	VMO	25-Nov-09	25-Nov-16	$94,531.72
Dr	Bissaker	Peter	Cardiac Surgery	VMO	01-Aug-08	01-Aug-15	$603,054.46
Dr	Bradshaw	Stephen	Vascular Surgery	VMO	01-Feb-12	01-Aug-14	$313,487.11
Dr	Brady	Marc	General Dentistry (OMFS)	VMO	31-Oct-13	30-Oct-14	$43,742.98
Dr	Brady	Marc	General Dentistry (OMFS)	VMO	31-Oct-12	30-Oct-13	$43,742.98
Dr	Bromley	Jonathan	Gastroenterology & Hepatology & MAPU	VMO	01-Jan-11	31-Dec-14	$125,912.11
Dr	Burke	Bill	Thoracic Medicine	VMO	02-Oct-13	01-Oct-14	$137,365.48

Title	Surname	First Name	Speciality	Description Of Contract	Date Contract Commences	Date Contract Expires	Total Amount (Exclusive of GST)
Dr	Burns	Alexander	Orthopaedic Surgery	VMO	01-Jun-08	01-Jun-15	$173,541.89
Dr	Carney	Gavin (GM Carney Pty Ltd)	Renal Medicine	VMO	24-Aug-10	01-Nov-14	$115,081.80
Dr	Chapman	Peter	ENT Surgery	VMO	01-Oct-07	01-Oct-14	$73,480.05
Dr	Chong	Guan	General Surgery	VMO	02-Jul-12	01-Jul-15	$313,147.59
Dr	Comber	Lois	Radiology	VMO	23-Dec-13	22-Dec-14	$45,299.45
Dr	Corbett	Michael	Gastroenterology	VMO	07-Sep-10	06-Feb-15	$83,744.82
Dr	Crawford	Antony	Paediatrics	VMO	01-Dec-12	30-Nov-14	$37,200.43
Dr	Crawshaw	Ian	Paediatrics	VMO	01-Oct-07	30-Sep-14	$115,898.32
Dr	Damiani	Maurizio	Orthopaedic Surgery	VMO	07-Jul-13	06-Jul-16	$251,744.60
Dr	Davies	Stephen	Anaesthesia	VMO	01-Mar-08	01-Mar-15	$34,085.90
Dr	Davis	Ian	General Surgery	VMO	01-Sep-07	01-Sep-14	$217,520.45
Dr	Drini	Musa	General Medicine	VMO	21-Jul-13	20-Jul-14	$30,002.73
Dr	Drummond	Catherine	Dermatology	VMO	01-Nov-10	31-Oct-14	$51,723.84
Dr	Duke	David	Cardiac Anaesthesia	VMO	21-Jan-08	21-Jan-15	$234,968.08
Dr	Edwards	Joanne	Paediatrics	VMO	22-Aug-13	21-Aug-16	$168,771.50
Dr	Fahey	Caroline	Anaesthesia	VMO	01-Sep-07	01-Sep-14	$110,515.08
Dr	Findlay	Michael	Plastic Surgery	VMO	12-Jun-13	11-Jun-14	$98,405.58
Dr	Fitzgerald	Ailene	General Surgery	VMO	31-Jul-12	30-Jul-13	$28,152.62
Dr	Fletcher	Victoria	Anaesthesia	VMO	11-Feb-08	10-Feb-15	$183,776.86
Dr	Freckmann	Mary-Louise	Clinical Genetics	VMO	01-Jul-08	30-Jun-15	$76,145.01
Dr	French	James	Anaesthesia	VMO	02-Sep-12	01-Sep-15	$246,337.97
Dr	Fuller	John	Neurosurgery	VMO	02-Aug-13	01-Sep-16	$325,834.64
Dr	Gillmore	Colin	Anaesthesia	VMO	01-Feb-08	31-Jan-15	$69,872.27
Dr	Gross	Michael	Orthopaedic Surgery	VMO	10-Aug-13	09-Aug-16	$147,067.01
Dr	Hamid	Celine	Paediatric Surgery	VMO	10-Apr-14	09-Apr-15	$322,142.64
Dr	Hardman	David	Vascular Surgery	VMO	01-Jul-08	01-Jul-15	$404,793.44
Dr	Hayes	Deborah	Cardiology (Paediatrics)	VMO	02-Mar-12	01-Mar-15	$30,748.24
Dr	Hehir	Andrew	Anaesthesia	VMO	27-Jan-08	27-Jan-15	$292,336.00
Dr	Hufton	Ian	Paediatric Medicine	VMO	02-Jul-11	01-Jul-14	$31,165.92
Dr	Jeans	Phil	General Surgery	VMO	12-Aug-12	11-Aug-15	$283,482.50
Dr	Kaye	Graham	Gastroenterology	VMO	07-Sep-10	30-Aug-14	$260,954.37
Dr	Khoo	Kenneth	Rheumatology (TCH) General Medicine & Rheumatology (CHC)	VMO	01-May-14	30-Apr-15	$91,253.45
Dr	Klar	Brendan	Orthopaedic Surgery	VMO	07-Aug-12	01-Aug-15	$118,298.35
Dr	Kulisiewicz	Gawel	Orthopaedic Surgery	VMO	07-Aug-09	07-Aug-15	$226,252.93
Dr	Kwan	Bernard	Anaesthesia	VMO	01-Sep-07	01-Sep-14	$56,221.52
Dr	Kwon	Jason	Anaesthesia	VMO	05-Dec-11	04-Dec-14	$114,554.41
Dr	Lah	Frank	Anaesthesia	VMO	01-Aug-11	31-Jul-14	$193,975.71
Dr	Lane	Stuart	Intensive Care	VMO	01-Oct-13	30-Sep-14	$37,418.38
Dr	Lang	Robert	Anaesthesia	VMO	26-Jan-13	25-Jan-16	$180,960.01
Dr	Lau	Yeong-Joe	Orthopaedic Surgery	VMO	20-Feb-14	19-Feb-15	$63,323.51
Dr	Lavieuville	Megan	Emergency	VMO	29-Jul-13	28-Jul-14	$56,896.20
Dr	Lee	Elaine	Anaesthesia	VMO	11-Oct-12	10-Oct-15	$513,234.48
Dr	Lee	Tack-Tsiew	ENT Surgery	VMO	01-Jun-08	01-Jun-15	$97,520.82

Title	Surname	First Name	Speciality	Description Of Contract	Date Contract Commences	Date Contract Expires	Total Amount (Exclusive of GST)
Dr	Leerdam	Carolyn	Paediatric Medicine	VMO	01-Jul-08	01-Feb-15	$95,563.85
Dr	Lefter	Mihaela (Lefter Medical Services)	Plastic Surgery	VMO	09-Dec-13	08-Dec-14	$31,276.99
Dr	Lim	James	General Surgery	VMO	30-Nov-13	29-Nov-16	$142,561.46
Dr	Liyanage	Thaminda	Renal Medicine	VMO	05-Dec-13	04-Dec-14	$29,025.08
Dr	Lu	Don Bunnag	Anaesthesia	VMO	05-Oct-10	01-Dec-14	$40,105.41
Dr	Major	Jennifer	Anaesthesia	VMO	02-Nov-10	02-Nov-14	$48,175.73
Dr	Makeham	Timothy	ENT Surgery	VMO	14-Feb-14	13-Feb-17	$111,487.71
Dr	Malecky	George	Paediatric Surgery	VMO	01-Nov-07	31-Oct-14	$545,208.46
Dr	Malhotra	Ram	Neurology	VMO	01-Apr-14	31-Mar-17	$74,867.42
Dr	Marshall	Natalie	Anaesthesia	VMO	01-Aug-07	31-Jul-14	$499,666.29
Dr	McCredie	Simon	Urology	VMO	02-Jul-13	01-Jul-16	$238,898.60
Dr	McDonald	Tim	Paediatrics	VMO	01-Aug-07	01-Aug-14	$388,462.98
Dr	McInerney	Carmel	Anaesthesia	VMO	01-Jul-12	01-Jun-15	$52,598.00
Dr	Melhuish	Nicholas	Cardiac Anaesthesia	VMO	01-Oct-07	01-Oct-14	$260,479.62
Dr	Miller	Andrew	Dermatology	VMO	30-Nov-13	29-Nov-16	$69,255.15
Dr	Morrissey	Phillip (P Morrissey Pty Ltd)	Anaesthesia	VMO	02-Nov-13	01-Nov-16	$143,936.85
Dr	Mosse	Charles	General Surgery	VMO	01-Dec-13	30-Nov-16	$106,605.42
Dr	Mulcahy	Maurice	Urology	VMO	02-May-13	01-May-16	$399,994.98
Dr	Neilson	Wendell	Vascular Surgery	VMO	01-Jul-13	30-Jun-16	$649,773.01
Dr	Nicholls	Anthony John	Thoracic Medicine	VMO	03-May-06	03-May-13	$83,330.17
Dr	O'Connor	Simon	Cardiology	VMO	01-Oct-07	30-Sep-14	$362,329.15
Dr	OKera	Salim	Ophthalmology	VMO	12-Apr-10	12-Apr-17	$75,680.52
Dr	Peady	Clifford	Anaesthesia	VMO	24-Aug-10	01-Aug-14	$258,988.95
Dr	Peake	Ross	Anaesthesia	VMO	23-Jul-13	22-Jul-16	$81,665.74
Dr	Pham	Tuan	ENT Surgery	VMO	02-Jun-13	01-Jun-16	$324,288.35
Dr	Ponniah	Senthan	Anaesthesia	VMO	24-Jan-14	23-Jan-17	$199,983.36
Dr	Powell	Suzanna	Paediatric Medicine	VMO	01-Jun-08	31-May-15	$64,072.08
Dr	Preda	Martina	Radiology	VMO	24-Feb-14	23-Feb-15	$24,095.45
Dr	Quah	Yeow Leng (Valerie)	Anaesthesia	VMO	17-Jan-14	16-Jan-17	$107,995.82
Dr	Rangiah	David	General Surgery	VMO	31-Oct-11	01-Feb-15	$188,941.66
Dr	Reiner	David	Anaesthesia	VMO	01-Sep-11	31-Aug-14	$41,289.48
Dr	Riddell	James (J Riddell Pty Ltd)	General Medicine & Gastroenterology	VMO	10-Dec-09	30-Nov-14	$25,484.15
Dr	Roberts	Chris	Orthopaedic Surgery	VMO	01-Nov-07	01-Nov-14	$58,269.09
Dr	Robson	Stephen	O&G	VMO	01-Aug-11	31-Jul-14	$138,883.73
Dr	Rosier	Michael	Paediatric Medicine	VMO	01-Aug-07	01-Aug-14	$133,948.53
Dr	Sathasivam	Sivapirabu	Plastic Surgery	VMO	29-Jul-13	28-Jul-14	$218,967.11
Dr	Simpson	Erroll	Paediatric Surgery	VMO	19-Jun-12	31-Oct-14	$325,634.75
Dr	Smith	Paul	Orthopaedic Surgery	VMO	02-Feb-14	01-Feb-17	$535,848.37
Dr	Smith	Damian	Orthopaedic Surgery	VMO	01-Jul-08	01-Jul-15	$290,431.63
Dr	Smith	Joseph	Orthopaedic Surgery	VMO	12-Mar-14	31-Jul-14	$385,079.35
Dr	Speldewinde	Geoffrey	Anaesthesia	VMO	01-Nov-07	01-Nov-14	$31,417.08
Dr	Stone	Hilton	ENT Surgery	VMO	01-Feb-14	31-Jan-17	$94,338.30
Dr	Storey	Desmond	General Dentistry	VMO	30-Nov-13	29-Nov-16	$33,029.93
Dr	Tharion	John	Thoracic Surgery	VMO	02-Aug-12	01-Aug-15	$476,881.87
Dr	Thomson	Andrew	Gastroenterology	VMO	01-Oct-07	01-Oct-14	$444,741.51
Dr	Tin	Stephen	Dental Surgery	VMO	01-Sep-07	01-Sep-14	$60,264.60

Title	Surname	First Name	Speciality	Description Of Contract	Date Contract Commences	Date Contract Expires	Total Amount (Exclusive of GST)
Dr	Tse	Heman	Anaesthesia	VMO	01-Apr-14	31-Mar-15	$43,071.85
Dr	Vrancic	Sindy	Orthopaedic Surgery	VMO	01-Sep-09	01-Sep-16	$173,591.51
Dr	Wilson	Michael	Anaesthesia	VMO	01-Nov-07	01-Nov-14	$95,429.50
Dr	Yousif	Khalid (Trauma & Medical Services Pty Ltd)	Emergency	VMO	23-Sep-13	22-Sep-14	$72,750.00
1.2 Mental Health, Justice Health and Alcohol and Drug Services							
Dr	Behrens	Raymond	Psychiatry	VMO	02-Jul-13	01-Jul-14	$35,813.33
Dr	Bromley	Jennifer	General Practice (Corrections Health Program)	VMO	07-Feb-14	06-Feb-17	$64,943.29
Dr	Crowder	Rachel	Psychiatry	VMO	06-Jan-14	05-Jan-15	$99,888.86
Dr	Eldridge	James Neil	General Practice (Corrections Health Program & Clinical Forensics ACT)	VMO	23-Dec-13	01-Feb-17	$206,424.33
Dr	Fernando	Sellupperumage Noel	Psychiatry	VMO	28-Feb-14	27-Feb-15	$167,217.19
Dr	Fitzgerald	Paul	Psychiatry	VMO	01-Aug-07	01-Aug-14	$164,743.70
Dr	George	Graham	Psychiatry	VMO	02-Dec-12	01-Dec-15	$39,520.57
Dr	Henderson	A Scott	Psychiatry	VMO	01-Nov-07	31-Oct-14	$220,212.25
Dr	Kasinathan	John	Psychiatry	VMO	01-Jul-08	01-Jul-15	$323,173.58
Dr	Manoharan	Jayaseelan Augosten	Psychiatry	VMO	19-May-14	18-May-15	$54,228.75
Dr	Owen	Cathy	Psychiatry	VMO	01-Nov-07	01-Nov-14	$102,066.42
Dr	Paull	Annita	Psychiatry	VMO	06-Feb-14	05-Feb-15	$166,148.33
Dr	Thomson	Graeme	General Practice (Corrections Health Program & Clinical Forensics ACT)	VMO	06-Jan-14	13-Jan-17	$217,311.35
Dr	Westcombe	David	Psychiatry	VMO	30-Nov-10	30-Nov-13	$168,228.99
Dr	Wurth	Peter	Psychiatry	VMO	01-Feb-08	31-Jan-15	$47,371.90
1.3 Public Health Services							
Dr	Harkness	Benjamin	General Practice	VMO	01-Apr-14	30-Jun-14	$55,878.15
Dr	Liang	Rachel	General Practitioner	VMO	24-Jul-12 29-Mar-14	23-Jul-13 30-Jun-14	$255,500.85
Dr	Mathew	Laji (L. Mathew Pty Ltd)	General Practice	VMO	02-Oct-12	01-Oct-15	$80,579.41
1.4 Cancer Services							
Drs	Applied Imaging Pty Ltd	Elizabeth Lim and Nigel Hunter	Radiology – BreastScreen	VMOs	01-Sep-08	01-Sep-15	$86,244.29
Dr	Bell	Susanne	Radiology – BreastScreen	VMO	11-Nov-11	10-Nov-14	$126,502.21
Dr	Chen	Suet Wan	Radiology – BreastScreen	VMO	01-Nov-11	31-Oct-14	$107,179.54
Dr	Cranney	Brendan	Radiology – BreastScreen	VMO	02-Jul-11	01-Jul-14	$42,765.18
Dr	Hazan	Georges	Radiology – BreastScreen	VMO	01-Sep-08	01-Sep-15	$256,013.21



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) for the year ended 30 June 2014 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.

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 2014, 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
16 September 2014

Health Directorate
Statement of Performance
For the Year Ended 30 June 2014

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 2014 and also fairly reflects the judgements exercised in preparing it.

Dr Peggy Brown
Director-General
Health Directorate
16 September 2014

Output Class 1: Health and Community Care

Output 1.1 Acute Services

Description

The Canberra Hospital provides 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 focusing on:

- implementing work arising from the National Health Reform Agreement (NHRA) which the Commonwealth Government has put into place, that contains a number of national partnerships and agreements, with the aim of improving services to the Australian community;
- strategies to improve access to emergency services under the NHRA;
- meeting the increasing demand for elective surgery in the Territory and reducing the number of people waiting longer than the recommended standard waiting times;
- strategies to meet performance targets for the emergency department, elective and emergency surgery; and
- continuing to increase the capacity of acute care services within the ACT and surrounding region.

	Original Target 2013–14	Amended Target 2013–14	Actual Result 2013–14	% Variance from Original/ Amended Target[1]	Explanation of Material Variances	Notes
Total Cost ($000's)	700,337	704,203	705,797	-		2
Government Payment for Outputs (GPO) ($000's)	83,832	87,224	83,564	–4%	The actual result is lower than target due to deferral of Commonwealth funding including the Improving Public Hospital and Treating more Public Dental Patients National Partnership Agreements to align revenue with the latest planned timing of delivery of services and delayed finalisation of some collective agreements.	2
Accountability Indicators Patient activity						
a. Admitted – National Weighted Activity Units {13}	78,680	62,217	61,705	-1%		3,4
b. Non-Admitted – National Weighted Activity Units {13}	33,945	23,023	23,107	-		3,5

Notes

1. *If the target has not been amended the variance is from the Original target, otherwise the variance is from the amended target.*
2. *The amended targets for Total Cost and Government Payment for Outputs relates to funding provided in the Appropriation Act, 2013–14 (No 2) for funding to cover payrises from collective agreement outcomes. In addition, the amended targets reflect changes in Commonwealth grant funding and other minor ACT Government transfers.*
3. *The original targets relating to National Weighted Activity Units (NWAU) were calculated incorrectly. New national counting rules provide guidelines as to how to count hospital activity. Errors were made in the application of these rules in setting targets for 2013–14. The errors related to the application of the calculation methods and the inclusion of some activity that is outside of the scope for the counting of public hospital services.*
4. *Acute services delivered at Canberra Hospital and Health Services, excluding those provided to cancer patients, rehabilitation patients or mental health patients. Activity measured as defined by the National Efficient Price Determination 2013–14 published by the Independent Hospital Pricing Authority. Acute services is care in which the clinical intent or treatment goal is to: manage labour; cure illness or provide treatment of injury; provide surgery; relieve symptoms of illness (excluding palliative care); reduce severity of an illness or perform diagnostic or therapeutic procedures.*
5. *Services provided to clients who were not admitted into hospital, measured in accordance with the National Efficient Price Determination 2013-14. It excludes activity provided for rehabilitation, cancer services or aged and community care.*

Output Class 1: Health and Community Care (continued)

Output 1.1 Acute Services (continued)

	Original Target 2013–14	Amended Target 2013–14	Actual Result 2013–14	% Variance from Original/ Amended Target[1]	Explanation of Material Variances	Notes
c. Emergency – National Weighted Activity Units {13}	7,534	8,115	8,172	1%		3,6
d. Mean waiting time for clients on the dental services waiting list	12 Months		5 months	–58%	The positive result is due to extra funding from the National Partnership Agreement (NPA) to reduce public waiting times. Additional staff have been employed and extra referrals directed to private dental practices.	7
e. 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%	-		8

Notes

6. *Services provided to clients in the emergency department of the hospital, measured in accordance with the National Efficient Price Determination 2013–14.*
7. *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.*
8. *This accountability indicator provides an indication of the availability of services.*

Output Class 1: Health and Community Care (continued)

Output 1.1 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 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; and
- providing hospital and community based alcohol and drug services and health care assessments for people detained in corrective facilities.

	Original Target 2013–14	Amended Target 2013–14	Actual Result 2013–14	% Variance from Original/ Amended Target[9]	Explanation of Material Variances	Notes
Total Cost ($000's)	122,129	124,316	120,289	–3%		10
Government Payment for Outputs (GPO) ($000's)	47,419	49,338	47,938	–3%		10
Accountability Indicators						
a. Admitted – National Weighted Activity Units {13}	3,507	2,586	2,944	14%	The variance is attributable to growth in demand for alcohol and drug services.	11,12
b. Non-Admitted – National Weighted Activity Units {13}	1,507	1,488	1,512	2%		11,12

Notes

9. *If the target has not been amended the variance is from the Original target, otherwise the variance is from the amended target.*
10. *The amended targets for Total Cost and Government Payment for Outputs relates to funding provided in the Appropriation Act, 2013–14 (No 2) for funding to cover payrises from collective agreement outcomes. In addition, the amended targets reflect changes in Commonwealth grant funding and other minor ACT Government transfers.*
11. *The original targets relating to National Weighted Activity Units (NWAU) were calculated incorrectly. New national counting rules provide guidelines as to how to count hospital activity. Errors were made in the application of these rules in setting targets for 2013–14. The errors related to the application of the calculation methods and the inclusion of some activity that is outside of the scope for the counting of public hospital services.*
12. *Services provided to clients by the Mental Health, Justice Health, Alcohol and Drug Services. Activity is measured in accordance with the National Efficient Price Determination 2013–14.*

Output Class 1: Health and Community Care (continued)

Output 1.2 Mental Health, Justice Health and Alcohol and Drug Services (continued)

	Original Target 2013–14	Actual Result 2013–14	% Variance from Original Target	Explanation of Material Variances	Notes
c. Adult mental health community service contacts	100,000	114,648	15%	The variance is attributable to growth in demand for services.	13
d. Children and youth mental health program community service contacts	65,000	63,430	–2%		14
e. ACT wide mental health program community service contacts	97,000	102,087	5%	The variance is attributable to growth in demand for services provided by the Crisis Assessment and Treatment Team.	15
f. Proportion of detainees at the Alexander Maconochie Centre with a completed health assessment within 24 hours of detention	100%	100%	-		16
g. Proportion of detainees in the Bimberi Youth Detention Centre with a completed health Assessment within 24 hours of detention	100%	98%	–2%		16
h. Justice Health Services community contacts	103,000	111,765	9%	The variance reflects demand due to an increased number of detainees at the Alexander Maconochie Centre (AMC).	17
i. Percentage of current clients on opioid treatment with management plans	98%	99%	1%		18
j. Alcohol and Drug Services Community contact	70,000	69,352	–1%		19

Notes

13. *Mental Health ACT Adult community occasions of services (Age group 18-64).*
14. *Mental Health ACT Children and Adolescents community occasions of service (Age group 0-17).*
15. *ACT wide mental health services community program includes Aboriginal and Torres Strait Islander Services, Mobile Intensive Treatment Team (MITT) North, Mental Health Service Intellectual Disability, Neuropsychology, Mental Health Dual Diagnosis, Crisis Assessment and Treatment Team (CATT) and Older Persons Mental Health Community team.*
16. *Percentage of detainees inducted into Bimberi and Alexander Maconochie 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 are excluded from this indicator.*
17. *Community service contacts are occasions of service with or about the client resulting in a dated entry in the clinical file. Service contacts include both direct and indirect clinical contact, reported for all community mental health service units in the Justice Health program.*
18. *On presentation for opioid replacement treatment, a management plan is developed. This indicator represents the percentage of clients with management plans.*
19. *Direct occasions of service with a client (appointment, contact or dose).*

Output Class 1: Health and Community Care (continued)

Output 1.3 Public Health Services

Description

Improving the health status of the ACT population through interventions which promote behaviour changes to reduce susceptibility to illness, alter the ACT environment to promote the health of the population and promote interventions that remove or mitigate population health hazards. This includes programs that evaluate and report on the health status of the ACT Population, assist in identifying particular health hazards and measure to reduce the risk to the health of the public from communicable diseases, environmental hazards and the supply of medicines and poisons.

	Original Target 2013–14	Amended Target 2013–14	Actual Result 2013–14	% Variance from Original/ Amended Target[20]	Explanation of Material Variances	Notes
Total Cost ($000's)	28,864	30,056	29,357	–2%		21
Government Payment for Outputs (GPO) ($000's)	25,850	26,896	25,904	–4%	The actual result is due deferral of Commonwealth funding mainly associated with the Improving Public Hospitals National Partnership Agreement to align revenue with the latest planned timing of delivery of services and delayed finalisation of some collective agreements.	21
Accountability Indicators						
a. Samples analysed	7,800		10,765	38%	Significant increase in samples analysed in particular in the area of asbestos and an increase in illicit drug seizures.	22
b. Compliance of licensable, registrable and non licensable activities at the time of inspection	85%		76%	–11%	The compliance rates recorded primarily relate to regulated food business. The non-compliance is a continuation of previous trends in food safety compliance which is attributed to routine inspections, complaint based inspections and re-inspections of non-compliant premises.	23
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%		97%	–3%		24

Notes

20. *If the target has not been amended the variance is from the Original target, otherwise the variance is from the amended target.*
21. *The amended targets for Total Cost and Government Payment for Outputs relates to funding provided in the Appropriation Act, 2013–14 (No 2) for funding to cover payrises from collective agreement outcomes. In addition, the amended targets reflect changes in Commonwealth grant funding and other minor ACT Government transfers.*
22. *Number of samples analysed during the period by the ACT Government Analytical Laboratory.*
23. *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.*
24. *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 Class 1: Health and Community Care (continued)

Output 1.4 Cancer Services

Description

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 cancer meet targets, waiting time for access to essential services such as radiotherapy are consistent with agreed benchmarks, and increasing the proportion of women screened through the BreastScreen Australia program for the target population (aged 50 to 69 years) to 70 per cent over time.

	Original Target 2013–14	Amended Target 2013–14	Actual Result 2013–14	% Variance from Original/ Amended Target[25]	Explanation of Material Variances	Notes
Total Cost ($000's)	70,609	70,938	68,491	–3%		26
Government Payment for Outputs (GPO) ($000's)	7,128	7,416	7,120	–4%	The actual result is due deferral of Commonwealth funding for the Improving Public Hospitals and Expansion of the BreastScreen Australia Program National Partnerships Agreements to align revenue with the latest planned timing of delivery of services delayed finalisation of some collective agreements.	26
Accountability Indicators						
a. Admitted – National Weighted Activity Units {13}	4,570	3,640	4,122	13%	There has been greater than anticipated demand for Cancer Services, particularly in the areas of Rheumatology and Immunology.	27,28
b. Non-Admitted National Weighted Activity Units {13}	1,963	1,605	1,658	3%		27,28

Notes:

25. If the target has not been amended the variance is from the Original target, otherwise the variance is from the amended target.

26. The amended targets for Total Cost and Government Payment for Outputs relates to funding provided in the Appropriation Act, 2013–14 (No 2) for funding to cover payrises from collective agreement outcomes. In addition, the amended targets reflect changes in Commonwealth grant funding and other minor ACT Government transfers.

27. The original targets relating to National Weighted Activity Units (NWAU) were calculated incorrectly. New national counting rules provide guidelines as to how to count hospital activity. Errors were made in the application of these rules in setting targets for 2013–14. The errors related to the application of the calculation methods and the inclusion of some activity that is outside of the scope for the counting of public hospital services.

28. Services provided to clients for cancer services, measured in accordance with the National Efficient Price Determination 2013–14. Non-admitted services relate to medical oncology (including chemotherapy), radiation oncology, immunology and haematology outpatient services at Canberra Hospital.

Output Class 1: Health and Community Care (continued)

Output 1.4 Cancer Services (continued)

	Original Target 2013–14	Actual Result 2013–14	% Variance from Original Target	Explanation of Material Variances	Notes
c. Total breast screens	14,907	16,379	10%	The target includes women in the primary Target Age Group (TAG) of 50-69, for which screens achieved exceeded the target by 280, and women Outside Of Target (OOT). OOT screens were the main contributor to the variance particularly women aged from 40-49 and women 70+ years. The OOT cohort made up a majority (62%) of the additional screens achieved and was primarily a result of a media campaign in December.	29
d. Number of breast screens for women aged 50 to 69	12,552	12,832	2%		30
e. Percentage of women who receive results of screen within 28 days	100%	100%	-		31
f. Percentage of screened patients who are assessed within 28 days	90%	93%	3%		32

Notes:

29. *Total number of women screened in the period.*
30. *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.*
31. *The percentage of women with a 'normal' result who receive notice of this outcome within 28 days of their screening appointment. Consistent with national methods, 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.*
32. *The percentage of women requiring assessment who wait 28 days or less from their breast screen appointment to their assessment appointment.*

Output Class 1: Health and Community Care (continued)

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 is 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.

	Original Target 2013–14	Amended Target 2013–14	Actual Result 2013–14	% Variance from Original/ Amended Target[33]	Explanation of Material Variances	Notes
Total Cost ($000's)	106,676	108,346	108,600	-		34
Government Payment for Outputs (GPO) ($000's)	36,036	37,502	35,889	–4%	The actual result is due to deferral of Commonwealth funding for the Improving Public Hospitals, Home and Community Care for Veterans and Indigenous Smoking Cessation Program National Partnership Agreements to align revenue with the latest planned timing of delivery of service and delayed finalisation of some collective agreements.	34
Accountability Indicators Patient activity						
a. Admitted – National Weighted Activity Units {13}	5,764	3,183	4,134	30%	At the time of setting the amended target, approximately 460 National Weighted Activity Units (NWAUS) were excluded in error. These records have now been included for performance reporting. NWAUs for this measure are dependent on patient length of stay. ACT Health delivered additional NWAUs due to higher levels of extended stay patients in 2013-14.	35,36
b. Non-Admitted – National Weighted Activity Units {13}	2,476	734	660	–10%	The variance relates to a small decline in the number of services (74 NWAUs).	35,36
h. Number of nursing (domiciliary and clinic based) occasions of service	82,000		78,677	–4%		37
i. Number of allied health regional services (occasions of service)	22,600		23,789	5%	The variance is due to a slight increase in staff positions and increase in clinical demand.	38

Notes

33. *If the target has not been amended the variance is from the Original target, otherwise the variance is from the amended target.*
34. *The amended targets for Total Cost and Government Payment for Outputs relates to funding provided in the Appropriation Act, 2013–14 (No 2) for funding to cover payrises from collective agreement outcomes. In addition, the amended targets reflect changes in Commonwealth grant funding and other minor ACT Government transfers.*
35. *The original targets relating to National Weighted Activity Units (NWAU) were calculated incorrectly. New national counting rules provide guidelines as to how to count hospital activity. Errors were made in the application of these rules in setting targets for 2013-14. The errors related to the application of the calculation methods and the inclusion of some activity that is outside of the scope for the counting of public hospital services.*
36. *Services provided to clients for rehabilitation, aged and community care measured in accordance with the National Efficient Price Determination 2013–14.*
37. *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.*
38. *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 Class 1: Health and Community Care (continued)

Output 1.6 Early Intervention and Prevention

Description

Improving the health and wellbeing of the ACT population through a range of programs, services and initiatives, focused on early intervention, prevention and health promotion. The key strategic priorities for early intervention and prevention include encouraging and promoting healthy lifestyle choices to decrease the rates of conditions like obesity and diabetes and reducing risky health behaviours such as smoking and alcohol consumption and maintaining high levels of immunisation.

	Original Target 2013–14	Amended Target 2013–14	Actual Result 2013–14	% Variance from Original/ Amended Target[39]	Explanation of Material Variances	Notes
Total Cost ($000's)	81,094	82,537	83,405	1%		40
Government Payment for Outputs (GPO) ($000's)	30,835	32,104	28,647	–11%	The variance relates mainly to the deferral of Commonwealth funding for Preventitive Health and Essential Vaccines National Partnership Agreements to align revenue with the latest planned timing for delivery of services.	40
Accountability Indicators						
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%		41
b. Proportion of clients attending 'Well Women's Check' within the Women's Health Service that are from culturally and linguistically diverse communities	35%		42%	20%	Increased targeting of culturally and linguistically diverse women through promotion of the location services are provided from an awareness of the services.	42
c. Proportion of children aged 0–14 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%		100%	25%	All clients referred to the Health Directorate received a health and wellbeing screen.	43

Notes

39. If the target has not been amended the variance is from the Original target, otherwise the variance is from the amended target.

40. The amended targets for Total Cost and Government Payment for Outputs relates to funding provided in the Appropriation Act, 2013–14 (No 2) for funding to cover payrises from collective agreement outcomes. In addition, the amended targets reflect changes in Commonwealth grant funding and other minor ACT Government transfers.

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

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

43. 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.

ANNEXED REPORTS
ATTACHMENT 1

ACT LOCAL HOSPITAL NETWORK DIRECTORATE

Management Discussion and Analysis for the ACT Local Hospital Network Directorate, For the Financial Year Ended 30 June 2014

General Overview

Purpose

The ACT Local Hospital Network Directorate (ACT LHN) was established under the *Health Act 1953* (the Act), and is administered by the Director-General of the Health Directorate and supported by staff from the Health Directorate.

The ACT Local Hospital Council (Council), constituted under the Act, provides advice to the Director-General of the Health Directorate on the clinical and corporate governance framework needed to support the improvement in standards of patient care and services provided through the ACT LHN. The Council also advises on way to support, encourage and facilitate community and clinician involvement in the planning of services that form part of the ACT LHN. The Council reports to the Minister for Health on the state of the ACT LHN and any recommendations relating to improvement of the ACT LHN that the Council considers necessary.

The ACT LHN receives Activity Based Funding (ABF) from both the Commonwealth and the ACT Governments, and block funding for teaching, training and research. It purchases pubic hospital services from four ACT public hospital providers:

- Canberra Hospital;
- Calvary Public Hospital;
- Clare Holland House; and
- Queen Elizabeth II Family Centre.

Risk Management

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

Estimated public hospital activity is higher than the actual activity delivered by the entities in the ACT Local Hospital Network that results in a reduction to funding from the Commonwealth Government.

The Commonwealth Government will fund 45 per cent of the growth in public hospital activity from 2014–15 and the ACT Government and the Directorate will agree on the process for managing fluctuation in activity and costs from 2014–15.

The above risk is monitored regularly throughout the year.

Financial Performance

The following financial information is based on the audited financial statements for 2013–14, and the forward estimates contained in the 2014–15 Health Directorate and ACT LHN Budget Statements.

Total Net Cost of Services

	Actual 2012–13 $m	Budget 2013–14 $m	Actual 2013–14 $m	Budget 2014–15 $m	Forward Estimate 2015–16 $m	Forward Estimate 2016–17 $m	Forward Estimate 2017–18 $m
Total Expenses	713.8	906.3	915.4	957.1	1,004.6	1,054.5	1,100.4
Total Own Source Revenue	165.0	356.3	377.2	355.3	384.5	416.0	453.3
Net Cost of Services	**548.8**	**550.0**	**538.2**	**601.8**	**620.1**	**638.5**	**647.1**

Comparison to Budget

The Directorate's net cost of services for 2013–14 of $538.2 million was $11.8 million or 2.2 per cent lower than the 2013–14 budget (refer to Attachment A). The decrease is mainly due to higher than budgeted cross border revenue following finalisation of a cross border agreement with the New South Wales Ministry of Health and updated estimates of revenue from Victoria.

Comparison to 2012–13 Actual Expenses

Future Trends

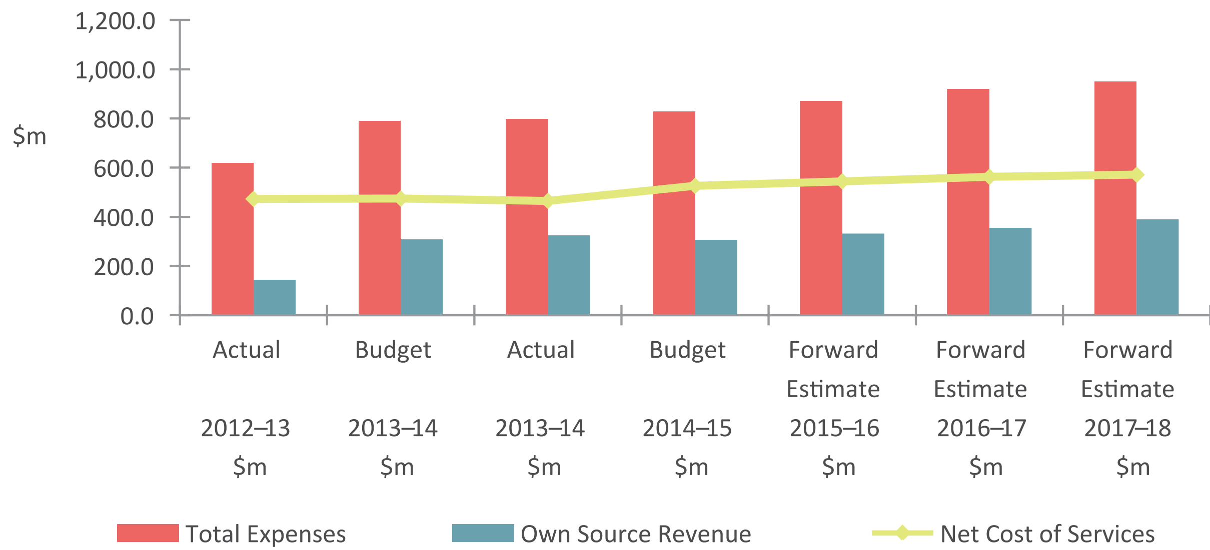


Figure 1: Net Cost of Services

As shown above in *Figure 1,* net cost of services is expected to slightly rise each year through to 2017–18.

Total Expenditure

Components of Expenditure

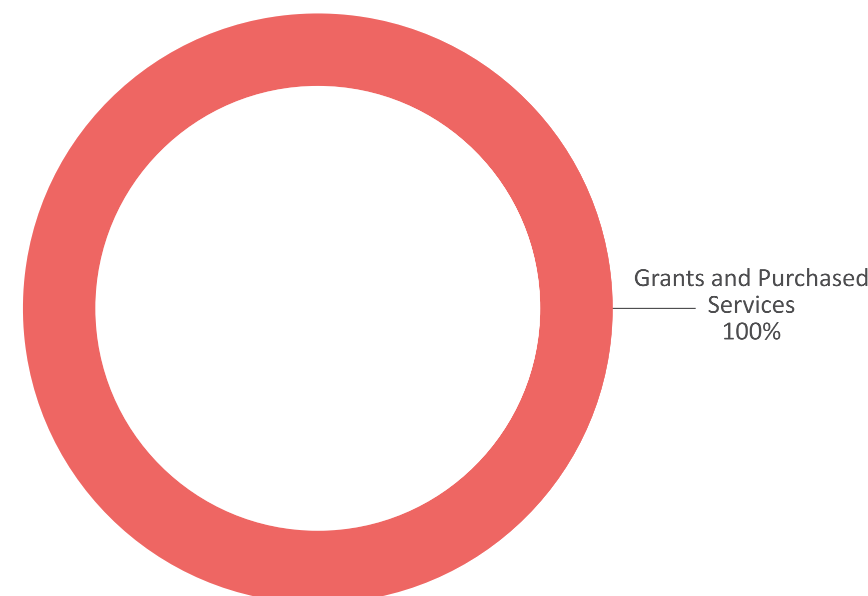


Figure 2 – Components of Expenditure

Figure 2 above shows that for the financial year ended 30 June 2014, the Directorate paid 100 per cent of expenditure to Grants and Purchased Services, spending a total of $915.4 million.

Comparison to Budget

Total expenses of $915.4 million were within $9.1 million, or 1.0 per cent of the original 2013–14 budget of $906.3 million.

Comparison to 2012–13 Actual Expenses

Total expenses were $201.6 million or 28.2 percent higher than the 2012–13 actual result. This was due to an increase in public hospital activities to be funded under the National Health Reform Agreement following a review of eligibility criteria, an increase in the National Efficient Price and growth in public hospital activities, including acute services, cancer services, rehabilitation, aged and community services and mental health services.

Future Trends

Expenses are budgeted to steadily increase until 2017–18.

Total Revenue

Components of Revenue

Figure 3 below indicates that for the financial year ended 30 June 2014, the Directorate received 59.3 per cent of its total revenue of $927.2 million from Government Payment for Outputs ($550.0 million), 11.0 per cent from Cross Border User Charges ($102.0 million), with the remaining 29.7 per cent made up of Grants from the Commonwealth ($275.2 million).

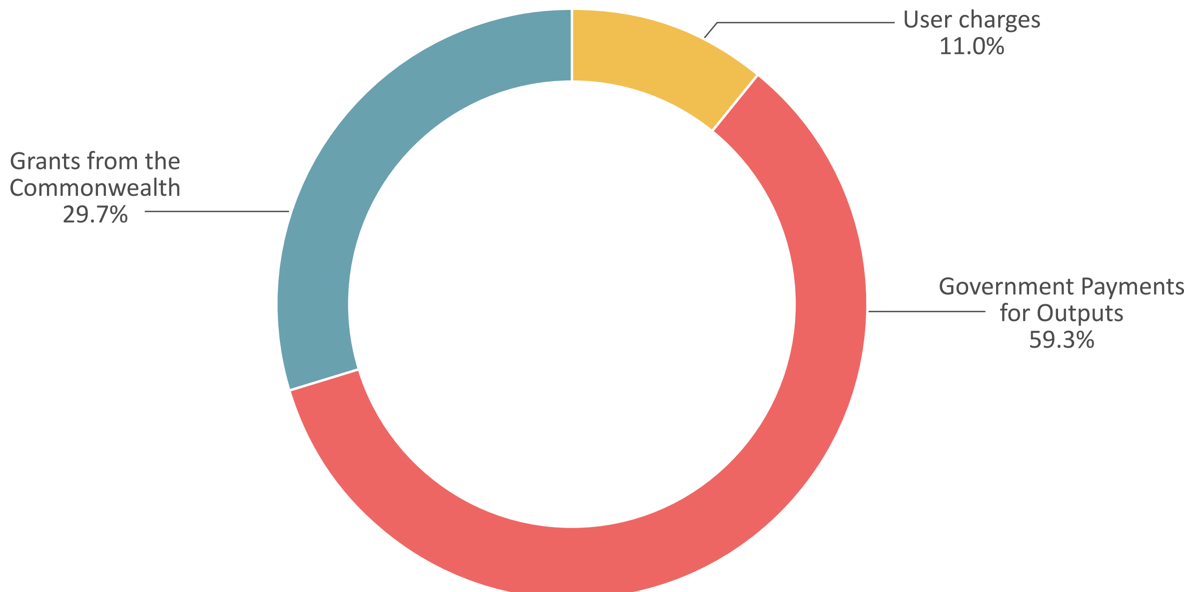


Figure 3 – Components of Own Source Revenue

Comparison to Budget

Own source revenue for the year ending 30 June 2014 was $377.2 million, which was $20.9 million or 5.9 per cent higher than the 2013–14 budget of $356.3 million. The increase is due to higher than budgeted cross border revenue.

Comparison to 2012–13 Actual Income

Own source revenue was $212.2 million or 128.6 percent higher than the 2012–13 result of $165.0 million.

This is due to delays in the prior year in the enactment of legislation to enable the establishment of the Local Hospital Network's National Health Funding Pool bank account. As a result of the delays in legislation, Commonwealth Government funding which was to be received as own source revenue was instead paid to the Chief Minister and Treasury Directorate and on-passed to the ACT Local Hospital Network Directorate as Government Payment for Outputs in 2012–13. In 2013–14 these funds were received by the Directorate as own source revenue.

Future Trends

Total own source revenue is expected to decrease slightly in 2014–15 and then increase steadily until 2017–18.

Financial Position

The purpose of the Directorate is to receive Activity Based and Block Funding from the National Health Funding Pool created under the National Health Reform Agreement, and to purchase hospital services from ACT public hospitals. The ACT Local Hospital Network Directorate was never intended to have assets nor liabilities on its balance sheet, therefore no budget was set.

Total Assets

Components of Total Assets

Figure 4 below indicates that, as at 30 June 2014, the Directorate held 66.1 per cent of its assets in receivables and 33.9 per cent in cash and cash equivalents.

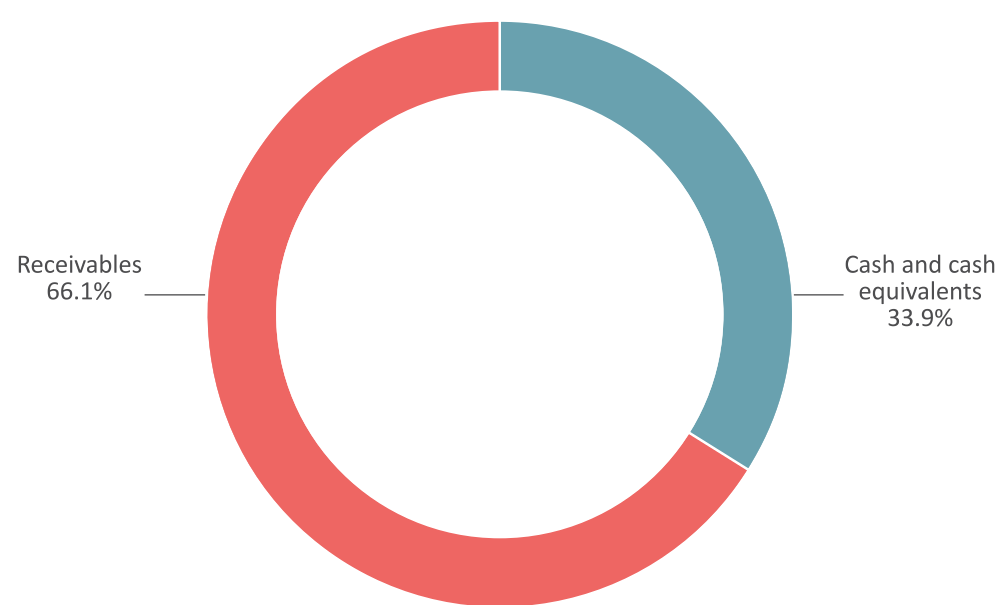


Figure 4 – Total Assets as at 30 June 2014

Comparison to Budget

The total asset position as at 30 June 2014 is $36.2 million, which is $36.2 million higher than the nil 2013–14 budget.

The variance reflects the increase in:

- Cash and Cash Equivalents ($12.3 million) – partially due to the provision of a cash buffer from Chief Minister and Treasury Directorate to allow for the timing of Goods and Services Tax (GST) transactions and the receipt of outstanding 2012–13 cross border revenue; and
- Receivables ($23.9 million) – which relates to the cross border receivables from other jurisdictions for the treatment of their residents in ACT hospitals and an Australian Taxation Office refund for GST.

Comparison to 2012–13 Actual

The Directorate's total asset position is $50.6 million lower than the 2012–13 actual result of $86.8 million. This is mainly due to a lower amount of cross border receivables owing from the New South Wales Ministry of Health for the treatment of their residents in ACT hospitals in 2013–14. The 2012–13 amount was high due to the delay in finalising a cross border agreement with the New South Wales Ministry of Health until 2013–14.

Total Liabilities

Components of Total Liabilities

Figure 5 below indicates that 100 per cent of the Directorate's liabilities relates to payables.

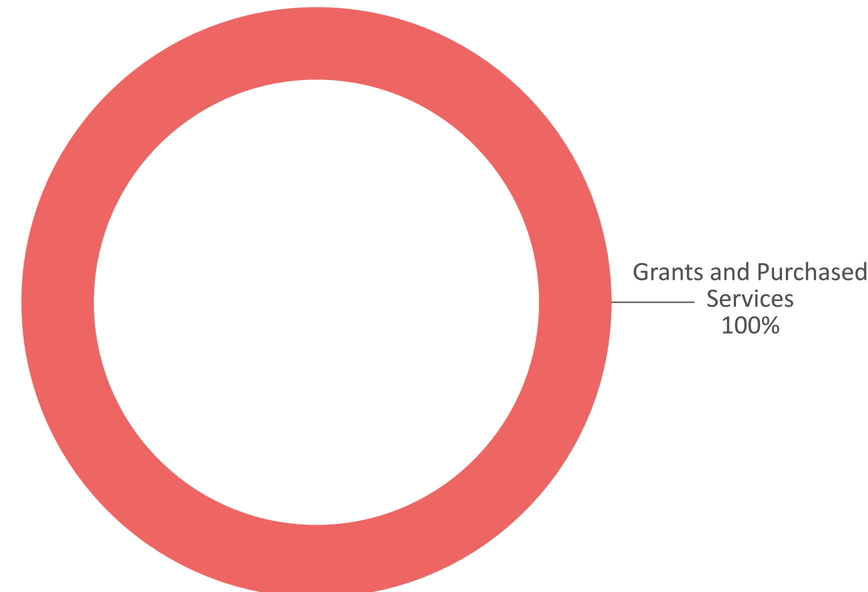


Figure 5 – Total Liabilities as at 30 June 2014

Comparison to Budget

The Directorate's liabilities as at 30 June 2014, of $9.3 million, are $9.3 million higher than the nil 2013-14 budget.

This is due to payables ($9.3 million) which relates to cross border payables owed to other jurisdictions for admitted and non-admitted patient services provided to residents of the ACT in hospitals outside of the ACT.

Comparison to 2012–13 Actual

Total liabilities were $62.5 million lower than the actual results as at 30 June 2013 of $71.8 million.

This is due to lower payables ($62.5 million) which relates to cross border payments having been owed in the prior year to the Health Directorate as well as to other jurisdictions.

Net Assets

The Directorate's net assets as at 30 June 2014 were $26.8 million higher than the nil position budgeted.

This is mainly due to cross border revenue being higher than the budget for the last two financial years.

Attachment A – Comparison of net cost of services to budget 2013–14

Description	Original Budget $'000	Plus AAO Transfers $'000	Total Funding $'000	Less Actual $'000	Variance to be Explained $'000	Variance to be Explained %
Expenses						
Purchased Services	886,520	–	886,520	915,400	–28,800	–3.3%
Other Expenses	14,420	–	14,420	-	14,420	100.0%
Transfer Expenses	5,400	–	5,400	0	5,400	100.0%
Total Expenses	**906,340**	**–**	**906,340**	**915,400**	**9,060**	**-1.0%**
Own Source Revenue						
User Charges	76,750	–	76,750	101,992	–25,242	–32.9%
Grants from the Commonwealth	279,536	–	279,536	275,181	4,355	1.6%
Total Own Source Revenue	**356,286**	**–**	**356,286**	**377,173**	**20,887**	**–5.9%**
Total Net Cost of Services	**550,054**	**–**	**550,054**	**538,227**	**11,827**	**2.2%**

AUDITOR-GENERAL AN OFFICER OF THE ACT LEGISLATIVE ASSEMBLY

INDEPENDENT AUDIT REPORT

ACT LOCAL HOSPITAL NETWORK DIRECTORATE

To the Members of the ACT Legislative Assembly

Report on the financial statements

The financial statements of the ACT Local Hospital Network Directorate (the Directorate) for the year ended 30 June 2014 have been audited. These comprise the operating statement, balance sheet, statement of changes in equity, cash flow statement, statement of appropriation and accompanying notes.

Responsibility for the financial statements

The Director-General of the Health 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 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.

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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 2014:

(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 2014 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
5 September 2014

ACT Local Hospital Network Directorate
Financial Statements
For the Year Ended 30 June 2014

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 2014 and the financial position of the Directorate on that date.

Dr Peggy Brown

Director-General

ACT Local Hospital Network Directorate

2 September 2014

ACT Local Hospital Network Directorate
Financial Statements
For the Year Ended 30 June 2014

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 2014 and the financial position of the Directorate on that date.

R Foster

Mr Ron Foster

Chief Finance Officer

ACT Local Hospital Network Directorate

2 September 2014

ACT Local Hospital Network Directorate Controlled Financial Statements For The Year Ended 30 June 2014

ACT Local Hospital Network Directorate Operating Statement For the Year Ended 30 June 2014

	Note No.	Actual 2014 $'000	Original Budget 2014 $'000	Actual 2013 $'000
Income				
Revenue				
Government Payment for Outputs	3	550,054	550,054	560,272
User Charges–Non-ACT Government	4	101,992	76,750	83,300
Grants from the Commonwealth	5	275,181	279,536	81,695
Total Revenue		**927,227**	**906,340**	**725,267**
Total Income		**927,227**	**906,340**	**725,267**
Expenses				
Grants and Purchased Services	6	910,084	886,520	708,909
Other Expenses [a]		-	14,420	-
Transfer Expenses	7	5,316	5,400	4,842
Total Expenses		**915,400**	**906,340**	**713,751**
Operating Surplus		**11,827**	**-**	**11,516**
Total Comprehensive Income		**11,827**	**-**	**11,516**

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 ACT Local Hospital Network Output Class. A separate disaggregated disclosure note has therefore not been included in these Financial Statements.

a. 'Cross Border Health Costs' payable to New South Wales was classified as 'Other Expenses' in the budget. As actual costs of $23.6 million in 2013–14 ($15.5 million in 2012–13) are 'Grants and Purchased Services', the actual results have been classified as 'Grants and Purchased Servies'.

ACT Local Hospital Network Directorate
Balance Sheet
For the Year Ended 30 June 2014

	Note No.	Actual 2014 $'000	Original Budget 2014 $'000	Actual 2013 $'000
Current Assets				
Cash and Cash Equivalents	11	12,277	-	2,323
Receivables	12	23,827	-	84,477
Other Assets	13	79	-	-
Total Current Assets		**36,183**	**-**	**86,800**
Total Assets		**36,183**	**-**	**86,800**
Current Liabilities				
Payables	14	9,340	-	71,784
Total Current Liabilities		**9,340**	**-**	**71,784**
Total Liabilities		**9,340**	**-**	**71,784**
Net Assets		**26,843**	**-**	**15,016**
Equity				
Accumulated Funds		26,843	-	15,016
Total Equity		**26,843**	**-**	**15,016**

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 ACT Local Hospital Network Output Class. A separate disaggregated disclosure note has therefore not been included in these Financial Statements.

ACT Local Hospital Network Directorate
Statement of Changes in Equity
For the Year Ended 30 June 2014

	Accumulated Funds Actual 2014 $'000	Total Equity Actual 2014 $'000	Original Budget 2014 $'000
Balance at 1 July 2013	**15,016**	**15,016**	**-**
Comprehensive Income			
Operating Surplus	11,827	11,827	-
Total Comprehensive Income	**11,827**	**11,827**	**-**
Transactions Involving Owners Affecting Accumulated Funds			
Capital Injections	-	-	-
Total Transactions Involving Owners Affecting Accumulated Funds	**11,827**	**11,827**	**-**
Balance at 30 June 2014	**26,843**	**26,843**	**-**

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

	Accumulated Funds Actual 2013 $'000	Total Equity Actual 2013 $'000
Balance at 1 July 2012	**-**	**-**
Comprehensive Income		
Operating Surplus	11,516	11,516
Total Comprehensive Income	**11,516**	**11,516**
Transactions Involving Owners Affecting Accumulated Funds		
Capital Injections	3,500	3,500
Total Transactions Involving Owners Affecting Accumulated Funds	**3,500**	**3,500**
Balance at 30 June 2013	**15,016**	**15,016**

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

ACT Local Hospital Network Directorate
Cash Flow Statement
For the Year Ended 30 June 2014

	Note No.	Actual 2014 $'000	Original Budget 2014 $'000	Actual 2013 $'000
Cash Flows from Operating Activities				
Receipts				
Government Payment for Outputs		550,054	550,054	560,272
User Charges		162,730	76,750	-
Grants Received from Commonwealth		275,181	279,536	81,695
Goods and Services Tax Input Tax Credits from the Australian Taxation Office		18,634	-	14,372
Total Receipts from Operating Activities		**1,006,599**	**906,340**	
Payments				
Grants and Purchased Services		972,608	886,520	637,125
Goods and Services Tax Paid to Suppliers		18,721	-	15,549
Other		-	14,420	-
Payments to the Health Directorate		5,316	5,400	4,842
Total Payments from Operating Activities		**996,645**	**906,340**	**657,516**
Net Cash Inflows/(Outflows) from Operating Activities	**19**	**9,954**	**-**	**(1,177)**
Cash Flows from Financing Activities				
Receipts				
Capital Injections		-	-	3,500
Total Receipts from Financing Activities		**-**	**-**	**3,500**
Net Cash Inflows from Financing Activities		**-**	**-**	**3,500**
Net Increase in Cash and Cash Equivalents		**9,954**	**-**	**2,323**
Cash and Cash Equivalents at the Beginning of the Reporting Period		2,323	-	-
Cash and Cash Equivalents at the End of the Reporting Period		**12,277**	**-**	**2,323**

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

ACT Local Hospital Network Directorate Controlled Statement of Appropriation For the Year Ended 30 June 2014

	Original Budget 2014 $'000	Total Appropriated 2014 $'000	Appropriation Drawn 2014 $'000	Appropriation Drawn 2013 $'000
Controlled				
Government Payment for Outputs	550,054	554,427	550,054	560,272
Capital Injections	-	-	-	3,500
Total Controlled Appropriation	**550,054**	**554,427**	**550,054**	**563,772**

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 Total Appropriated to the Directorate relates to a new Commonwealth agreement 'Public Hospital System – Additional Funding'. The Public Hospital System – Additional Funding was introduced by the Federal Government to offset reductions in the National Health Reform Agreement associated with indexation and population adjustments.

Variances between 'Total Appropriated' and 'Appropriation Drawn'

Government Payment for Outputs

The difference between the Total Appropriated and the Appropriation Drawn relates to the timing of payment by the Commonwealth for the new funding agreement 'Public Hospital System – Addition Funding'. The payment was received by the ACT Government on the 27th June 2014 which did not allow enough time for onpassing to the Directorate.

ACT Local Hospital Network Directorate
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Note 1. Objectives of the ACT Local Hospital Network Directorate

Operations and Principal Activities

The ACT Local Hospital Network Directorate (the Directorate) is administrated by the Director-General of the Health Directorate and supported by Health Directorate staff.

The ACT Local Hospital Council (the Council) provides advice to the Director-General on the clinical and corporate governance framework needed to support improvement of standards of patient care and services under the local hospital network and ways in which to support, encourage and facilitate community and clinician involvement in the planning of services that form part of the Directorate.

The Council also reports to the Minister for Health on the state of the local hospital network and any recommendations relating to the improvement of health services provided by the Directorate that the Council considers necessary.

The Directorate receives Activity Based Funding from the Commonwealth and ACT Governments and block funding for teaching, training, research and community mental health. It purchases public hospital services from four ACT public hospital providers:

- Canberra Hospital and Health Services;
- Calvary Public Hospital;
- Clare Holland House; and
- Queen Elizabeth II Family Centre.

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:

ii. an Operating Statement for the year;
iii. a Balance Sheet at the end of the year;
iv. a Statement of Changes in Equity for the year;
v. a Cash Flow Statement for the year;
vi. a Statement of Appropriation for the year;
vii. an Operating Statement for each class of output for the year;
viii. a summary of the significant accounting policies adopted for the year; and
ix. 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.

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.

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

The Directorate is an individual reporting entity.

Note 2. Summary of Significant Accounting Policies (continued)

(b) Controlled and Territorial Items

The Directorate produces Controlled financial statements. The Controlled financial statements include income, expenses, assets and liabilities over which the Directorate has control.

The Directorate does not produce Territorial financial statements because it does not administer any resources on behalf of the Territory.

(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 2014 together with the financial position of the Directorate as at 30 June 2014.

(d) Comparative Figures

Budget Figures

To facilitate a comparison with Budget Papers, as required by the *Financial Management Act 1996*, budget information for 2013–2014 has been presented in the financial statements. Budget numbers in the financial statements are the original budget numbers that appear in the Budget Papers.

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:

Government Payment for Outputs

Government Payment for Outputs are recognised as revenues when the Directorate gains control over the funding. Control over appropriated funds is normally obtained upon the receipt of cash.

Cross Border (Interstate) Health Revenue

Revenue for cross border (interstate) health services is recognised when the number of patients and complexities of treatments provided can be measured reliably using the National Efficient price that is determined by the Independent Hospital Pricing Authority. 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.

The National Health Reform Agreement specifies that each jurisdiction will make funding contributions through the National Health Funding Pool for services provided by other jurisdictions to its residents either on an ad hoc basis reflecting actual activity, or on a regular basis as scheduled through a Cross Border agreement. For 2013–14 the ACT has Cross Border Agreement in place with the New South Wales Ministry of Health, South Australia Department of Health and Tasmania Department of Health and Human Services.

Note 2. Summary of Significant Accounting Policies (continued)

(f) Revenue Recognition (continued)

Commonwealth Grants

Commonwealth Grants relate to Activity Based Funding and Block Funding under the National Health Reforms. They also include the Commonwealth funding component of cross border health costs for New South Wales residents treated in ACT public hospitals.

Activity Based Funding refers to a system for funding public hospital services provided to individual patients using national classifications, price weights and nationally efficient price as set by the Independent Hospital Pricing Authority.

Block funding is provided to support public hospital functions that are recognised by the Independent Hospital Pricing Authority as services acceptable to be funded on this basis and that conform to the Independent Hospital Pricing Authority's national pricing model.

Revenue Received in Advance

Revenue Received in Advance is recognised as a liability if there is a present obligation to return the funds received, otherwise all funds received are recorded as revenue.

(g) Waivers of Debt

Debts that are waived during the year under Section 131 of the *Financial Management Act 1996* are expenses during the year in which the right to payment was waived. Further details of waivers are disclosed at Note 9: Waivers, Impairment Losses and Write-offs.

(h) 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.

(i) 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.

Note 2. Summary of Significant Accounting Policies (continued)

(j) Receivables

Accounts receivable 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.

Accrued Cross Border revenue relates to the estimated number of interstate patients treated in an ACT public hospital for 2013–14. Under the National Health Reform Agreement, States and Territories are required to pay for Cross Border activity using the National Efficient Price that is determined by the Independent Hospital Pricing Authority. The actual level of revenue will be subject to an acquittal process to be completed in subsequent years.

The allowance for impairment losses represents the amount of 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 off against the allowance 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.

(k) Payables

Payables are a financial liability and are initially recognised at fair value based on the transition costs and subsequent to initial recognition at amortised cost, 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.

(l) Employee Costs and Employee Benefits Liabilities

The Directorate was established as a consequence of the ACT implementing the National Health Reform Agreement. The objective of the Directorate is to receive Activity Based Funding and Block Funding from the Commonwealth and ACT Governments, and to purchase hospital services from ACT public hospitals. The Directorate does not employ any staff. All staff providing administrative support are employed by the Health Directorate. Therefore, the Directorate does not incur any employee costs and does not have any employee benefit liabilities.

(m) Equity Contributed by the ACTGovernment

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.

(n) 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:

Cross Border (Interstate) Health Receivables: is an estimation based on the number of interstate patients converted into a National Weighted Activity Unit and paid at the National Efficient Price consistent with the National Health Reform Agreement. Interstate patient numbers for the current year is an estimation based on the actual patient numbers for the nine months to 31 March 2014. 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.

Note 2. Summary of Significant Accounting Policies (continued)

(o) 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 2017);
- AASB 127 Separate Financial Statements (application date 1 January 2014 for not-for-profit entities);
- AASB 1031 Materiality (application date 1 January 2014);
- AASB 1055 Budgetary Reporting (application date 1 July 2014);
- AASB 2010-7 Amendments to Australian Accounting Standards arising from AASB 9 (December 2010) [AASB 1, 3, 4, 5, 7, 101, 102, 108, 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 2017);
- AASB 2011-7 Amendments to Australian Accounting Standards arising from the Consolidation and Joint Arrangements Standards [AASB 1, 2, 3, 5, 7, 9, 2009-11, 101, 107, 112, 118, 121, 124, 132, 133, 136, 138, 139, 1023 & 1038 and Interpretations 5, 9, 16 & 17] (application date 1 January 2014 for not-for-profit entities);
- AASB 2012-3 Amendments to Australian Accounting Standards – Offsetting Financial Assets and Financial Liabilities [AASB 132] (application date 1 January 2014);
- AASB 2013-3 Amendments to AASB 136 Recoverable Amount Disclosures for Non-Financial Assets (application date 1 January 2014);
- AASB 2013-8 Amendments to Australian Accounting Standards – Australian Implementation Guidance for Not-for-Profit Entities – Control and Structured Entities [AASB 10, AASB 12 & AASB 1049] (application date 1 January 2014); and
- AASB 2013-9 Amendments to Australian Accounting Standards – Conceptual Framework, Materiality and Financial Instruments Part B Materiality (application date 1 January 2014) Part C Financial Instruments (application date 1 January 2015).

Note 3. Government Payment for Outputs

Government Payment for Outputs (GPO) is revenue received from the ACT Government for the purchase of hospital services from ACT public hospitals. The ACT Government pays GPO appropriation on a fortnightly basis.

	2014 $'000	2013 $'000
Revenue from the ACT Government		
Government Payment for Outputs[a]	550,054	560,272
Total Government Payment for Outputs	**550,054**	**560,272**

a. The 2012–13 amount includes part year funding from the Commonwealth as, until the *Health (National Health Funding Pool and Administration) Act 2013*, was enacted, the Commonwealth made payments to the ACT Treasury which were passed onto the LHN Directorate as Government Payment for Outputs. In 2013–14 these Commonwealth payments are included in the Grants from the Commonwealth revenue item. The 2013–14 amount also includes an increase in funding for growth in patient activity for acute services, cancer services, rehabilitation, aged and community services and mental health services.

Note 4. User Charges – Non-ACT Government

User charge revenue is derived by providing public hospital services to interstate residents. User charge revenue is not part of ACT Government appropriation and is paid by other state or territory governments. This revenue is driven by demand for health services from interstate patients and is not for profit in nature.

	2014 $'000	2013 $'000
User Charges – Non-ACT Government		
Cross Border (Interstate) Health Revenue[a]	101,992	83,300
Total User Charges – Non-ACT Government	**101,992**	**83,300**

a. The increase is due to higher levels of interstate patient numbers treated in the ACT, finalisation of prior year acquittals for several jurisdictions and an increase in the National Efficient Price.

Note 5. Grants from the Commonwealth

Grants from the Commonwealth reflect contributions from the Commonwealth for Activity Based Funding and Block Funding, as well as a contribution for public health services.

	2014 $'000	2013 $'000
Grants from the Commonwealth		
Grants[a]	275,181	81,695
Total Grants from the Commonwealth	**275,181**	**81,695**

a. The 2012–13 amount is only part year funding from the Commonwealth as, until the *Health (National Health Funding Pool and Administration) Act 2013* was enacted, the Commonwealth made payments to ACT Treasury which were passed onto the Directorate as Government Payment for Outputs. The higher 2013–14 amount is for a full financial year and also includes an increase in the National Efficient Price and growth in activity for public hospital services funded through the National Health Reform Agreement.

Note 6. Grants and Purchased Services

Grants and Purchased Services reflect public hospital payments to the Canberra Hospital and Health Services, Calvary Public Hospital, Clare Holland House, Queen Elizabeth II Hospital, and other states and territory for cross border patient services.

	2014 $'000	2013 $'000
Purchased Services		
Payments to Service Providers		
– Canberra Hospital and Health Services[a]	711,956	537,917
– Calvary Public Hospital[a]	167,133	148,517
– Clare Holland House	4,870	4,564
– Queen Elizabeth II Hospital	2,482	2,410
Cross Border (Interstate) Health Costs[b]	23,643	15,501
Total Grants and Purchased Services	**910,084**	**708,909**

a. The increase is mainly due to additional public hospital services considered as satisfying the Commonwealth's criteria for activity based funding, an increase in the National Efficient Price and growth in public hospital services.

b. The increase is mainly due to additional public hospital services considered as satisfying the Commonwealth's criteria for activity based funding, finalisation of prior year acquittals for several jurisdictions and an increase in the National Efficient Price.

Note 7. Transfer Expenses

Transfer Expenses relate to the on-passing of Commonwealth public health funding to the Health Directorate.

	2014 $'000	2013 $'000
Transfer Expenses[a]	5,316	4,842
Total Transfer Expenses	**5,316**	**4,842**

a. The increase is due to indexation and population growth factors in the Health Specific Purpose Payment.

Note 8. Auditor's Remuneration

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

	2014 $'000	2013 $'000
Audit Services		
Audit Fees Paid or Payable to the ACT Auditor-General's Office	44	50
Total Audit Fees	**44**	**50**

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

All amounts in the Auditor's Remuneration note are inclusive of GST.

Note 9. 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 Directorate had no waivers, impairment losses or write-offs in 2013–14 (nil, 2012–13).

Note 10. Act of Grace Payments

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

The Directorate made no Act of Grace Payments during 2013–14 (nil, 2012–13).

Note 11. Cash and Cash Equivalents

The Directorate holds a number of bank accounts on which it does not earn interest. These funds are able to be withdrawn upon request.

	2014 $'000	2013 $'000
Cash at Bank[a]	12,277	2,323
Total Cash and Cash Equivalents	**12,277**	**2,323**

a. The increase is due to the payment, in 2013–14, by the New South Wales Ministry of Health of cross border receivables.

Note 12. Receivables

	2014 $'000	2013 $'000
Current Receivables		
Accrued Revenue[a]	22,563	83,300
Net GST Receivable	1,264	1,177
Total Current Receivables	**23,827**	**84,477**
Total Receivables	**23,827**	**84,477**

a. The reduction is due to a lower amount of cross border monies being owed by the New South Wales Ministry of Health. No payments were made by the New South Wales Ministry of Health in 2012–13 due to a delay in the finalisation of the Cross Border Agreement.

Ageing of Receivables	Not Overdue $'000	Overdue Less Than 30 days $'000	Overdue 30 to 60 days $'000	Overdue Greater Than 60 days $'000	Total $'000
2014					
Not Impaired Receivables[a]	23,827	-	-	-	23,827
Impaired Receivables	-	-	-	-	-
2013					
Not Impaired Receivables	84,477	-	-	-	84,477
Impaired Receivables	-	-	-	-	-

a. This mainly relates to cross border receivables, for admitted and non-admitted patient services provided to residents of the states and territory. 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.

	2014 $'000	2013 $'000
Classification of ACT Government/Non-ACT Government Receivables		
Receivables with Non-ACT Government Entities		
Other Receivables	22,563	83,300
Net Good and Services Tax Receivables	1,264	1,177
Total Receivables with Non-ACT Government Entities	23,827	84,477
Total Receivables	**23,827**	**84,477**

Note 13. Other Assets

	2014 $'000	2013 $'000
Current Other Assets		
Prepayment	79	-
Total Current Other Assets	**79**	**-**
Total Other Assets	**79**	**-**

Note 14. Payables

	2014 $'000	2013 $'000
Current Payables		
Accrued Expenses[a]	9,340	71,784
Total Current Payables	**9,340**	**71,784**
Total Payables	**9,340**	**71,784**

a. The 2012–13 figure included accrued cross border expenses owing to the Health Directorate. This was related to the timing of finalisation of the cross border payables agreement with the New South Wales Ministry of Health.

	2014 $'000	2013 $'000
Payables are aged as follows:		
Not Overdue	9,340	71,784
Overdue for Less than 30 Days	-	-
Overdue for 30 to 60 Days	-	-
Overdue for More than 60 Days	-	-
Total Payables	**9,340**	**71,784**

Classification of ACT Government/Non-ACT Government Payables		
Payables with ACT Government Entities		
Accrued Expenses[a]	-	56,283
Total Payables with ACT Government Entities	**-**	**56,283**
Payables with Non-ACT Government Entities		
Accrued Expenses[b]	9,340	15,501
Total Payables with Non-ACT Government Entities	**9,340**	**15,501**
Total Payables	**9,340**	**71,784**

a. This is accrued cross border expenses owed to the Health Directorate in the prior year for admitted and non-admitted patient services provided to residents of the states and territory in the Canberra Hospital and Health Services.

b. This is accrued cross border expenses owed to the states and territory for admitted and non admitted patient services provided to residents of the ACT in the states and territory. The reduction is mainly due to the commencement, in 2013–14, of provisional payments to the New South Wales Ministry of Health.

Note 15. 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 is considered to have no exposure to interest rate risk, as it holds only cash and cash equivalents with Westpac Banking Corporation and Reserve Bank of Australia that generate no interest, and receivables are non-interest bearing.

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

Note 15. 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. The Directorate's credit risk is limited to the amount of the financial assets held less any allowance for impairment.

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

Cash and cash equivalents are held with the Westpac Banking Corporation, a high credit, quality financial institution, in accordance with whole of ACT Government banking arrangements at year end and the Directorate holds no investments.

The Directorate's receivables mainly consist of amounts owed from the New South Wales Ministry of Health. As the New South Wales Government has a AAA credit rating it is considered that there is a very low risk of default for these receivables. Any credit risk for receivables with New South Wales Ministry of Health is managed by having an agreement in place, providing required activity data in a timely manner and requiring provisional payments for these activities.

Liquidity Risk

Liquidity risk is the risk that the Directorate will encounter difficulties in meeting obligations associated with financial liabilities that are settled by delivering cash or another financial asset.

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.

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 by factors affecting all similar financial instruments traded in the market.

The Directorate holds no financial instruments 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.

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 2014 $'000	Fair Value 2014 $'000	Carrying Amount 2013 $'000	Fair Value 2013 $'000
Financial Assets				
Cash and Cash Equivalents	12,277	12,277	2,323	2,323
Receivables	22,563	22,563	83,300	83,300
Total Financial Assets	**34,840**	**34,840**	**85,623**	**85,623**
Financial Liabilities				
Payables	9,340	9,340	71,784	71,784
Total Financial Liabilities	**9,340**	**9,340**	**71,784**	**71,784**

Note 15. 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 2014. 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:				
	Note No.	Weighted Average Interest Rate	Floating Interest Rate $'000	1 Year or Less $'000	Over 1 to 5 Years $'000	Over 5 Years $'000	Non-Interest Bearing $'000	Total $'000
Financial Instruments								
Financial Assets								
Cash and Cash Equivalents	11		-	-	-	-	12,277	12,277
Receivables	12		-	-	-	-	22,563	22,563
Total Financial Assets			**-**	**-**	**-**	**-**	**34,840**	**34,840**
Financial Liabilities								
Payables	14		-	-	-	-	9,340	9,340
Total Financial Liabilities			**-**	**-**	**-**	**-**	**9,340**	**9,340**
Net Financial Assets			**-**	**-**	**-**	**-**	**25,500**	**25,500**

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 2013. 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:				
	Note No.	Weighted Average Interest Rate	Floating Interest Rate $'000	1 Year or Less $'000	Over 1 to 5 Years $'000	Over 5 Years $'000	Non-Interest Bearing $'000	Total $'000
Financial Instruments								
Financial Assets								
Cash and Cash Equivalents	11			-	-	-	2,323	2,323
Receivables	12		-	-	-	-	83,300	83,300
Total Financial Assets			**-**	**-**	**-**	**-**	**85,623**	**85,623**
Financial Liabilities								
Payables	14		-	-	-	-	71,784	71,784
Total Financial Liabilities			**-**	**-**	**-**	**-**	**71,784**	**71,784**
Net Financial Assets			**-**	**-**	**-**	**-**	**13,839**	**13,839**

Carrying Amount of Each Category of Financial Asset and Financial Liability	2014 $'000	2013 $'000
Financial Assets		
Loans and Receivables Measured at Amortised Cost	22,563	83,300
Financial Liabilities		
Financial Liabilities Measured at Amortised Cost	9,340	71,784

Fair Value Hierarchy

The Directorate does not have any financial assets or financial liabilities at fair value. As such no Fair Value Hierarchy disclosures have been made.

Note 16. Commitments

The Directorate has no commitments as at 30 June 2014 (nil, 30 June 2013).

Note 17. Contingent Liabilities and Contingent Assets

There were no contingent liabilities or contingent assets as at 30 June 2014 (nil, 30 June 2013). There were no indemnities as at 30 June 2014 (nil, 30 June 2013).

Note 18. Events Occurring After Balance Date

There were no events occurring after the balance date, which would affect the financial statements as at 30 June 2014, or in the future reporting periods.

Note 19. 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	2014 $'000	2013 $'000
Total Cash and Cash Equivalents Recorded in the Balance Sheet	12,277	2,323
Cash and Cash Equivalents at the End of the Reporting Period as Recorded in the Cash Flow Statement	**12,277**	**2,323**

b. Reconciliation of Net Cash Outflows from Operating Activities to the Operating Surplus/(Deficit)	2014 $'000	2013 $'000
Operating Surplus	11,827	11,516
Cash Before Changes in Operating Assets and Liabilities	**11,827**	**11,516**
Changes in Operating Assets and Liabilities		
(Decrease/Increase) in Receivables	60,650	(84,477)
(Increase) Decrease in Other Assets	62,444	-
(Decrease)/Increase in Payables	(67,749)	71,784
Net Changes in Operating Assets and Liabilities	**1,873**	**(12,693)**
Net Cash Inflows/(Outflows) from Operating Activities	**9,954**	**(1,177)**

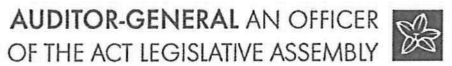
Note 20. Service Concession Assets

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 2013–14 financial year was $175.1 million (2012–13 $167.8 million) in recurrent funding, recognised in the Health Directorate's ($3.1 million) and the ACT Local Hospital Network Directorate's ($172.0 million) grants and purchased services expenditure. In addition there was $3.85 million for capital projects and $0.76 million for capital upgrades of assets subject to these service concession arrangements. The capital funding was administered through the Health Directorate Statement of Income and Expenses on Behalf of the Territory.

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



REPORT OF FACTUAL FINDINGS

ACT LOCAL HOSPITAL NETWORK DIRECTORATE

To the Members of the ACT Legislative Assembly

Report on the statement of performance

The statement of performance of the ACT Local Hospital Network Directorate (the Directorate) for the year ended 30 June 2014 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 2014, 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.

M. Cooper.

Dr Maxine Cooper
Auditor-General
2 September 2014

ACT Local Hospital Network Directorate
Statement of Performance
For the Year Ended 30 June 2014

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 2014 and also fairly reflects the judgements exercised in preparing it.

Dr Peggy Brown
Director-General
Health Directorate
18 August 2014

Output Class 1: ACT Local Hospital Network

Description

The ACT Local Hospital Network receives funding under National Health Reform Agreement and purchases public hospital services from the Canberra Hospital and Health Services, Calvary Public Hospital, Clare Holland House and Queen Elizabeth II Family Centre.

	Original Target 2013–14	Amended Target 2013–14	Actual Result 2013–14	% Variance from Original/ Amended Target[1]	Explanation of Material Variances	Notes
Total Cost ($000's)	906,340		915,400	1%	The increase relates mainly to higher cross border payments associated with changes through the National Health Reform Agreement. The changes also resulted in increased revenue being received by the Territory.	
Government Payment for Outputs (GPO) ($000's)	550,054		550,054	-		
Accountability Indicators **Number of National Weighted Activity Units**						
a. Admitted	109,948	95,358	94,856	–1%		2,3
b. Non-Admitted	39,810	9,770	17,832	83%	The variance is due to increased capacity to capture records that meet national counting requirements. Under these requirements, only records that can be identified by a Medicare number are considered in-scope by the National Health Funding Body. Many non-admitted services can be counted as in scope public hospital activity. When setting the amended target, most of these records could not be included in the estimate as the Medicare number was not known. The Medicare number has now been attached to these records, which enables the Directorate to include these services in the actual result.	2,3

Notes

1. *If the target has not been amended the variance is from the original target, otherwise the variance is from the amended target.*
2. *The original targets relating to National Weighted Activity Units (NWAU) were calculated incorrectly. New national counting rules provide guidelines as to how to count hospital activity. Errors were made in the application of these rules in setting targets for 2013-14. The errors related to the application of the calculation methods and the inclusion of some activity that is outside of the scope for the counting of public hospital services.*
3. *Activity purchased by the Local Hospital Network is consistant with the criteria in the National Health Reform Agreement. Activity is measured in National Weighted Activity Units (Version 13/14) as defined by the Independent Hospital Pricing Authority's National Efficient Price Determination 2013–14. At the time of publication, admitted data was 96.75% coded and extrapolated for the full year, and non-admitted data was fully coded.*

	Original Target 2013–14	Amended Target 2013–14	Actual Result 2013–14	% Variance from Original/ Amended Target[4]	Explanation of Material Variances	Notes
c. Emergency	14,153	13,648	13,663	-		5,6
d. Total	163,911	118,776	126,351	6%	The variance is a direct consequence of the issue relating to adjustments applied to non-admitted patient data (please see indicator 1.b) which forms part of the total for this measure.	5,6
e. Percentage of mental health clients with outcome measures completed	65%		64%	–2%		7
f. Proportion of mental health clients contacted by a Health Directorate community facility within 7 days post discharge from inpatient services	75%		88%	17%	Community follow-up post discharge from an acute inpatient facility continues to reflect the high rate of contact in the ACT. This is consistent with the results achieved above target for service contacts at Health Directorate 1.2.c and 1.2.e. Almost all public mental health inpatient episodes are within the ACT wide and Adult Mental Health Program population.	8

Notes

4. *If the target has not been amended the variance is from the original target, otherwise the variance is from the amended target.*
5. *The original targets relating to National Weighted Activity Units (NWAU) were calculated incorrectly. New national counting rules provide guidelines as to how to count hospital activity. Errors were made in the application of these rules in setting targets for 2013-14. The errors related to the application of the calculation methods and the inclusion of some activity that is outside of the scope for the counting of public hospital services.*
6. *Activity purchased by the Local Hospital Network is consistent with the criteria in the National Health Reform Agreement. Activity is measured in National Weighted Activity Units (Version 13/14) as defined by the Independent Hospital Pricing Authority's National Efficient Price Determination 2013–14. At the time of publication, admitted data was 96.75% coded and extrapolated for the full year, and emergency data was fully coded.*
7. *Proportion of eligible mental health registered clients receiving ongoing mental health care having clinical outcome measures completed appropriate to each episode of care and service setting and the outcome measure collection protocol. Service settings included are inpatient, community and residential care. All age groups included. Eligible clients are people receiving mental health services on an ongoing basis, have a case manager assigned and are in contact with mental health services in the reference period.*
8. *The proportion of clients admitted to a public mental health acute inpatient facility within the Local Hospital Network and having direct contact with mental health services within seven days post discharge. Day of discharge is not included as part of the seven days. Same day admissions are excluded.*

CALVARY HEALTH CARE LTD

Annual performance statement 2013–14

Calvary Health Care ACT delivers public health and hospital services from Calvary Health Care Bruce and from Clare Holland House in Barton. Calvary's services are available to any person in need, and we provide comfort and healing mainly to ACT residents and people from surrounding communities.

Calvary Health Care ACT provides services on behalf of the ACT Government. Funding and services are negotiated annually and formalised in the Calvary Network Agreement.

Calvary Health Care Bruce is a fully accredited health service comprising 275 beds in the Bruce and Barton campuses. The modern facilities are recognised for contemporary and multidisciplinary team-based care. At both campuses the natural environment contributes to holistic healing.

Calvary Health Care Bruce is Canberra's second major public hospital and health service, and works in partnership with other acute care and community services. The ACT Government and Calvary are committed to expanding the services on the campus to meet the needs of the growing ACT population.

Calvary enjoys a reputation in the Canberra community for exemplary care. Services at the Bruce campus include:

- a 24/7 emergency department
- intensive and coronary care
- medical and surgical inpatient services
- maternity services
- aged care and rehabilitation services
- voluntary psychiatric services
- specialist outpatient clinics, and
- the Hospital in the Home service.

Calvary Health Care Bruce is a teaching hospital associated with the Australian Catholic University, the Australian National University and the University of Canberra.

Calvary Health Care Bruce operates the ACT Specialist Community Palliative Care Service. This comprises:

- Clare Holland House, the 19-bed inpatient and respite hospice
- palliative care outpatients clinic, and
- palliative care in residential settings.

The Calvary services in the ACT continue the mission of the Sisters of the Little Company of Mary by responding to the needs of the communities we serve.

Achievements

During 2013–14, Calvary Health Care dealt with:

- 55,276 emergency department presentations (preliminary)
- 5051 elective surgery procedures (preliminary)
- 880 emergency surgery procedures (preliminary)
- 1760 births (preliminary), and
- 24,915 cost weights total activity (preliminary).

During 2013–14, Calvary implemented a consistent program of facility and service enhancement. Service enhancements included:

- refinement of patient flow processes, featuring improved discharge planning
- expansion of the Calvary Hospital in the Home program
- formalising more efficient and rapid admission of patients from the emergency department
- introducing 24-hour emergency surgery capability not reliant on on-call staffing
- developing and introducing the continuity of a midwifery care model to operate in parallel with the traditional maternity model of care
- designing and commencing both a Rapid Assessment and Planning Unit and a Medical Assessment and Planning Unit for medical patients
- designing and commencing a four-bed Stroke Service Unit, and
- commencing specialist outpatient clinics.

- Facility enhancements in the reporting period included:
  - design and construction of the Calvary Birth Centre
  - design and construction of the Rapid Assessment and Planning Unit, the Medical Assessment and Planning Unit and the Stroke Service Unit
  - establishment of the dedicated outpatient clinic accommodation, and the fit-out of office and administration accommodation for the consultant medical officers
  - progressive replacement of floor coverings in public and clinical areas in accordance with hygiene and infection-control best practice
  - introduction of public wi-fi in the emergency department and public areas of Calvary
  - upgrading of utilities, and
  - establishment of the Calvary Health Care Bruce Business Support Facility in Thynne Street, which is formative to the expansion of clinical services on the Bruce campus.

We are extremely proud that these facility enhancements were completed without disrupting the provision of clinical and medical services. These achievements represent the collective work and collaboration of our facilities team, our users, consumers and project groups, and a diverse group of contractors.

In particular, Calvary recognises the involvement of the Barmco Mana Partnership, an ACT 2014 Telstra Australian Business Awards finalist in the micro-business category, who provided us with a construction and engineering consultancy built around re-engineering existing facilities to accommodate new and contemporary clinical and other services. Their philosophy is strongly aligned with our value of stewardship.

Issues and challenges

Calvary Health Care Bruce is responding to the recognised growth in demand for public health services in the ACT and across Australia. The immediate issue at the Bruce campus is the pressure on car parking that, at busy times, inhibits convenient access to the campus for patients and visitors.

The 2014–15 ACT Budget includes funding for the construction of a 700-space multi-level car park. This project will commence in the second half of 2014 and is expected to take 12 months. The nearby Bruce CIT has offered off-site parking for Calvary staff, and this will ensure the least possible impact on patients and visitors while a large part of the existing car park capacity is taken up with the building works.

While originally seen as a northside hospital in Canberra, Calvary Health Care Bruce is becoming increasingly central in population distribution terms, with ACT population growth rates and numbers being highest in Gungahlin and Molonglo. This foreshadows growing demand for Calvary's services and significant variations in the demographic of our nearby populations.

Calvary and the ACT Government work closely to monitor these trends and to ensure that the services most needed are accessible and available. In the meantime, role delineation supported by formal clinical services networks between Calvary Health Care and Canberra Hospital and Health Services ensures efficient and clinically safe pathways and agreed procedures and protocols to govern the transfer and escalation of patient care.

Future directions

The ACT Government Health Infrastructure Program describes the plans for facility and service expansion on the Calvary Health Care Bruce campus. This program identifies as a priority for 2014–15 the centralisation of elective ophthalmology services at Calvary as well as additional beds in the second year of a four-year program at Calvary Bruce.

The general expansion of the public hospital capacity at Calvary Bruce has been foreshadowed. This will be enabled by the relocation of Calvary Private Hospital from the sixth floor of the Xavier Building later in this decade.

Complementing these physical developments, Calvary Health Care Bruce will continue to improve processes to make more efficient use of the resources at our disposal. This embraces bed management and patient flow, improved theatre utilisation, expanded multidisciplinary care commenced earlier in the patient journey, and increased engagement with patients around their acute and ongoing care programs.

Calvary Health Care Bruce will also assess the opportunities for safe and high-quality care to be provided in non-acute settings. The existing Hospital in the Home program and the successful provision of palliative care in a residential setting provide ample evidence that patients can be properly cared for, feel connected and safe, and make clinical progress in a non-acute setting.

Calvary is committed to partnering with the ACT Government to explore and embrace new technology and new thinking, whilst still holding firm to kind and compassionate human values, and to continue to provide consistently high-quality care to our patients and support to their families.

ACT CARE COORDINATOR

Annual Report, December 2012 to 30 June 2014

The following report is made in compliance with section 120E of the *Mental Health (Treatment and Care) Act 1994.*

The ACT Care Coordinator is a statutory appointment made by the Minister for Health, under Section 120A of the ACT *Mental Health (Treatment and Care) Act 1994*. The ACT Care Coordinator is responsible for the coordination of the provision of treatment, care and support to people with a mental dysfunction in accordance with community care orders made by the ACT Civil and Administrative Tribunal (ACAT). The Executive Officer for the ACT Care Coordinator was located within the Public Advocate of the ACT until December 2012 and resumed this function in February 2014. ACT Health provided administrative support to the ACT Care Coordinator during the period from December 2012 to February 2014.

During the period 1 January 2013 to 30 June 2014, a total of 23 people were subject to a Community Care Order (CCO). There were 14 men and 9 women for whom community care orders were made. There were 17 people for whom new community care orders were made and 6 people had orders reviewed and renewed. During the period for the 23 CCOs made, 9 people were referred by the courts, 13 people were referred by clinical services and one person was referred by their family.

For the 23 people subject to CCOs: 5 people had an intellectual disability, 8 people had dementia, 2 had an acquired brain injury, 2 people had personality disorders and 3 people had alcohol dependency problems. Another 3 people had individual conditions, including severe self-harming behaviours in young people, and neurological conditions (other than dementia).

Ages:

Age	≤18	19–29	30–39	40–49	50–59	60–69	70–79	80+
Number	2	7	3	1	2	2	3	3

As at 30 June 2014 there are 5 people subject to a community care order. Four of these orders are newly made orders and one order has been reviewed and renewed.

Ms Marina Buchanan-Grey
Acting ACT Care Coordinator
25 August 2014

CHIEF PSYCHIATRIST

Annual Report 2013–14

The *Mental Health (Treatment and Care) Act 1994* was implemented in the Australian Capital Territory (ACT) on 6 February 1995.

Section 120

A report prepared by the Chief Psychiatrist under the *Annual Reports (Government Agencies) Act 2004* for a financial year must include:

a. statistics in relation to people who have a mental illness during the year

b. details of any arrangements with New South Wales (NSW) during the year in relation to people who have a mental illness.

Emergency apprehension

The following table shows the number of emergency apprehensions in 2013–14, with a breakdown of who initiated them.

Emergency apprehensions (total)	Police officer	Mental health officer	Medical practitioner
968	695	169	104

Emergency detention

The following table shows the number of emergency detention notifications issued in 2013–14 in comparison to previous years. Applications for extension of emergency detention (for a further period of up to seven days) and applications for mental health orders and variations of mental health orders are made to the ACT Civil and Administrative Tribunal (ACAT).

Emergency detentions			
July 2010–June 2011	July 2011–June 2012	July 2012–June 2013	July 2013–June 2014
596	614	689	596

Outcome of those detained

	July 2010–June 2011	July 2011–June 2012	July 2012–June 2013	July 2013–June 2014
Revocation of 72-hour detention and/or 72-hour detention being allowed to lapse	322	389	363	295
Applications for extension of involuntary detention	274	225	326	299

Psychiatric treatment orders

Under the *Mental Health (Treatment and Care) Act 1994*, the Chief Psychiatrist is responsible for the treatment and care of a person to whom a psychiatric treatment order (PTO) applies. The maximum duration of a PTO is six months.

	July 2010–June 2011	July 2011–June 2012	July 2012–June 2013	July 2013–June 2014
PTOs granted by the tribunal	884	864	924	890
PTOs revoked	119	148	127	167
Breach of PTO	59	76	82	80
Restriction orders	3	5	16	15

Other matters

The *Mental Health (Treatment and Care) Act 1994* provides for the authorisation of involuntary electro-convulsive therapy (ECT), including emergency ECT. It also has provisions for the interstate application of mental health laws, including for the transfer of people to and from the ACT.

The *Crimes Act 1900* provides for the court to order removal of an individual to the Canberra Hospital for the purposes of an emergency assessment to determine whether immediate treatment and care are required.

	July 2010–June 2011	July 2011–June 2012	July 2012–June 2013	July 2013–June 2014
Application for ECT authorised	17	16	13	7
Application for emergency ECT authorised	2	1	1	0
Transfers to/from NSW	4	10	8	9
Court ordered removal for assessment—s309 of the *Crimes Act 1900*	36	54	40	44

Key points arising

The following trends in key areas of activity related to the Office of the Chief Psychiatrist are noteworthy.

In 2013–14, 968 people were apprehended and brought to the Canberra Hospital for assessment. This is an increase of 10 per cent from the previous year, when it was 876. Emergency detention revocations have decreased from 363 to 295, an 18 per cent decrease from the previous year and a 27 per cent decrease over the last two reporting periods. This reflects continuing efforts to move to least restrictive care at an early opportunity if at all possible. There was also an 8 per cent decrease in the number of applications for extension of further involuntary detention (of up to seven days), indicating the treating team's efforts to continue to appropriately stabilise an acute episode of illness. As previously reported, an increased stability during an admission provides a greater chance of successful ongoing management when a person is discharged to the community. ACAT held 1265 hearings throughout the year and granted 890 PTOs. This is a decrease of 3 per cent from 2012–13. Upon application by a consultant psychiatrist, or of its own motion, ACAT revoked 167 orders, compared to 127 in the previous reporting period.

There were seven electro-convulsive therapy applications authorised, a significant decrease from the previous year. There were no applications for emergency ECT made to the tribunal.

Eight cross-border agreements were made between the ACT and NSW. The ACT accepted six transfers from NSW, and two transfers were made to NSW facilities. One transfer was also made to a Queensland facility.

Breaches of PTOs decreased from 82 to 80 in 2013–13. This amounts to a decrease of 2.5 per cent from 2012–13. Thirty-eight people were brought to the Mental Health Assessment Unit for medication or assessment purposes, and nine were admitted to hospital as a result. Community teams make every effort to anticipate and manage crises early. Often, if this is successful, a breach is not required.

The ACT Magistrates Court made 44 referrals for assessment pursuant to section 309 of the *Crimes Act 1900*, an increase of 10 per cent from the previous year. Of these, 27 people required admission to the Adult Mental Health Unit for assessment purposes, with 17 being returned to court on the same day. The Court Assessment Liaison Service continues to provide assessment and advice to the courts at the time of the hearing, which in many circumstances means that a section 309 referral is not required.

The review of the current *Mental Health (Treatment and Care) Act 1994* continues, and a revised amendment bill was presented to cabinet during the first half of 2014.

Plans are in place for the anticipated requirements for training for the revised Act, particularly to support, educate and familiarise clinicians with accompanying changes in assessment and practice.

Dr Peter Norrie
Chief Psychiatrist

HUMAN RESEARCH ETHICS COMMITTEE

Annual Report 2013–14

The ACT Health Human Research Ethics Committee (HREC) continues its work of reviewing human research proposals to ensure they meet the ethical standards set out in the National statement on ethical conduct in human research (2007), prepared by the National Health and Medical Research Council (NHMRC), the Australian Research Council and the Australian Vice-Chancellors' Committee. During the reporting period, HREC has been an active contributor to the NHMRC consultation process on the proposed national reforms in research ethics administration.

HREC and its subcommittees aim to provide ethical review and approval in the shortest possible time, conscious of the pressures on researchers and their teams. During the reporting period, HREC reviewed 93 research applications, with an average time of 33.6 days from submission to approval. The Low Risk Subcommittee reviewed 207 submissions.

HREC has continued to prepare for the advent of national programs of single ethical approval of multisite research. The Research Ethics and Governance Manager, August Marchesi, has continued to represent HREC and ACT Health on the Jurisdictional Working Group that is progressing the single review system.

The Clinical Trials Subcommittee (CTSC), the Social Research Subcommittee (SRSC) and the Survey Resource Group (SRG) have continued to provide HREC with expert advice on the merit and integrity of research proposals. The Low Risk Subcommittee (LRSC), which reviewed more than two-thirds of all proposals received, has been expanded to a core membership of three long-term members, including a medical member, a social researcher and a chair. The aim of this change is to provide more consistency in decisions and a breadth of expertise commensurate with the variety of proposals that come forward. All three current members of LRSC are also HREC members.

In April 2014, Professor John SG Biggs, long-serving HREC Chairman, retired from the committee. I am very pleased to have this opportunity to thank Professor Biggs for his dedication to HREC and to acknowledge the many valuable improvements made by HREC under his leadership. On behalf of HREC, its subcommittees and support staff, I wish Professor Biggs the very best in his future endeavours.

HREC and its subcommittees draw on the expertise available in ACT Health, the wider ACT research community and more broadly the ACT community. The current Chair has an earlier academic background in sociology and anthropology and more recent experience at senior levels in the Commonwealth Public Service.

I would like to thank the members of HREC and its subcommittees for their hard work and dedication to the enterprise of ethical review. On behalf of the committee, thanks is given to the administrative staff, August Marchesi and Gillian Fox, for their tireless work in keeping HREC and its processes operating at the highest standards.

Louise Morauta

Louise Morauta PSM PhD
Chair

Membership of the committee

Professor John Biggs	Chairman (resigned April 2014)
Dr Louise Morauta	Chair (from April 2014), lay member (2010–14)
Associate Professor Peter Hickman	Deputy Chair
Professor Walter Abhayaratna	clinical member (cardiology)
Professor Geoff Farrell	clinical member (hepatology)
Professor Doug Boer	member providing health care (psychology)
Associate Professor Frank van Haren	clinical member (intensive care)
Associate Professor Marian Currie	member with research experience (nursing and midwifery)
Dr Dipti Talaulikar	clinical member (haematology)
Dr Jason Mazanov	member with research experience (psychology)
Dr Ray Lovett	member with Aboriginal and Torres Strait islander health research expertise
Rev Doug Hutchinson	member providing pastoral care
Luke Williamson	lay member
Kimberley Baillie	lawyer member (alternate)
John Morrissey	lawyer member (alternate)
Lyn Todd	member with pharmacy expertise
Julie Kussy	member with nursing expertise

Number of research projects

During 2013–14, HREC reviewed 93 proposals; 82 were approved. Of the remaining 11 proposals, four were withdrawn by the applicant, four were quality-improvement activities that did not require ethical approval, and three remain in consultation, progressing towards approval.

Meetings

The committee met 11 times from 1 July 2013 to 30 June 2014. Meetings are held monthly.

Subcommittees

The Clinical Trials Subcommittee (CTSC) reviewed 39 proposals, in each instance making recommendations to the main committee.

The Social Research Subcommittee (SRSC) reviewed 40 proposals, in each instance making recommendations to the main committee.

The Low Risk Subcommittee (LRSC) reviewed 207 proposals and approved 172. Of the remaining 35, six were referred for consideration by the main committee, two were withdrawn by the applicant, 19 are in consultation towards approval and, due to a change in guidelines provided by the NHMRC, eight proposals were deemed quality-improvement activities and did not require ethical approval.

The Survey Resource Group (SRG) reviewed 94 proposals. In 60 instances the SRG provided recommendations to either HREC or LRSC. In 34 cases the SRG provided endorsement of projects not requiring ethical review.

Key points arising

Throughout 2013, the Chairman and Manager assessed the readability of participant information sheets submitted with research proposals. In November, Professor Biggs presented the findings of this project at the Australasian Ethics Network Conference in Fremantle, Western Australia. An article has been prepared and publication is pending.

RADIATION COUNCIL

Annual Report 2013–14

Chair's review

It is my pleasure to present the Annual Report of the Radiation Council for 2013–14.

Membership of the council changed significantly during the reporting period, with three longstanding members retiring in 2013. Tony Agostino, Keith Fifield and Jean Bennett donated their time and provided a wealth of knowledge to council, with their appointments to council amounting to a combined 51 years of experience. I would like to take this opportunity to thank these past members for the significant contribution they have made to radiation safety in the ACT, and wish them well for their future endeavours.

The council welcomes three new members, Ms Pamela Brown, Dr Stephen Tims and Dr Donald McLean who were appointed in December 2013 for a three-year term. Dr Mervyn Despois and I were reappointed for a three-year term commencing December 2013, joining existing members Dr Sean Geoghegan and Dr Ahmad Javaid. During this appointment process I was appointed as Chair of the council, and Dr Geoghegan was appointed as Deputy Chair.

The council has had a productive year, continuing to issue licences, register radiation sources and consider issues that may affect the ACT community with regard to radiation safety and protection.

I wish to express my appreciation to the members of the council for their expert contribution and to the staff of the Health Protection Service for their ongoing support.

Council functions

The *Radiation Protection Act 2006* (www.legislation.act.gov.au) controls the safe use, storage, transportation and disposal of radioactive material and irradiating apparatus. The Radiation Council is established under Part 5 of the *Radiation Protection Act 2006*, and has the following functions:

- issuing licences
- registering regulated radiation sources
- advising the minister on radiation protection issues
- exercising any other function given to it under the *Radiation Protection Act 2006* or another territory law.

Council membership

The composition of the Radiation Council is specified in section 65 the *Radiation Protection Act 2006.* There are currently seven members appointed to the council.

Name	Position Held	Appointed Until
Elizabeth Croft	Chair	30 November 2016
Sean Geoghegan	Deputy Chair	30 September 2015
Mervyn Despois	Member	30 November 2016
Donald McLean	Member	30 November 2016
Stephen Tims	Member	30 November 2016
Ahmad Javaid	Member	30 September 2015
Pamela Brown	Community Representative	30 November 2016
Tony Agostino	Outgoing Chair	30 November 2013
Keith Fifield	Outgoing Deputy Chair	30 November 2013
Jean Bennett	Outgoing Member	30 November 2013

Council meetings 2013–14

The council meets approximately every six weeks and met eight times during the year. Meetings were held in August, September, October and December of 2013 and in January, March, April and May of 2014.

Regulatory standards

A number of standards, codes of practice, safety guides, and recommendations are referred to by council when considering matters relating to radiation protection, and when issuing licences and approving registrations under the Radiation Protection Act 2006. This includes documents in the ARPANSA Radiation Protection Series, which are available free of charge from www.arpansa.gov.au.

National Directory for Radiation Protection

The *National Directory for Radiation Protection* (the Directory) provides the basis for achieving uniformity of radiation protection practices across Australian jurisdictions, and is an incorporated document under the *Radiation Protection Act 2006*. The Directory is designed to be regularly updated to reflect the best radiation protection practice of the time. The Directory is prepared by the ARPANSA Radiation Health Committee, and is only updated in accordance with prescribed processes.

The Directory was republished in February 2014 to include Amendment No.6. This amendment added exemption requirements for lighting products that include krypton-85, clarified competency requirements for chiropractors that use x-ray equipment, and updated schedule 13, which relates to the national incident reporting framework.

The council is regularly briefed on developments with regard to the work of the ARPANSA Radiation Health Committee. ACT Health has a jurisdictional representative appointed to the committee.

Approvals and decisions

Licences

The council issued 188 new licences during the 2013–14 year, while 131 licences were not renewed. Overall this represents a 5.1 per cent increase (57 licences), bringing the total number of licence holders in the ACT to 1114.

Registrations

The council registered 69 new radiation sources during the 2013–14 year, while 36 sources were decommissioned or transferred interstate. Overall this represents a 5.6 per cent increase (33 sources), bringing the total number of registered radiation sources in the ACT to 586.

Radiation incidents

The following radiation incidents were reported to the council during the year and underwent further investigation:

- Dental sources: one incident involved equipment malfunction
- Soil density gauges: one incident involved damage to, or malfunctioning of, a radiation apparatus or sealed source.

In line with the ACT Health Risk Management Guidelines, the incident with the dental source was deemed insignificant and required no further action. The incident with the soil density gauge was considered to be of minor consequence and was referred to ARPANSA for inclusion on the Australian Radiation Incident Register. Both of the areas involved reviewed their working systems and where necessary amended procedures to reduce the likelihood of similar incidents occurring in the future.

Enforcement and remedial actions by the council

No investigations or legal proceedings were commenced in 2013–14.

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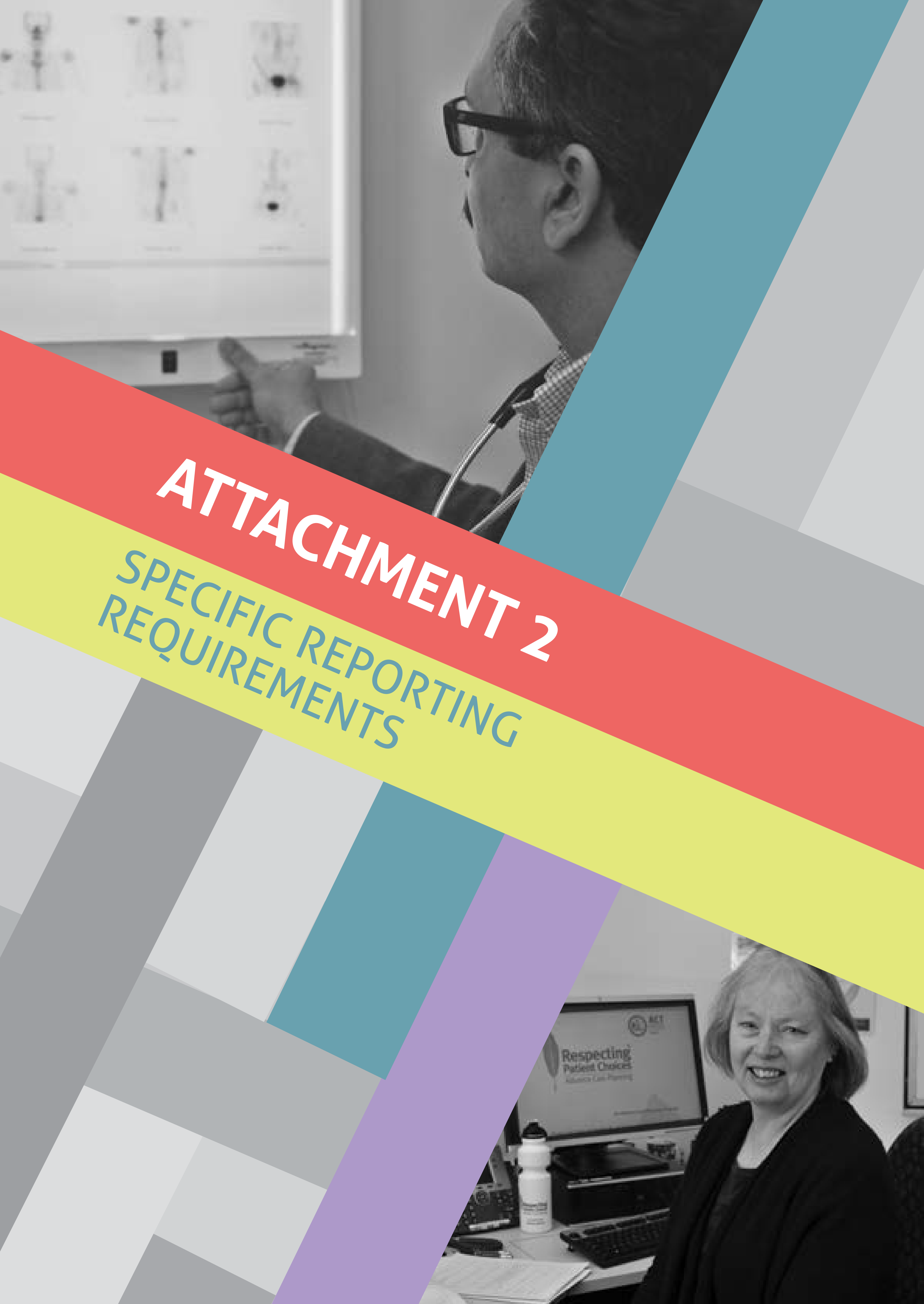
Elizabeth Croft
Chair
July 2014


ATTACHMENT 2
SPECIFIC REPORTING REQUIREMENTS
Respecting Patient Choices
Advance Care Planning

TOBACCO ACT 1927

During 2013–14, the Office of Regulatory Services did not conduct any tobacco compliance tests. As a result, no contraventions to section 14 (supply of smoking product to under 18-year-olds) were detected and no action was taken.*

*Information provided by the Justice and Community Safety Directorate. This information will be reported in the Justice and Community Safety Directorate Annual Report in future years.

ATTACHMENT 3

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** A national Medical Radiation Scientists Board was established for the entire year of 2013–14. Therefore, an ACT-based board annual report is no longer produced.*

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